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Lawyers Service Newsletter

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Editorial

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It is not long now until the clocks go back, and we can hopefully start to enjoy some kinder weather, but whatever the weather the ACNC will be going ahead in Leeds on 20th – 22nd March, we look forward to welcoming you all then.

The last few months have seen further challenges to clinical negligence practice. Kate Lumbers, barrister at 7 Bedford Row, considers ***"The landmark decision of the Supreme Court on Secondary Victim claims"***. The Supreme Court decision to strike out these claims because they had no prospect of succeeding will have considerable consequences for claimant clinical negligence lawyers and their clients across the country.

The government has now confirmed that clinical negligence claims with a value of £25,000 - £100,000 will only be allocated to the Intermediate Track if there has been a full admission of liability and causation in the pre action protocol period – see p5, (vi). However, we still do not know if disbursement costs are to be included in the FRC cost figures proposed or are in addition to it.

Similarly, having been advised back in September that a FRC regime for low value clinical negligence claims (up to £25,000) would be introduced on 6th April 2024, there has been little follow up. We know from the Civil Procedure Rules Committee (CPRC) minutes (October 2023) that they anticipated difficulties in meeting this timescale and while CPRC appointed a specialist subcommittee to draft the necessary Civil Procedure Rules they have still not reported. The lack of information and detail simply adds to the existing uncertainty and makes it difficult for firms to plan for the future.

AvMA's perspective is that if FRC is introduced as expected then there will be a great many more injured patients who will struggle to find legal representation or redress from anywhere other than the complaints process. The Parliamentary Health Service Ombudsman (PHSO) is already creaking under the weight of the existing level of public dissatisfaction with the NHS complaints process, so none of this bodes well for the future.

Given all that, perhaps the publication of the Patient Safety Commissioner, Henrietta Hughes' report options for redress for those harmed by valproate

and pelvic mesh claims should be seen as a potential way forward. Or do suggestions that such a scheme should be funded by *"the government, industry, or a combination of the two"* (p11) and its reference to general eligibility criteria and identifying *"qualifying injury"* feel a little like a gentle creep towards a no-fault compensation approach to litigation? Perhaps it was coincidental that The Times' "**Health Commissions 10 Recommendations to Save the NHS**" was published on 4th February, only three days before the Hughes Report. Point 5 is "**Introduce no-blame compensation for medical errors**".

Claimant practitioners are not the only ones feeling the pressure, Chris Bright KC of No 5 Chambers writes ***"2023: A Bad Year for (some) Part 35 Experts"*** and while Chris' article brings some welcome comic relief (I particularly liked the *"about as useful as an ashtray on a motorbike"* analogy) it is nonetheless a very important topic.

The assessment of the merits of any clinical negligence case pivot on the expert evidence, a failure to test that evidence will result in expensive mistakes being made. In fact, this topic is so important that we welcome Bella Webb from Old Square Chambers' contribution to this topic in ***"Traps for the unwary – The pitfalls and management of expert evidence"***. Bella's article carefully considers how best to manage the expert and offers some valuable advice on steps which instructing solicitors should take to get the most out of them.

Complex issues of causation are all too common in birth injury cases. James Maverick, barrister at St John's Chambers looks at the case of *CDE (By her mother and litigation friend, FGD) v Surrey & Sussex Health Care NHS Trust* [2023] EWCA 1330 and in unpicking that difficult case asks: ***"Does every minute count?"***. While the answer to that question appears to be, yes on factual causation, the answer in relation to medical causation is less clear.

Material contribution and causation is another complex area of law which clinical negligence practitioners have to grapple with. Thomas Herbert of Ropewalk Chambers, explores this more fully in ***"Holmes v Poeton Holdings ltd: A step forward for Claimants – But Questions Remain"***.

While the case of *Maguire v HM Senior Coroner Blackpool & Fylde & another* [2023] UKSC 20 confirms that the application of Article 2 claims in wrongful deaths in hospital is now very limited, Daniell Neill from Old Square Chambers reminds us in ***"Just satisfaction: Clinical negligence, Article 2 ECHR and the Human Rights Act 1998"*** that it is still possible.

I opened this editorial with reference to the case of *Paul, Polmear and others*, while the decision is disappointing it does at least offer some much-needed clarity on claims for secondary victims. I close with another case offering some clarity and recommend Emily Slocombe of Old Square Chambers article ***"Limitation in Fatal Accident claims – a review after Shaw v Maguire"***. Emily draws attention to the fact that Master Cooke recently found that the Court's discretion under Section 33 Limitation Act 1980 can be exercised in fatal accident claims where limitation expired prior to the deceased's death.

Our thanks to past and current contributors of AvMA's Lawyer Service Newsletter, we encourage anyone who is thinking of writing an article to contact **Norika@avma.org.uk** to come forward and let us have your suggestions. The next edition of the Newsletter will be published in June so there is plenty of time to give this some thought.

Finally, are you interested in volunteering for **AvMA's helpline**? If so, please see this edition of the Newsletter for our Helpline Development Officer, Gill Savage's shout out which includes details of what is involved and how to apply. We look forward to seeing you in Leeds this week.

Best wishes

Considering the landmark decision of the Supreme Court on Secondary Victim claims

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Introduction

In clinical negligence cases, it is very common for a misdiagnosis to occur at one time and for the death or serious injury to the patient caused by that misdiagnosis to occur much later. If, at the later date, the death or serious injury is witnessed by a close relative causing psychiatric injury, is the Defendant liable to that secondary victim? This question has long troubled the courts, producing seemingly inconsistent results.

On 11 January 2024 the Supreme Court handed down judgement in the conjoined appeals of *Paul and Another (Appellants) v Royal Wolverhampton NHS Trust (Respondent), Polmear and Another (Appellants) v Royal Cornwall Hospitals NHS Trust, Purchase (Appellant) v Ahmed (Respondent)* [2024] UKSC 1, giving much-needed and long-awaited clarity.

In each of the cases the defendant is alleged to have failed to diagnose the primary victim's life-threatening condition. Some time after that negligent omission, the primary victim suffered a traumatic death. In two of the cases (*Paul* and *Polmear*), the shocking death occurred in the presence of the close relatives, causing them psychiatric injury. In the case of *Purchase*, the close relative came upon the primary victim immediately after her death, again causing her (the mother in that case) psychiatric injury.

On 13 January 2022 the Court of the Appeal, with Sir Geoffrey Vos, Master of the Rolls giving judgement, considered that he was bound by the Court of Appeal in *Novo*, where Dyson LJ, having considered all the authorities, concluded where the negligence and the horrifying event were distinct in time, the defendant was not liable to the Claimant. However, both he and Underhill LJ expressed reservations as to whether *Novo* correctly determined the limitation on liability to secondary victims and permission was given to appeal to the Supreme Court to consider these issues.

The Judgement of the Supreme Court

Lord Leggatt and Lady Rose gave judgement, dismissing each of the appeals, by a majority of six to one, with Lord Burrows dissenting.

It was argued on behalf of the Respondents, and accepted by the Supreme Court, that the secondary victim had to witness an accident or a traumatic event external to the primary victim, in order for there to be recoverability. In the words of Lord Carloway: *"the key feature of these exceptional cases, in which recovery is permitted, is that the claimant is present at the scene of an accident or its immediate aftermath. There must be an accident to be witnessed"*.

The Court defined an accident as an unexpected and unintended event which caused injury (or risk of injury) by violent external means to one or more of the primary victims.

In approving the reasoning in *Taylor v A Novo (UK) Ltd* [2013] EWCA Civ [2014] QB 150 the Court considered that the requirement for an accident had the advantage. Firstly, it was normally a discrete event in the ordinary sense of the word: *'Whether someone was present at the scene and whether they directly perceived an accident are in most cases questions which admit of a clear and straightforward answer. These criteria for determining whether a person is eligible to claim compensation as a secondary victim therefore have the great merit of providing legal certainty.'* Secondly, witnessing an accident involving a close family member is likely to be disturbing and upsetting. Thirdly, it is difficult or arbitrary to distinguish between the primary and secondary victims in such circumstances.

The Court concluded that secondary victim claims are an exception to the rule that the law opposes granting remedies to third parties for the effect of injuries to other people, but, *'there is a rough and ready logic in limiting recovery by secondary victims to individuals who were present at the scene, witnessed the accident and have a close tie of love and affection with the primary victim.*

These limitations are justified, not by any theory that illness induced by direct perception is more inherently worthy of compensation than illness induced by other means; but rather by the need to restrict the class of eligible claimants to those who are most closely and directly connected to the accident which the defendant has negligently caused and to apply restrictions which are reasonably straightforward, certain and comprehensible to the ordinary person'.

It followed therefore that *Walters* had been wrongly decided, and *Ronyane*, *Shorter* and *Sion* had been correctly decided, but on the wrong basis and should have been dismissed for the simple reason that the Claimant did not witness an accident, or its aftermath.

The Court examined the question of whether the necessary proximity exists between a medical practitioner and a relative of a primary victim in the case of a medical mishap, such that a duty ought to be imposed. There are circumstances in the which the duty of care owed by a medical practitioner may extend beyond the health of their patient to include other people (the Court gave examples at paragraph 134), but stated at 138, *'We are not able to accept that the responsibilities of a medical practitioner, and the purposes for which care is provided, extend to protecting members of the patient's close family from exposure to the traumatic experience of witnessing the death or manifestation of disease or injury in their relative. To impose such a responsibility on hospital and doctors would go beyond what, in the current state of our society, is reasonably regarded as the nature and scope of their role.'*

Whilst, at paragraph 123, it did not entirely close the door to secondary victims in clinical negligence claims, the Court left the question of when they might occur on the facts to those cases.

