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Lawyers Service Newsletter

March 2025

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Editorial

Lisa O'Dwyer
Director, Medico-Legal Services

It really has been all go, since our last Newsletter in November. As you may recall, September 2024, saw the publication of **Lord Darzi's independent review** of the NHS in England, it acknowledged that the NHS is "*in serious trouble*" and that public satisfaction was at its lowest level ever. It observed that there was a need to re-engage staff and re-empower patients and acknowledged that waiting times for treatment for cancer and cardiac care were being missed.

In October, the **full report of Dr Penny Dash's review** into the operational effectiveness of the CQC was published. It confirmed an urgent need for a rapid turnaround of the CQC, not least to improve its operational performance. Wasting no time, Sir Julian Hartley was appointed CEO of the CQC in December and more recently Professor Aidan Fowler was appointed as interim Chief Inspector of Healthcare covering Secondary and Specialist Care and Primary and Community Care. He is expected to be in the role for 6 months, on secondment from NHS England (NHSE), while permanent Chief Inspectors are appointed. Professor Ramani Moonesinghe has been appointed Interim National Director of Patient Safety while Aidan Fowler is on secondment to the CQC.

There has been considerable activity at NHS England (NHSE) in recent weeks, with CEO Amanda Pritchard, resigning (Sir James Mackey, to stand in as interim CEO) and Dr Penny Dash being appointed as Chair, but then the shock news on 13th March that NHSE is to be abolished! NHSE functions as an Arms Length Body (ALB) and its purpose was to agree funding and priorities for the NHS alongside overseeing delivery of safe and effective NHS services. The reasons given for its abolition include reducing duplication, freeing up funds (the move is expected to generate £100 Million in savings) which can then be spent on doctors, nurses and frontline services, cutting red tape thereby speeding up improvements in the health service. NHSE will be brought back in under DHSC – there are interesting times ahead!!

Meanwhile, AvMA has been busy reviewing the feedback on its **Harmed Patient Pathway** (HPP), consultation which closed on 2nd December – our thanks to everyone who participated. We responded to the DHSC invitation to comment on government's 10-year Health Plan to Fix the NHS and in January submitted our response to the CJC Review of Litigation Funding

Consultation – whilst not without its difficulties, third party funding has been pivotal in enabling the public to access justice. In February, we submitted our response to the DHSC consultation on "*Leading the NHS: proposals to regulate NHS Managers*", at the heart of this lies the need for greater accountability. We are also pleased and excited to be one of three charities (along with **Patient Safety Watch**, and the **Clinical Human Factors Group** (CHFG)) to have joined forces to serve as secretariat to the **APPG on Patient Safety** and look forward to working with stakeholders to secure a safer future for patients across the UK.

An allegation of fundamental dishonesty, can have extreme consequences for a claimant, potentially discrediting them and resulting in them losing their representation. **Chris Hough** of Serjeants' Inn illustrates the risk for claimants in his article ***"Fundamental Dishonesty: Cullen v Henniker-Major"*** [2024] EWHC 2809. Chris, who was instructed in the case by Leigh Day, demonstrates how firms who hold their nerve in the face of unfounded allegations can rightly reap the rewards of an indemnity costs award. **Leslie Keegan** of 7 Bedford Row offers his thoughts on another important case, that of *PMC (a child by his mother and litigation friend FLR) v A Local Health Board* [2024] EWHC 2969 (KB). This case challenges practitioners often held presumption that children and protected parties should have anonymity after approval of a settlement. Leslie's article "***Are anonymity orders involving protected parties in peril?***" looks at when you should seek anonymity orders and highlights some of the ramifications of the case more generally.

For all the difficulties with the NHS, initiatives such as the 100,000 Genomes Project are fantastic and while diagnosis of rare conditions cannot change the disorder, knowing what the disorder is can nonetheless change lives for the better. For all the genius behind the development of identifying hitherto unknown