The Court took the opportunity to clarify two matters. Firstly, in order to succeed in a secondary victim claim, there was no need to prove that the psychiatric illness was caused by a '*sudden shock*' or a '*sudden appreciation of a horrifying event*'. Such notions referenced an outdated theory of the aetiology of psychiatric illness and did not establish an additional restriction on the recovery of damages. Secondly, a Claimant is not required to prove that the event that gave rise to the psychiatric illness was '*horrifying*'. Although said to involve an objective test, it is unavoidably subjective and required a judge to engage in an impossible and invidious exercise comparing a claimant's experience to determine whether it was more or less horrifying than another.

Conclusion

• The close relative must have been present at the scene of an accident or its immediate aftermath and witnessed the traumatic event external to the primary victim, in order to succeed.

• The Court defined an accident as an unexpected and unintended event which caused injury (or risk of injury) by violent external means to one or more of the primary victims.

• The circumstances in which secondary victims claims in clinical negligence are likely to succeed are now very limited.

• This judgement, whilst disappointing for claimants and their lawyers, brings some much- needed clarity to the law as it applies to clinical negligence claims, which since *Walters* has been unclear.

• Whilst the door has not entirely closed to secondary victim claims, it has been pushed quite close-to. It is clear that an accident in a clinical setting cannot be an omission, it must be a commission and the accident or its immediate aftermath must be witnessed. There may be some limited circumstances where a relative witnesses such an accident: perhaps a fall from a hospital bed, or the repeated erroneous application of forceps in the context of a traumatic delivery, which might give rise to liability, but these cases are likely to be rare and hard-fought by defendants.

• In relation to personal injury claims, not involving negligence by clinical practitioners, the court has clarified that:

  - The length of time between the negligence and the accident is immaterial;
  - There is no requirement that the events be objectively '*horrifying*'; and
  - There is no need to prove that the psychiatric injury was caused by a sudden shock.

2023: A Bad Year for (some) Part 35 Experts

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Throughout 2023 there was a flurry of cases in which Part 35 experts were the subject of strong judicial criticism. The judgments may therefore be of passing interest in distilling the principles and approach that should avoid your experts suffering the same fate.

Medico-legal experts are paid to stick their heads above the parapet. In doing so, they are (or should be) fully aware of their duty to the Court as set out in paragraphs 2.1-2.5 of Practice Direction 35 as amplified by paragraphs 9-15 and 48-60 of the Guidance issued by the Civil Justice Council in August 2014. They sign a formal declaration that they understand that duty and have complied with it. Experts know (or should know) that, if the matter proceeds to trial, at best a judge will need to find a basis, even courteously, to prefer the views of one expert over those of another. Some will appreciate that, at worst and if judicial brickbats start to fly, Kevlar helmets may be the order of the day. Few however would expect the sort of criticism reflected in the 2023 cases.

For example, in his judgment of 13th January in the case *Snow v Royal United Hospitals Bath NHSFT* [2023] EWHC 42 (KB), HHJ Roberts gave Mr Luke Meleagros, Consultant Colorectal Surgeon, what might accurately be described as a thorough judicial 'kicking'. The judge described him as "*flying a kite*" in relation to his argument that the need for training, mentoring and supervision in and of the relevant surgical procedure only came about via the "*watershed moment*" of a particular clinical paper which, as the judge observed, Mr Meleagros had read for the first time only during the trial (paragraphs 82-84). His argument was therefore "*unsustainable and damaged his credibility*". Other views put "*a misleading spin on the NICE guidance*" (paragraph 110 (i)-(v)). In overall terms the judge found Mr Meleagros "*to lack the independence required of an expert and to be unreliable*" (paragraph 171(i)-(iv)). In his view Mr Meleagros had misunderstood his duties as an expert to obtain and read relevant medical literature, in not answering questions put to him and by seeking to defend reporting errors before then admitting them (paragraphs 172-177).

So, there it is - a neat experts' template of how **not** to do it.

In July in the case of *Jayden Astley (by his father and litigation friend Craig Astley) v Lancashire Teaching Hospitals NHSFT* [2023] EWHC 1921 (KB), the midwifery expert Linda Crocker-Eakins was for the defendant Trust and, to say the least, Mr Justice Spencer was not impressed. Bizarrely, in her final report for trial she addressed the initial allegations of breach of duty in the Letter of Claim, rather than the different and refined allegations in the Particulars (paragraph 28 (i)). Secondly and to the Judge's greater concern, "*...she failed to address adequately what was clearly the most important feature of the Claimant's case, namely the inconsistency between the fetal heart rate recordings from 15:05 and the agreed paediatric evidence that, during this period, the baby would have been severely bradycardic*" (paragraphs 28 (ii)-31), although the outcome of the case ultimately turned on the factual midwifery evidence and obstetric opinion (paragraphs 45-49).

Again in July, Mr Justice Ritchie handed down a CP quantum judgment in *CCC v Sheffield Teaching Hospitals NHSFT* [2023] EWHC 1770 (KB) (a 'must read' for those of us involved in CP/neonatal injury work), which contained criticism of the defendant's paediatric neurologist Dr. Peter Baxter, whom the judge noted had been employed by the defendant trust in the past and retained a close working relationship with his ex-colleagues there. Dr Baxter could not explain the absence of some important points from his main reports and why he had placed an undue emphasis on others in the experts' joint statement (see paragraphs 79-82). The judge "*found his answer in relation to these questions deeply unimpressive and formed the conclusion that he was being intentionally selective...*" and, in relation to another opinion expressed, said "*I gained the impression that he had not done a sufficient read through the medical notes, physiotherapy*

notes and indeed the eye therapy notes to reach that conclusion" (paragraph 80).

It is also worth noting that, as well as identifying wide ranging points of principle in the assessment of damages (paragraphs 103-141), under the headings *"Assessment of…"*, the trial judge set out his reasons for preferring one or other of the competing experts in care, OT, physiotherapy and accommodation (see paragraphs 89-90, 96, 101 and 161-162 respectively). In relation to the latter (Steven Docker vs David Cowan), the judge found differences in their approach in that, in his view, "*Mr Docker was driven by detail and principle and hard work*" but "*Mr Cowan's approach was remote, internet based, rather laid back and notional*" (paragraph 159). More worryingly, Mr Cowan's statement that a hydrotherapy pool was not recommended by the Defendant's therapists was not true or accurate and, as he himself accepted, *"was* "crystal ball gazing" *based on his knowledge from other cases"*, such that the judge concluded that Mr Cowan "*was pre-judging or fabricating evidence based on a hunch outside his field of expertise*" (paragraph 160), with, in addition, Mr Cowan's "*lack of detail and superficiality*" leading to him largely preferring the evidence of Mr Docker (paragraph 161).

In the case of *Parsons v Isle of Wight NHS Trust* [2023] EWHC 3115 (KB), the doubly unfortunate Ms Parsons was diagnosed with bowel cancer and then suffered significant intra-operative damage to her spinal cord during right hemi-colectomy when the epidural anaesthetic trocar travelled straight through the spinal-cord and out of the other side. In his judgment of 5th December 2023 Mr Justice Ritchie (him again) set out the guidance upon the duties and responsibilities of expert witnesses in civil cases at paragraph 81 of the judgment of Creswell J in the *"Ikarian Reefer": National Justice Compania Naviera SA v Prudential Assurance Co Ltd* [1993] 2 Lloyd's Rep 68 and the subsequent guidance of Fraser J at paragraph 237 of the judgment in *Imperial Chemical v Merit Merrell* [2018] EWHC 1577 (see paragraphs 17 and 18).

Mr Justice Ritchie found that the approach of Dr McCrirrick, the anaesthetic expert for the defendant trust, in substantially focusing on the evidence of the defendant's treating anaesthetist, *"rather disclosed… his thought process because it did not identify the issue, which was a factual one for the Court"*, but instead *"he presumed to determine that issue by accepting Doctor Rice's account despite her making no medical record. I refer back to the expert's duties set out above in the Ikarian Reefer"* (paragraph 79). In relation to the allegation of negligent technique, the judge found Doctor McCrirrick's contention that nerve injury does not in itself imply negligent care and his assertion that the claimant had provided no evidence to indicate a failure to exercise reasonable care to be *"a remarkable approach by an expert who was being asked to advise the Court* (the judge's emphasis) *on the evidence and the medical notes about whether there has been a breach of duty in relation to the technical standard required by professionals when carrying out epidurals"* (paragraph 80). In his view it was not the expert's job to assess the evidential sufficiency of the claimant's case of negligent technique, as opposed to advising on whether, in his opinion, there was a breach of duty on such technique. Further, under judicial questioning as to why he assumed that Doctor Rice's evidence was correct, Dr McCrirrick "*apologised for stepping outside his field of expertise and adopting the judicial function*" (see the end of paragraph 83). Ouch!

In his assessment of the expert anaesthetists the judge, perhaps somewhat charitably in the case of Dr McCrirrick, considered that *"both expert anaesthetists were doing their best in the witness box to assist the Court*", before largely preferring the evidence of the claimant's expert Professor Hardman and ultimately finding that a failure to obtain the claimant's informed consent was causative of the spinal cord injury and entering judgement for her (paragraphs 109-113).

Perhaps saving the best for last, in his judgment of 8th December 2023 in the case of *Beatty v Lewisham and Greenwich NHS Trust* [2023] EWHC 3163 (KB), Mr Justice Jay considered the factual and vascular expert evidence in relation to an alleged failure to diagnose an embolism leading to a BKA. Having reviewed the vascular expert evidence of Mr John Scurr (paragraphs 43-55), he extensively criticised Mr Scurr as not being *"a satisfactory witness"* in that he was "*combative*" in answering some of the defendant's counsel's *"perfectly fair and reasonable questions, and betrayed at several points in his evidence a degree of partisanship which came close to advocacy"* (paragraph 75). When asked about a previous case in which he was also the subject of judicial criticism for making mistakes and failing to justify his conclusions (paragraph 52), in a jaw-dropping display of hubris Mr Scurr explained to the court that the trial judge in that case had "*failed to understand the evidence*", and, when pressed, said that it was "*one of the few cases I was involved in we didn't win*" (paragraph 75)! Undeterred, Mr Justice Jay identified mistakes by Mr Scurr of the sort that "*should not be made in expert reports*" and, more importantly, that he made no or no adequate "*attempt to identify the key issue… or to supply any reasoning directed to the conclusion that the standard of care was inadequate*" (paragraph 76).

In particular, the judge considered that Mr Scurr did not establish "*a solid platform*" in his report for his conclusion that a CT angiogram was mandatory (paragraph 76), and that there was "*the same looseness of language*" in the joint statement, in that his acceptance of the adjective "*optimal*" was not a synonym for "*mandatory*" i.e. Bolam negligent. According to the judge however, "*...perhaps Mr Scurr's most egregious shortcoming was to reach an opinion in his main* (i.e. final trial) *report without properly analysing* (the treating vascular surgeon's) *witness statement*", as it emerged in cross-examination "*that he wrote his report before reading that statement but did not sign it off until he had done so*", saying that there "*was nothing in it to cause him to change his mind*" (paragraph 77).

Further, Mr Scurr's answers in the joint statement were "*unacceptably terse*" and contrary to an expert's duty under the CPR "*to set out the reasoning for his conclusions*" (paragraph 78), and in the judge's view it "*...was only in cross-examination that Mr Scurr began to develop a reasoned argument to support the proposition that CT angiography was mandatory*" (paragraph 79), which argument the judge ultimately rejected in, sadly but unsurprisingly, dismissing the claim.

So, some of the hard lessons to be learned in 2023? Know your duties as an expert and stick to them. Address the central issues and the entirety of the clinical and witness evidence fairly and non-selectively before reaching a settled view. Set out the reasoning for your conclusions. Don't fly a theoretical kite or attempt to spin the NICE guidance and/or clinical literature - at any time but certainly not at trial. Listen to and answer questions with care and courtesy. Stay within your area of expertise and defer where appropriate. Leave the trial judge to determine issues of fact, evidential sufficiency, and negligence. And, perhaps most importantly, a combative, partisan, arrogant expert is about as useful as an ashtray on a motorbike.

Ultimately however, these judgments speak for themselves, such that, to misapply the language of Mr Justice Jay in the case of Beatty, at least a brief review of them would be "*optimal*" if not "*mandatory*" for any lawyer or medico-legal expert with an interest in how **not** to give Part 35 expert evidence in clinical negligence cases.

Chris Bright KC is Head of the Clinical Negligence Group of No5 Barristers' Chambers, which in November 2023 was awarded the Chambers UK Bar Awards National Clinical Negligence Set of the Year.

Traps for the unwary - The pitfalls and management of expert evidence

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Medical expert evidence plays a central role in most clinical negligence claims. It is of course required that, where any allegation of professional negligence is pleaded, the allegations must be supported in writing by a relevant professional with the necessary expertise.

The court will rely upon the evidence of experts when determining issues of breach of duty, causation and condition and prognosis and the view that the judge at trial takes of the expert evidence is frequently the difference between success and failure at court. As such, medicolegal expert evidence assumes a significance far greater in this field than in many other areas of the law and that makes it all the more important to ensure that the expert evidence is not just as cogent as it can be, but that the experts themselves are appropriate, reliable, credible, persuasive and well versed in the requirements of acting as a medico-legal expert.

It can be easy to forget the basic premise upon which expert evidence is given in civil proceedings through the desire to instruct an expert who will likely be most supportive of your client's case. CPR 35.3 is the starting point and provides that:

"(1) It is the duty of experts to help the court on matters within their expertise.

(2) This duty overrides any obligation to the person from whom experts have received instructions or by whom they are paid...."

Moreover, CPR 35.10 in conjunction with PD 35 provides strict requirements for the content of any expert report and the general requirements of expert evidence. In particular:

(a) Expert evidence should be the independent product of the expert uninfluenced by the pressures of litigation.

(b) Experts should assist the court by providing objective, unbiased opinions on matters within their expertise and should not assume the role of an advocate.

(c) Experts should consider all material facts, including those which might detract from their opinions.

(d) Experts should make it clear when a question or issue falls outside their expertise and when they cannot reach a definite opinion – ie: if they lack sufficient information.

(e) If, after completing their report, an expert's view changes on any material matter, that should be communicated to **all** parties without delay and when appropriate to the court.

The report must:

(a) Be addressed to the court and not the instructing party.

(b) Include a statement at the end to the effect that the expert has understood and complied with their duty to the court and includes a statement of truth in the form set out in PD35.

(c) State the substance of all material instructions, written or oral on the basis of which the report is written.

(d) Give details of the expert's qualifications and details of any literature or other material relied upon.

(e) State the substance of all facts and instructions material to the opinions expressed.

(f) Make clear which facts stated are within the expert's own knowledge.

(g) Say who carried out any examination, test etc: which the expert has used when writing the report, and include details of that person's qualifications and whether the expert supervised the test.

(h) Where there is a range of opinion on the matters dealt with in the report they must summarise that range, give reasons for their own opinion and summarise the conclusions reached. If the opinion is subject to a qualification that must be stated.

Many of those more basic provisions are often overlooked and can lead to unnecessary and unhelpful criticism at trial. As such, it is imperative that the more substantive considerations of the evidential content of the report aside, one should always use the practice direction as a checklist to ensure that the report is compliant. I have little doubt that every clinical negligence practitioner will have dealt with many a report where the content is good but the details of qualifications/CV, statement of instructions, literature relied upon or even the statement of truth are missing.

There are a plethora of cases dealing with criticisms of expert evidence. In more recent years, a few have highlighted some of the pitfalls of which practitioners should be wary. In *Robinson v (1) Liverpool University Hospital NHS Foundation Trust (1) Dr Mercier* (2021) 9WLUK 400, a first instance judgement of Recorder Abigail Hudson at Liverpool County Court, the court initially made a third-party costs order against the Claimant's expert dental practitioner after the Claimant withdrew her claim at the conclusion of his evidence. The claim related to dental care afforded to the Claimant after referral by her dentist for extraction of her UL7 (and two lower molars) under general anaesthetic at hospital. The surgery was carried out and various allegations of negligence were made in relation to the actions of the oral surgeon conducting the extraction, principally relating to the decision to leave the UL7 in situ.

Recorder Hudson granted the Defendant's application for a third-party costs order. Cogent criticism was made of the expert in some of the strongest language I have seen. In essence, the Defendant asserted and the judge accepted that as a general dental practitioner it should have been clear to him that he could not comment upon whether an oral surgeon had made errors which could be deemed negligent on applying the *Bolam* test. Furthermore, throughout his evidence at court, he had failed to make any reference to the differences between his role and that of an oral and maxillofacial surgeon, and had failed to even address his mind to whether there were differences to which he could not speak. The Recorder therefore considered that he had shown a flagrant and reckless disregard for his duties to the court and had done so from the outset in preparing a report on subject matter in which he had no expertise.

It should be noted that the third-party costs order was successfully appealed on 11th January 2023 before Mr Justice Sweeting. In short, the judge did not consider that the case reached the high threshold of establishing that the expert had demonstrated a flagrant or reckless disregard of his duty to the court. However, in reaching that decision Mr Justice Sweeting did not agree that the expert had stepped outside the boundaries of his expertise. He did not need to be a maxillofacial surgeon to comment upon what should have been done based upon an examination which the surgeon should have carried out prior to extraction, or indeed to comment upon the viability of the tooth. Had it not been for the Claimant's fear of dental procedures the procedure would have been performed by a general dentist who could therefore opine about the performance of extractions, the taking and reporting of x-rays and assessment of tooth viability.

The appeal judgement notwithstanding, the case brings home the importance of assessing at the outset which discipline(s) of expert evidence are required to establish, or as a Defendant, to respond on breach of duty and causation. In doing so the nature of the injury will need to be carefully considered as will the expertise of the medics whose actions are under scrutiny. Even if the expert in *Robinson* was not a wholly inappropriate expert for the purposes of reaching the high threshold for making a third-party costs order, it must still be questioned whether he was the **most** appropriate expert to comment upon all of the issues which required consideration. Unnecessary weakening of the claim or distraction from the substantive issues is to be avoided. As such, at the outset of any case, practitioners should undertake a careful review of the records and ascertain the expertise of the medics whose actions are in question. Where there are multiple different disciplines expert reports may be required from more than one expert, in which case an ordered approach to obtaining evidence with an eye to causation and proportionality should be undertaken.

It should nonetheless be noted that the criticisms made of the expert in *Robinson* were not limited to whether he strayed beyond his expertise. The appeal court commented only in bland terms upon some of those other issues. The issues upon which criticism was focused included:

(i) That he had advanced arguments in evidence which were not in his report and had not explained adequately the basis for his opinions.

(ii) His report reached unsustainable conclusions upon the evidence.

(iii) He had seen a radiograph from September 2015 only on the day of the joint experts' meeting but had not gone back to reconsider his conclusions in light of it. It was suggested by the Recorder that he had stuck "*intransigently to his position*" and that he had inappropriately reached conclusions based upon evidence which he had neither

seen nor requested and upon the basis of incomplete evidence.

(iv) He demonstrated either a *"sheer unwillingness to consider other propositions or a fundamental lack of understanding of the legal test..."* with an opinion that *"fluctuates to whatever he feels will win the case...."*

As such, once you have determined what expertise you require, the thorny question of who to instruct within that field arises and in doing so, one is looking for an expert who is not only hopefully going to be helpful for your client's case substantively, but who is reliable and sensible with a good understanding of the legal tests underpinning the evidence they will be required to give. That was highlighted in *Robinson* (above) and also in *Thimmaya v Lancashire NHS Foundation Trust and Mr Jamil (30/1/20 Manchester County Court)* in which HHJ Claire Evans awarded a third party costs order against the Claimant's expert Spinal surgeon following a clinical negligence trial which was discontinued after the expert's evidence.

The facts of the case are unimportant for present purposes. The critical issue was that the expert was suffering from cognitive and memory issues which rendered him unfit to give evidence. He was unable to recall or explain the *Bolam* or *Bolitho* tests for negligence in spite of repeated questioning. In the circumstances he should not have continued to act as an expert and had not complied with his duties to the court. That notwithstanding the judge also commented, albeit not considering the same to amount to an exceptional failing for the purposes of making a wasted costs order, that the expert:

> *"... was not, on my reading of his reports and the file notes of the Claimant's solicitors, a very good expert. Whilst he did not have a great deal of expertise in carrying out this particular operation, having only done in twice (and then under supervision), he explained to the Claimant's solicitors that he was able to give an opinion as he had treated a lot of patients recovering from this procedure...."*

Whilst it can be tempting to opt for an expert who is known to do a very high proportion of only Claimant or Defendant work, that is not always helpful. Some decisions about who to instruct may be governed to a degree by time constraints and cost, but recommendation and personal (preferably recent) experience will always be the best guides. Consider whether you have observed the expert's work not just on paper but in conference and court. Is the expert still in clinical practise (or were they at the time of the alleged breach(es))? Do you need someone with a sub-specialism within the relevant discipline? It is always worth looking at recent case reports to ascertain whether experts have been commended, or found wanting at trial and ask around to see if your colleagues have experience of your proposed experts. If multiple experts are needed, it can be helpful to instruct experts who you know have worked well together before. Whilst it may sound obvious, always take time to check for any conflicts or links to any of the parties. In *Arrassey Properties Ltd v Nelsons Solicitors (unreported), 15 July 2022, (Central London County Court)*, albeit a professional negligence claim in the setting of a conveyancing matter, the court entirely rejected the evidence of an expert valuer who had not disclosed a conflict of interest and displayed little understanding of his duties as an expert. Similarly, in *EXP v Barker* (2015) EWHC 1289, the Defendant's lawyers used an expert witness personally recommended by the Defendant who at trial, was shown to be a colleague of the Defendant who had both trained and worked with him. It is for Instructing lawyers to ensure that the experts and their clients understand the relevant rules and requirements.

Hopefully, with a well-chosen expert, potential problems will be minimised. Nonetheless, once the report is in, it is imperative to test it in conference, and in clinical negligence claims in particular, it is sensible to start with an early conference, before the claim is pleaded, as well as before / after exchange of evidence. It is important not only to check compliance with the basic CPR requirements set out above, but to examine in depth the conclusions reached and the reasons for them against any literature (which should be requested and read in detail – it is amazing how many times literature does not in fact say what the expert says it does!).

Check the expert's understanding of the legal test and that it is properly formulated in the report. Ensure that the expert has and has considered and referred to all material documents (and been updated accordingly after ie: a defence has been served, where new evidence such as witness evidence or additional documents become available – for which see *Arksey v Cambridge University Hospitals NHS Foundation Trust* (2019) EWHC 1276 (QB) in which the Claimant's served neurosurgical reports were extraordinarily prepared prior to the service of proceedings and without the expert having reviewed the defence and amended defence or the Defendant's witness evidence). Take time to check with the expert whether they consider that any expected records or other documents are missing and get those gaps plugged early. Ensure that they have dealt upfront with any issues which might be considered detrimental to the case presented, and that any relevant range of opinion is addressed. Check that the expert has not strayed beyond their expertise. Look for excessive

partisanship or over rigidity. Dealing with some of these matters at the earliest stage and before identification and necessary disclosure of expert evidence can of course, allow any deficiencies to be remedied early and maximise the chances of successful settlement or success at trial. Take care therefore to consider the appropriate frequency and timing of expert conference when budgeting the case.

The cases of *Scarcliffe v Brampton Valley Group Ltd* (2023) EWHC 1565 (KB) and *Beatty v Lewisham and Greenwich NHS Trust* (2023) EWHC 3163 (KB) illustrate the pitfalls of omitting these steps. In *Scarcliffe*, it was the Claimant's care expert who came under fire. Mr Justice Cotter stated:

"Ms Lewis, who gave expert evidence as to care will have found it a very uncomfortable experience indeed as obvious mistakes and omissions were pointed out. Significant parts of her evidence were unsatisfactory and/or ill thought through. I find it very concerning indeed that such evidence underpinned a very large, and when properly tested, in part clearly unsupportable claim within the schedules. Worryingly it is not the first time that I have had very real concerns about the approach to care evidence in a high value claim…The analysis of the complex issues in this case was not sufficiently thorough and matters which obviously required further investigation had not been followed up…."

Whilst the Defendant's expert was more careful generally, she also displayed a partisan approach on one issue. Mr Justice Cotter went on to refer to the case of *Muyepa -v-Ministry of Defence* [2022] EWHC 2648 (KB) in which he stated:

*"Experts should constantly remind themselves throughout the litigation process that they are not part of the Claimant's or Defendant's "*team*" with their role being the securing and maximising, or avoiding or minimising, a claim for damages…"*

In the *Beatty* case, a clinical negligence claim in which the Claimant alleged a failure to diagnose an embolism which resulted in below knee amputation, Mr Justice Jay found the Claimant's vascular expert to be unsatisfactory. He noted:

*"He was combative in answering some of Ms Hughes' perfectly fair and reasonable questions, and betrayed at several points in his evidence a degree of partisanship which came close to advocacy…Further, there are mistakes…Mistakes such as these should not be made in expert reports… More importantly, nowhere… do we see any attempt to identify the key issue in this case or to supply any reasoning directed to the conclusion that the standard of care was inadequate… The adjective "*optimal*" is not a synonym for "*mandatory*"…most egregious shortcoming was to reach an opinion in his main report without properly analysing Mr Aston's witness statement… answers to Qs. 13 and 14 in the joint agenda were unacceptably terse. An expert is required under the CPR to set out the reasoning for his conclusions. This obligation exists even if the reasons seem blindingly obvious to the maker of the opinion…."*

The expert was even referred to a previous case in which his evidence had been criticised, to which he responded that the judge did not understand the evidence. Never helpful.

After thoroughly testing ones' experts, it is crucial to prepare properly for the joint statements. Ensure that the expert is clear on the issues and has familiarised themselves again with the relevant tests, their reports, and all of the material evidence. Ensure that nothing is missing and that they are aware of the need to fully explain the reasoning for conclusions. Where appropriate provide a clear agenda, but be careful not to seek to influence the expert. In *Andrews v Kronospan Ltd* (2022) EWHC 479 (QB), a group litigation nuisance case relating to the emission of dust, noise and odours from a wood manufacturing plant, the court revoked permission for the Claimants to rely on their expert's evidence, where he had been in continuous contact with their solicitors over the content of the joint discussions and the draft joint statement, with them offering him advice and suggestions on repeated occasions, without the Defendant's knowledge.

If and when one finally gets to trial, take time to consider how best to deal with the opposing parties' expert evidence. Look for the very failings in compliance with the CPR, partisanship, failure to deal with all of the evidence or prior criticism that one has already tried to exclude in one's own experts. Don't jump too soon – in *Fawcett & Ors v TUI UK Ltd* (2023) EWHC 400 (KB) the Claimant's attempt to exclude the Defendant's expert evidence prior to trial upon the basis that he did not have the appropriate expertise and lacked impartiality, was unsuccessful. Mr Dexter Dias KC considered that such matters were for the trial judge to consider after hearing evidence. And yet, don't be tempted (although unlikely in a clinical negligence case) to leave criticism of an expert to closing submissions without serving contrary expert evidence or cross examining the opposing expert at trial where one considers an opponent's report to be seriously deficient. In *Griffiths v TUI UK Ltd* (2023) 3 WLR 1204 the Supreme Court confirmed the general civil rule that a party must challenge by cross examination the evidence

of any witness, factual or expert, of the opposing party on a material point which they claim should not be accepted. That rule was there to ensure fairness. There were some circumstances where that rule might be relaxed including where there was a bold assertion of opinion in an expert's report without any reasoning to support it – a bare assertion, or where the expert had been given a sufficient opportunity to respond to criticism of, or otherwise clarify their report. The defined exceptions should be read in full, but it seems to the author that it would be a brave or perhaps foolish lawyer to risk not responding to opposing expert evidence in most clinical negligence trials.

Finally, at trial, and where possible, get your experts to hear not only the other side's experts at least of equivalent discipline, but also the witness evidence of the relevant issues. At the very least ensure that the expert has a full note of any such evidence (without comment) in advance of them giving their own evidence.

It is to be hoped that with comprehensive management throughout the life of the claim, your experts will be the help that you and the court require, rather than the hindrance that poor management can lead to.

Does every minute count?

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Case Note: *CDE (by her mother & litigation friend, FGD) v Surrey & Sussex Health Care NHS Trust* [2023] EWCA 1330

Overview

The case of *CDE* is important reading for all clinical negligence practitioners.

Both the first instance judgment of Ritchie J ([2022] EWHC 2590) and the Court of Appeal judgment handed down in November 2023 address complex issues of causation that arise in birth injury cases but also corollary matters relating to pleadings and the presentation of witness evidence.

The Claimant had suffered acute profound hypoxic ischaemia ('PHI') at birth on 4th June 2018 which had led to cerebral palsy.

Her claim failed on factual causation before Ritchie J on the basis that the established breaches of duty would not have led to earlier delivery.

The Court of Appeal have now overturned a key finding of fact below and found that there was a single minute of avoidable delay in the delivery of the Claimant. *CDE* has been remitted to the Judge to consider what difference, if any, the saved minute would make to medical causation.

The Claimant's medical causation case is that '*every minute counts*' for the purposes of material contribution where there is negligence which increases the period of damaging PHI. This was a proposition accepted by Ritchie J in the case of *CNZ v Royal Bath Hospitals NHS Foundation Trust* [2023] EWHC 19 (KB). *CNZ* was a further birth injury case decided last year in which the Claimant succeeded on primary '*but for*' causation grounds given that damaging PHI would have been avoided altogether with earlier delivery.

The judgments of Nicola Davies LJ and Peter Jackson LJ in *CDE* leave open the question of whether there will be further appellate consideration of the medical causation issues raised by very short periods of avoidable but damaging PHI.

The Court of Appeal rejected the invitation of the Claimant to find that medical causation was established as a consequence of the Judge being overturned on factual causation.

This was on the basis that there had not been full consideration below of the impact of a saving of one minute of injurious PHI where the Claimant would still have suffered a significant period of non-negligent and injurious PHI on the Judge's findings (23-24 minutes of PHI had occurred in the event, with 25 minutes of PHI usually fatal).

The Appeal in CDE and the judgment below

As was established before Ritchie J (and not the subject of the appeal), there were critical failures in the care of the Claimant and her mother before delivery.

The Claimant's mother had not been transferred to the labour ward until just before 17.50hrs by which time 2 hours had passed since she had been on a CTG and assessed by an obstetrician with nothing done in response to her increasing pain save for analgesia. The clinical notes were silent entirely between 17.20hrs and 17.50hrs.

On arrival on the labour ward, a CTG had been attached and the transducer was sounding out that the Claimant's heartbeat was bradycardic by 17.51hrs.

Fortuitously, a consultant obstetrician was stood outside the room and immediately heard the bradycardia and entered the room at 17.52hrs. The consultant's prompt action led to delivery by emergency c-section by 18.08hrs. As the Judge found: *"She and her team then acted with hugely impressive professionalism and speed to deliver the baby within 17 minutes of the emergency. Few if any doctors could have done more."*

The Judge found that but for the breaches of duty of the Trust, there would have been a much earlier transfer

to the labour ward with the CTG attached but that the CTG trace would only have become bradycardic at 17.48-17.49hrs. The Judge found in such circumstances obstetric assistance would have been called within 1 to 3 minutes (effectively, a *Bolam* reaonsnable response window). As the consultant had been stood outside the room at 17.50hrs, the Judge found that she would have walked into the room at the same time she had done in real life on 4th June 2018.

Thus, the claim failed on factual causation as the breaches of duty would not have led to earlier delivery.

By the close of trial, the Claimant's medical causation case was that: "*Earlier delivery even by 1,2 or 3 minutes would have a material difference*". It had thus been argued that any saving of time would have made a material contribution to the brain injury which had been suffered.

The appeal ultimately turned on a single issue: should the Court of Appeal interfere with the Judge's findings of fact and find that the consultant obstetrician would have entered the room one minute earlier than he had found?

The Court of Appeal found that there was a flaw in the Judge's reasoning.

The Judge had accepted the proposition that '*reasonable timing*' would have allowed up to 3 minutes for obstetric assistance to arrive upon the CTG trace being bradycardic at 17.49hrs. That invoked *Bolam* reasoning. However, the causation question required the application of *Bolitho* reasoning and consideration of what the consultant would actually have done but for the breach of duty. As the Judge had found that she was stood outside the room at 17.50hrs, her entry would have been at 17.51hrs rather than at 17.52hrs as occurred in real life.

The Court of Appeal therefore overturned the Judge's finding of fact and held that entry into the room, and thus delivery of the Claimant, would have occurred one minute sooner but for the breaches of duty of the Trust.

The Judgment gives a helpful reminder of the distinct issues which arise in considering breach of duty and causation especially when it comes to counterfactual matters. There was detailed discussion of the Claimant's evolving causation case but this was a paradigm example of timings only been drawn into sharp focus upon specific findings of fact at trial.

Every minute therefore did count on factual causation and the lost minute in the Judge's reasoning was ultimately critical to the appeal. However, it remains unclear whether every minute will count for medical causation. The case has been remitted back to the Judge to consider the impact of the saved minute on medical causation.

In a case where injury would not have been avoided altogether by the established delay, the Claimant's case is that she ought nonetheless to recover damages in full because it is impossible on the medical science to determine what contribution the negligent PHI made to the brain injury.

This reasoning was accepted by Ritchie J in *CNZ*, however, in that case - but for the breach of duty - there would been less than 10 minutes of PHI and thus no injury at all (with it accepted science that the first 10 minutes of PHI is non-injurious). Therefore, it could be safely concluded that the Claimant would have avoided brain injury altogether but for that established negligence.

CDE is markedly different in terms of the PHI exposure. Ritchie J found that PHI was suffered in the event for around 23- 24 minutes, and the Claimant would likely have died after 25 minutes of PHI. The saved minute would therefore mean that there would still have been a sustained period of non-negligent injurious PHI.

One can therefore well envisage that *CDE* may yet return to the Court of Appeal in due course.

Holmes v Poeton Holdings Ltd: A Step Forward for Claimants – But Questions Remain

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Introduction

There has been much debate amongst clinical negligence practitioners in recent years as to whether the material contribution approach to causation (following *Bonnington Castings Ltd v Wardlaw* [1956] 1 AC 613) applies in cases of so-called '*indivisible injury*'. At High Court level, cases such as *John v Central Manchester and Manchester Children's Hospital Foundation Trust* [2016] 4 WLR 54 suggested that it did, but more recent cases such as *Thorley v Sandwell & West Birmingham Hospitals NHS Trust* [2021] EWHC 2604 (QB) pointed the other way.

That question has now been resolved in *Holmes v Poeton Holdings Ltd* [2023] EWCA Civ 1377, which was an industrial disease claim. In short, the Court of Appeal held that the material contribution approach to causation does apply in cases of indivisible injury (divisible conditions being approached differently).

This decision represents a positive step forward for claimants in clinical negligence cases. It expressly leaves open several questions, however, which are ripe for review at an appellate level.

Accordingly, this short article looks at the decision in *Holmes* and the questions that remain.

Setting the Scene

It is necessary to begin with some definitions. As Stuart-Smith LJ explained in *Holmes* at [31], it is characteristic of divisible conditions that, once initiated, their severity will be influenced by the total amount of the agent that has caused the condition (usually a noxious agent in an industrial disease context, but quite often a period of culpable delay in a clinical negligence context). By contrast, once an indivisible condition is initiated, its severity will not be influenced by the total amount of the agent that caused it. Accordingly, as Stuart-Smith LJ explained: *"The classic distinction in asbestos-related diseases is between asbestosis and mesothelioma. Mesothelioma is an indivisible disease because, although the risk of developing a mesothelioma increases in proportion to the quantity of asbestos dust and fibres inhaled, the condition once caused is not aggravated by further exposure and the severity of the condition, if it occurs, is not thought to be affected by variations in the victim's overall exposure. Asbestosis is a divisible disease because all of the victim's exposure to asbestos will contribute to the severity of his eventual disease"*.

Taking the point a little further, in *Sienkiewicz v Greif (UK) Ltd* [2011] 2 AC 229 (another industrial disease case) Lord Phillips of Worth Matravers gave examples of three different conditions at [12]-[14]:

(1) Malaria resulting from a single mosquito bite. *"The extent of the risk of getting malaria will depend upon the quantity of malarial mosquitoes to which the individual is exposed, but this factor will not affect the manner in which the disease is contracted nor the severity of the disease once it is contracted. The disease has a single, uniform, trigger and is indivisible."*

(2) Lung cancer caused by smoking. *"Ingestion of [cigarette smoke] operates cumulatively so that, after a threshold is passed, it causes the onset of the disease. [T]he disease itself is indivisible. The severity of the disease, once it has been initiated, is not related to the degree of exposure to cigarette smoke."*

(3) Asbestosis (and also silicosis, hand-arm vibration syndrome and noise-induced hearing loss). *"The agent ingested operates cumulatively first to cause the disease and then to progress the disease. Thus the severity of the disease is related to the quantity of the agent that is ingested."*

It can be seen from these examples is that there are two distinct concepts at play: on the one hand, the causal process by which contraction of the disease or condition occurs, i.e. cause; and, on the other hand, the severity of the condition, i.e. (extent of) harm. That the focus in determining divisibility is on the latter, *viz*. harm, is confirmed by *BAE Systems (Operations) Ltd v Konczak* [2018] ICR 1 at [71] per Underhill LJ.

The first two of Lord Phillips' examples are indivisible conditions, only the third is divisible. That said, both the second and third examples involve cumulative causal processes, whereas only the first has a discrete cause (namely the infected mosquito).

Thus, whereas all divisible injuries have cumulative causes, cumulative causes do not lead only to divisible injuries.

The Decision in *Holmes*

Against that background, *Holmes* was a case where the Claimant alleged (and the trial judge found) that he was exposed to unsafe levels of trichloroethylene (TCE) during his employment with the Defendant. The Claimant alleged that this exposure had materially contributed to his Parkinson's disease. Having heard extensive expert evidence, the trial judge accepted this proposition. The Defendant appealed on the basis, in broad terms, that the judge was: (i) wrong in law in holding that the material contribution approach to causation applied to what was agreed to be an indivisible injury; and (ii) wrong in any event to find that a material contribution was made out on the evidence.

As noted above, as to point (i) the Court of Appeal held that the material contribution approach does apply to indivisible injuries. The appeal was nonetheless allowed on point (ii), for reasons outside the scope of this article.

In tackling the material contribution question, Stuart-Smith LJ undertook a masterly analysis of the authorities, noting that this was an area of law "*bedevilled by apparent inconsistency and imprecision at the highest level on multiple occasions*".

Close analysis of the speeches in *Bonnington, Nicholson v Atlas Steel Foundry and Engineering Co Ltd* [1957] 1 WLR 613 and *McGhee v National Coal Board* [1973] 1 WLR 1 revealed, in Stuart-Smith LJ's judgment, that the injury in *Bonnington* (pneumoconiosis, which is now treated as a divisible condition) was treated in that case as if it were an indivisible injury: see [46]. Accordingly, "*the* Bonnington *principle was expressed in terms that were appropriate to indivisible diseases rather than to divisible ones.*" Stuart-Smith LJ's analysis also drew on *Bailey v Ministry of Defence* [2009] 1 WLR 1052, citing what he referred to as the **ratio** of Waller LJ's judgment at [46]-[47]:

> *"In a case where medical science cannot establish the probability that "but for" an act of negligence the injury would not have happened but can establish that the contribution of the negligent cause was more than negligible, the "but for" test is modified, and the claimant will succeed.*
>
> *"The instant case involved cumulative causes acting so as to create a weakness and thus the judge in my view applied the right test, and was entitled to reach the conclusion he did."*

Thus, Stuart-Smith LJ stated at [63]:

> *"I would … hold that we are bound in the light of* Bailey *to find that the* Bonnington *"material contribution" principle applies to cases of indivisible injury and that, where the principle applies, the claimant does not have to show that the injury would not have happened but for the tortious exposure for which the defendant is responsible."*

Stuart-Smith LJ went on to consider *AB v Ministry of Defence* (2011) 117 BMLR 101, relied upon for its conclusion that the *Bonnington* approach does not apply to cases of indivisible injury. At [65], he stated that he was "*unable to accept or adopt*" the analysis of Dame Janet Smith in AB in circumstances where it was inconsistent with the decision in *Bonnington* itself and its subsequent analysis at the highest level of authority.

The question '*does the material contribution approach to causation apply to cases of indivisible injury?*' thus finally has an authoritative answer: yes, it does.

The Court of Appeal has further confirmed that where a material contribution to an indivisible injury is demonstrated, the claimant will recover in full against the tortfeasor: see [58], and [124] per Underhill LJ.

In considering these conclusions, it is noteworthy that Stuart-Smith LJ stated at [60] that "*divisible [conditions] are approached differently*". This is surely right as a matter of logic. If it is possible to resolve the harm suffered into components causes by each agent or tortfeasor, then the '*but for*' test will be satisfied as regards each such component part of the overall injury and there is thus no room for the application of the material contribution approach.

Unanswered Questions

The decision in *Holmes* expressly leaves open a number of questions for consideration in future cases. These are:

(1) Whether there might in some circumstances be a rational or logical way in which responsibility might be allocated even where the injury or disease is of a type that is generally regarded as indivisible. As Stuart-Smith LJ noted at [120]: "*We were referred to dicta in* Rahman v Arearose Ltd *[2001] QB 351 at [19] per Laws LJ,* Hatton v Sutherland *[2002] ICR 613 at [36]-[42] per Hale LJ,* Dickins v O2 plc *[2009] IRLR 58 at [45]-[47] per Smith LJ and* BAE Systems (Operations) Ltd v Konczak *[2018] ICR 1 at [65]-*

[72] per Underhill LJ. While, in my respectful opinion, those dicta raise questions that might be important (and difficult) in another case, no question of apportioning liability arises in this case since no causative contribution has been shown."

These questions may well have arisen had the claim in *Holmes* succeeded. It remains to be seen how the court will grapple with this issue.

(2) The proper approach in cases involving oversubscribed causes. As Stuart-Smith LJ noted, again at [120], *"although the prospect was raised by the Court during the hearing, this is not a case which involves oversubscribed causes. These important and difficult questions should therefore be left alone until a case in which they actually arise."*

Oversubscription means a situation where are more causes present than are necessary to cause an event. An example from the academic literature is a cup of tea into which three tortfeasors each, in sequence, place a single drop of poison in circumstances where one drop alone is not enough to kill but two drops will prove fatal. The Court of Appeal heard arguments on some of these issues but accepted that *Holmes* was not such a case.

Taken together with Stuart-Smith LJ's suggestion at [63] that *"where the [material contribution] principle applies, the claimant does not have to show that the injury would not have happened but for the tortious exposure for which the defendant is responsible"*, this line of argument raises the prospect of causation being established but there being no provable loss or damage. It is not at all difficult to see how questions of this nature could arise in a clinical negligence context.

(3) The ambit of the decision in *Wilsher v Essex Area Health Authority* [1988] AC 1074. As Stuart-Smith LJ noted at [121]: *"[I]t is not necessary to decide whether this is a* Wilsher *case and I do not do so. My reluctance is based on the lack of necessity and because I consider that the present understanding of Parkinson's disease makes a decision on this issue particularly difficult and probably unreliable. Even if it is accepted that genetics and both internal and external environmental factors may all be relevant to the causation of Parkinson's disease, it is not clear on current understanding to what extent they may combine or, alternatively, may be discrete potential causes that could bring the case within the ambit of the principle established by* Wilsher*."*

It is, again, easy to envisage how clinical negligence cases may raise questions of multiple discrete (as opposed to cumulative) potential causes.

Conclusion

It can be seen from the above that the decision in *Holmes* represents a step forward for claimants in clinical negligence cases in that the material contribution argument remains open when faced with an indivisible injury.

It will be important going forwards to explore with medical experts not just whether them harm suffered it divisible or not, but also whether the causal process(es) at play operated cumulatively or discretely.

Moreover, an eye must be kept on whether a claim raises any of the unresolved questions left open by *Holmes*. Where such points arise, the ground for any legal argument will need to be laid by proper exploration of the issues with the relevant medical experts.

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‘Just satisfaction’: Clinical negligence, Article 2 ECHR & the Human Rights Act 1998

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We are no doubt all familiar with cases involving wrongful death in hospital. Such cases may arise from surgical or pharmacological negligence, or they may concern mentally ill patients who have taken their own lives.

We are no doubt all familiar too with the various limitations presented by claims arising from wrongful death. This article addresses one such limitation – the law in relation to bereavement damages – and identifies the limited circumstances and ways in which it may be overcome.

Claims arising from wrongful death typically break down into two elements. The estate may bring a claim under the LR(MP)A 1934 for PSLA and discrete items of special damage, and the dependants may bring a claim under the FAA 1976 for income and services that the deceased would have provided had they not died. A ‘*dependant*’ is defined at s1(3). It is a closed but broad category, extending to spouses, civil partners, cohabitants, parents and children, those treated as parents and (in certain circumstances) children, brothers and sisters, uncles and aunts, and more. The FAA 1976 also permits a claim for damages for bereavement, currently fixed at £15,120. Such a claim may only be brought for the benefit of certain persons, as defined at s1A(2). It is a closed and narrow category, encompassing only spouses, civil partners, cohabiting partners, the parents of a legitimate minor and the mother of an illegitimate minor. For reasons that are no doubt obvious, s1A(2) has been the subject of much criticism over the years. Parliament has been slow to respond. Civil partners were only added in 2004 and cohabitants in 2020 (with conditions). There is no indication that the category will be extended further any time soon.

What, then, of the mother of a nineteen-year-old man who dies due to a drug dispensing error? Or the daughter of a mentally ill woman who takes her own life? Or someone who loses their partner of ten years or more due to clinical negligence, but where they did not live together? Each of them has lost a loved one and may have suffered a bereavement reaction or other psychiatric injury. However, none of them is entitled to claim bereavement damages. In certain circumstances, the HRA 1998 may offer a way around this problem.

The HRA 1998 creates domestic rights expressed in the same terms as the ECHR. Courts must interpret all legislation compatibly with the Convention rights (insofar as it is possible to do so), and public authorities must act compatibly with those rights. Under s6, it is unlawful for a public authority to act in a way which is incompatible with a Convention right; and an ‘*act*’ includes a failure to act. In other words, public authorities must not only not interfere with individuals’ rights but take positive steps to protect them. Under s7, and with reference to Article 34 ECHR, where someone has been directly affected by an unlawful act or omission by a public authority, then they may be deemed a victim and entitled to bring proceedings against it in the appropriate court or tribunal. If their claim is upheld, then the court may grant such relief or remedy as it considers just and appropriate (s8(1)). It may award damages if, taking account of all the circumstances of the case, including any other relief or remedy granted, and the consequence of any decision in relation to the act that is complained of, it is satisfied that the award is necessary to afford just satisfaction to the person in whose favour it is made (s8(3)). In other words, damages are not awarded as of right. They lie within the discretion of the court.

How, then, might these provisions apply in the context of cases involving wrongful death in hospital? The first point to note is that there is no discrete procedure for human rights claims. They should be brought under the CPR, in the KBD or County Courts. (Various minor procedural modifications apply in respect of both human rights claims and fatal accident claims. These may be found in the CPR. The basic limitation period is one year, but this may be extended where it is considered equitable in all the circumstances to do so.) NHS Trusts are core public authorities. Any claim lies against them specifically (rather than the state in general). Relatives of the deceased are victims (*Rabone v Pennine Care NHS Foundation Trust* [2010] EWCA Civ 698), and in certain circumstances

individuals outside the immediate family may also qualify as such (*Daniel v St George's Healthcare NHS Trust* [2016] 4 WLR 32).

Article 2 ECHR enshrines the right to life. It imposes obligations to refrain from taking and to protect life (*X v UK* (App. No. 7154/75)). In *Savage v South Essex Partnership NHS Trust* [2009] 1 AC 681, Lord Rodger explained what the latter meant in practical terms: '*In the first place, the duty to protect the lives of patients requires health authorities to ensure that the hospitals for which they are responsible employ competent staff and that they are trained to a high professional standard. In addition, the authorities must ensure that the hospitals adopt systems of work which will protect the lives of patients. Failure to perform these general obligations may result in a violation of Article 2.*' In respect of mentally ill patients, Lord Rodger said this: '*If for example a health authority fails to ensure that a hospital puts in place a proper system for supervising mentally ill patients and as a result a patient is able to commit suicide, the health authority will have violated the patient's right to life under Article 2.*' It bears emphasising that mere negligence will not suffice to establish a breach of Article 2. What is needed is systemic failure. (*Lopes de Sousa v Portugal* (2018) 66 EHRR 28) If a health professional makes an error of judgment, then they may be personally liable in negligence (and the health authority may be vicariously liable).

Likewise, if several health professionals are negligent in their coordination of treatment of a patient. However, in neither instance will Article 2 be engaged. (*Powell v UK* (2000) 30 EHRR CD 362) It is the health authority itself that must be at fault, whether by reason of systemic failure or, in certain circumstances, the failure of operational measures to protect the lives of specific individuals. The operational duty arises where the health authority '*knew or ought to have known [...] of a real and immediate risk to the life of an identified individual or individuals [...] and that they failed to take measures within the scope of their powers which, judged reasonably, might have been expected to avoid that risk*'; and it may apply to voluntary mental health patients as well as to those who are detained. (*Osman v UK* (2000) EHRR 245; *Rabone v Pennine Care NHS Foundation Trust* (2012) UKSC 2)

The Supreme Court has recently considered the application and scope of the systemic and operational duties that may arise under Article 2 in *R (on the application of Maguire) v His Majesty's Senior Coroner for Blackpool & Fylde and another* [2023] UKSC 20. That case concerned the death from complications relating to a perforated ulcer of a woman with Down's Syndrome and learning disabilities who had been living in a care home. A claim was brought for judicial review of the coroner's decision that a short form verdict (as opposed to an expanded verdict) was required. In addressing that decision, the Supreme Court analysed the development of the substantive positive obligations under Article 2 by the European Court on Human Rights and the application and scope of the aforementioned duties in a healthcare setting. *Maguire* has been the subject of much commentary, including in the November 2023 edition of this newsletter. It emphasises (inter alia) that breach of the systemic duty will only arise '*in rare cases*', and that breach of the operational duty requires a failure to guard against a '*specific risk*' to life which was known or which ought to have been known. In most cases of wrongful death in hospital, it will be hard to prove either. In other words, the availability of redress by way of Article 2 is, regrettably, limited.

However, if a breach of Article 2 can be established then the claimant will have an easier task in proving causation than at common law. The '*but for*' test does not apply. Instead, what is required is a '*substantial chance*' or '*real prospect*' of a different outcome (*Savage*). Lord Brown of Eaton-Under-Heywood put it thus: '*It also seems to me to explain why a looser approach to causation is adopted under the Convention than in English tort law. Whereas the latter requires the claimant to establish on the balance of probabilities that, but for the defendant's negligence, he would not have suffered his claimed loss [...] under the Convention it appears sufficient generally to establish merely that he lost a substantial chance of this.*' (*Chief Constable of the Hertfordshire Police v Van Colle* [2008] UKHL 50).

Damages may then be awarded, in line with the principle of '*just satisfaction*' under s8(3). In *Van Colle*, where the claim for breach of Article 2 failed, the court said that it would have awarded £10,000 to the estate for the deceased's suffering and £7,500 to each of the parents for theirs. In *Rabone*, another Article 2 case, awards of £1,500 for each parent were increased to £5,000 each on appeal. (Lord Dyson considered that this remained too low.) Nowadays, general damages for breach of Article 2 tend to range between £10,000 and £20,000. In practice, the estate's claim under the LR(MP)A 1934 and the dependants' claim under the FAA 1976 remain a better route for achieving adequate compensation. That is unsurprising, since the primary aim of the HRA 1998 is to prevent unlawful interference with Convention rights rather than to obtain damages. However, there are circumstances where an award of damages may be obtained that would not be available at common law. One such circumstance is where relatives do not fall within the narrow category of

persons entitled to a bereavement award under s1A(2) of the FAA 1976. It is notable, and perhaps not coincidental, that the value of a bereavement award (£15,120) falls at the midpoint of the range of general damages typically awarded for breach of Article 2.

When dealing with cases involving wrongful death in hospital, then, practitioners should consider whether to bring a claim under the HRA 1998 alongside those under the LR(MP)A 1934 and the FAA 1976. The circumstances in which a HRA 1998 claim will be available are limited, but where they do exist the claim may present a way of obtaining damages comparable to a bereavement award that may be unavailable to the dependants. It may also give rise to a declaration of violation or an apology; and that, we all know, can go some way to achieving 'just satisfaction' for bereaved relatives struggling to process their loss.

Limitation in Fatal Accident claims - a review after *Shaw v Maguire*

EMILY SLOCOMBE
OLD SQUARE CHAMBERS

OLD SQUARE CHAMBERS

In the case of *Shaw v Maguire (Re Preliminary Issues)* [2023] EWHC 2155 (KB) Master Cook considered the limitation period in fatal accident claims as a preliminary issue.

In a preliminary hearing on 18 November 2022 Master Cook addressed:

- Whether the claim was brought in accordance with the provisions of the Limitation Act 1980; and if not;

- Whether it would be equitable to disapply the time limit under section 33 of the Limitation Act 1980.

These considerations included whether a claimant could utilise Section 33 of the Limitation Act 1980 in Fatal Accident Act claims where limitation had expired prior to the injured person's ('Deceased') death.

Background

The Claimant widower sued for the death of her husband alleging that the Defendant was clinically negligent in their treatment of him between 2007 and 2009.

In October 2007, the deceased was concerned about a lesion on his back and had a biopsy taken. The Defendant, a consultant pathologist, reviewed the cell sample taken in the biopsy and reported that the sample was benign, discharging the deceased without any follow-up treatment.

In November 2009, the deceased had a further biopsy taken, and this time the sample was reported as confirming malignant melanoma. In response to this finding, the 2007 sample was sent for re-testing and this was also found to contain malignancy.

The lesion was excised, and it was hoped that the melanoma had not metastasised, and the deceased would have an uneventful recovery.

In April 2013, the deceased developed a dry cough. Following an ultrasound, a CT scan and bronchoscopy in June 2013, the deceased was diagnosed with stage 4 metastatic melanoma. The deceased died in January 2014 of metastatic melanoma.

In November 2014 the Claimant instructed solicitors ('*the original solicitor*'). A claim form was issued on 17 January 2017, naming the deceased's dermatologist and BMI Healthcare as defendants. No claim was initiated against the Defendant at this point.

The Defendant was first notified of a potential claim by way of letter of claim dated 8 March 2017, and the claim form was amended on 18 May 2017 to substitute the Defendant in place of the dermatologist. However, the claim form was never served.

When the Defendant's representatives contacted the original solicitor in June 2017, they were informed the original solicitors were no longer acting for the Claimant, so closed the file.

In June 2020, the Claimant instructed new solicitors to pursue a professional negligence claim against the original solicitors, for failing to pursue the claim against the Defendant in 2017. Liability was denied.

On 2 November 2021, the original solicitor made a proposal to indemnify the Claimant against the costs of pursuing a claim against the Defendant out of time. The Claimant apparently agreed. As such a letter of claim was sent to the Defendant on 12 April 2022, and proceedings were issued on 10 August 2022.

The Defendant filed a defence denying liability and raising the issue of limitation.

The matter, therefore, came before Master Cook to consider limitation as a preliminary issue.

The application of S.33 of the Limitation Act where limitation expires before death

The Defendant's position at this point had been that the claim was statue barred **prior** to the deceased death, and the Court had no power to resurrect the cause of action

pursuant to section 33 of the Limitation Act as limitation had expired prior to death. They argued that the bar was absolute.

Master Cook made a finding that the Claimant and deceased's date of knowledge was June 2013. The deceased died in January 2014 and as such the claim was in time at the date of the deceased's death. Despite this, Master Cook went on to consider the appropriate application of the Limitation Act if the limitation period had expired. Within this consideration, Master Cook "*expressed some surprise that this issue had not been judicially considered*" previously.

The Defendant, in formulating their submissions on the point, referred to Kemp & Kemp at 3-010. This states "*[i]f the deceased failed to sue within his own limitation period then no Fatal Accidents Act claim may be pursued, and there is no power to make a retrospective s.33 application to disapply the limitation period once the victim has died: s.12(1).*"

The Claimant relied upon Clerk and Lindsell on Torts paragraph 31-70, to argue to the contrary. Clerk and Lindsell says inter alia "*[a]lthough the possibility that the deceased could have invoked the court's s.33 discretion is disregarded when determining whether his cause of action was statute-barred, the claimants in a Fatal Accidents Act claim may ask the court to exercise its discretion under s.33 of the Limitation Act 1980 and override the limitation period which would have barred the deceased's claim, and hence bars theirs. This is provided for by s.33*".

Master Cook opined that the answer is provided by careful reading of Section 12(1) and Section 33(2) of the Limitation Act, and that with careful reading "*S.33(2) of the Limitation Act 1980 provides the court may disapply s.12(1) where the reason the person injured could not maintain an action was because of the time limit provided by s.11(4)*". Therefore, he formed the view that the Section 33 discretion could be considered in fatal accident claims where limitation expired prior to the deceased's death.

Master Cook also relied upon the case of *MMG3 v Dunn* [2019] EWHC 882 (QB) in confirming his interpretation, however, it was acknowledged by the advocates and Master Cook, that MMG3 did not directly address the issue. In MMG3 it appeared that the claim proceeded on the basis that it was accepted that Section 33 of the Limitation Act permitted an extension to be sought by a Claimant in Fatal Accident claims, where limitation expired prior to the deceased's death.

Therefore, Master Cook's (obiter) judgment was that Section 33 of the Limitation Act can be utilised by Claimants where the litigation period expired prior to the deceased's death.

Whether or not the discretion should be applied in this case

Master Cook went on to consider whether the discretion in Section 33 of the Limitation Act should be used in this case where the claim was commenced five and a half years out of time. In doing so Master Cook considered the features set out within S33(3) of the Limitation Act.

Delay:

Master Cook acknowledged that the Claimant, in instructing the original solicitors, had taken reasonable steps to instruct what she had believed to be competent solicitors who specialised in clinical negligence claims. Overall, Master Cook felt that none of the delay was the Claimant's responsibility, and described the Claimant as being "*left high and dry to eventually attempt some form of recourse with the Legal Ombudsman*" and therefore, "*reasonably followed the course suggested by her new solicitors*".

Cogency of the evidence:

The Defendant asserted that they had no recollection of the relevant events which occurred over 15 years prior to this hearing and in circumstances where she had been told no claim would be pursued.

However, Master Cook acknowledged that the histology sample and the Defendant's report from the time were available, and this was going to be a case which would be subject to independent expert evidence as the issue would relate to interpretation to the sample. Therefore, he said it was difficult to understand how the Defendant's recollection would be relevant.

On causation, Master Cook said this would also be a matter of expert evidence, and the Claimant's evidence on causation would be largely based on documentary evidence which is common in Fatal Accident cases.

Defendant's conduct

There were no relevant issues with the Defendant's conduct.

Claimant's disability

This was not a relevant issue.

Whether the Claimant acted promptly and what steps she took to obtain medical, legal or other expert advice.

Master Cook reiterated that he did not take the view that the Claimant could be criticised for acting as she did, starting with the instruction of the original solicitors when she acquired the necessary knowledge.

Balancing exercise

In considering matters in totality the Defendant placed reliance upon this being a second action case where the Defendant have been told the first case would not be pursued and where the Claimant had an arguable case for professional negligence against the original solicitors.

In considering the second point, Master Cook referred to *Rayner v. Wolferstans* (A Firm) [2015] EWHC 2957 (QB) where Wilkie J pointed out that in the context of Section 33 applications, an action against the Claimant's former solicitor was one for the loss of chance and that, of necessity that would result in the Claimant recovering less than 100% of what she may recover in the personal injury claim.

Master Cook said *"In circumstances where I have found that the Claimant has not contributed to the delay caused by her former solicitors, I can see no reason to visit any of the faults of her lawyers on the Claimant. Nor can I be satisfied that the Claimant's claim against her former solicitor would succeed.... I am also clear that the Claimant's alternative remedy, if she were to win, would result in an award of less damages than if she were successful against the Defendant."*

Accordingly, Master Cook decided that the prejudice to the Claimant would outweigh the prejudice to the Defendant and utilised his section 33 discretion.

Overview

As the first reported case which directly addresses the applicability of the section 33 discretion in cases where the deceased died after the expiry of the limitation period, this judgement is incredibly helpful, especially in light of the contradictory textbooks. However, being an obiter decision, it will be interesting to see if or when this is challenged further in the future.

The second part of this judgment considering the facts of the case, is also a useful reminder of the steps a judge takes in considering whether to apply their discretion. In particular, the analysis of the Claimant's culpability for the delay and relevance of the Claimant's potential claim against the original solicitors is something to keep in mind for those where similar factual issues arise.

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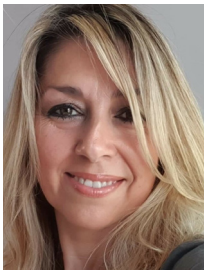

GILLIAN SAVAGE
HELPLINE DEVELOPMENT OFFICER

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I'll be at the AvMA Clinical Negligence Conference in Leeds this month so if you're there and have any questions please do find me, or email support@avma.org.uk

This is what some of our volunteers have to say about volunteering for our helpline:

Emily, Helpline Volunteer:

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Laura, Helpline Volunteer:

I see the effect of clinical negligence every day and sometimes you can't help as much as you would like within the confines of the legal system. I volunteer to help those who need either extra advice or help where the law cannot as yet. AvMA is invaluable at this and also in changing minds and legal process to benefit those that need it. The least I can do is help out.

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Court of Protection Conference

23 October 2024, 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 open Summer 2024.

AvMA Specialist Clinical Negligence Meeting

Afternoon of 29 November 2024, 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.

AvMA Holly Jolly Christmas!

Evening of 29 November 2024, Grand Connaught Rooms, London

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Clinical Negligence: Law Practice & Procedure

10-11 December 2024, Shoosmiths LLP, Birmingham

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

5 February 2025, America Square Conference Centre, London

This popular AvMA conference is returning to London on 5 February 2024, 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.

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AvMA Live Webinars in 2024

Medico-Legal Issues in the Management of Retinal Conditions with Mr Dominic McHugh, FRCS, FRCOphth, DO

Friday 1 March 2024

Over the course of the hour, Dominic will cover:

Conditions that are commonly the subject of litigation are:

• Retinal detachments and

• Retinal vascular diseases (for example age-related "wet" macular degeneration; diabetic retinopathy and retinal vein occlusions).

In the majority, with both classes of conditions, allegations of breach of duty relate to delays in diagnosis and treatment that allow progression of the condition, causing recordable visual loss. In a significant minority, an inadequate standard of care in the treatment of the condition, or in the management of postoperative complications (for example endophthalmitis) can also result in litigation. These matters will be explored during the presentation with representative illustrations from case reports.

BOOK NOW

Early Delays in Cancer Diagnosis with Dr Jeremy Platt, MBChB, MRCP

Wednesday 17 April 2024

Over the course of the hour Dr Jeremy Platt will cover:

• A general overview of the GP's responsibility in the early diagnosis of cancer

• Common cancers present in primary care

• Breaches of Duty Examples

• The GP perspective of the Covid 19 pandemic

BOOK NOW

Fixed Recoverable Costs & other Essential Costs Issues with Dominic Woodhouse, Advocate & National Training Manager, Partners in Costs

Thursday 9 May 2024

Over the course of the hour Dominic will cover:

• April 2024 changes made to the FRC for sub-£100,000 claims and how they affect you

• FRC for sub-£25,000 clinical negligence claims – introduction, or goodbye for now?

• Hourly rates – departing from the guidelines

• Essential costs caselaw update from the last six months

BOOK NOW

AI & The Future for Lawyers with Dr Guilia Gentile

Thursday 16 May 2024

Over the course of the hour Dr Giulia will cover:

• Definitions

• The Future of AI i.e: What will legal services and the professions that provide them look like in 5/10 years time? How to prepare for that future and get the best out of AI? AI's impact on access to justice?

• Case Studies – Examples of how firms are already utilising AI and where this is likely to go next.

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Complex Regional Pain Syndrome with Dr Rajesh Munglanli

Friday 25 October 2024

Details and booking information will open in the early summer, for now please save the date.

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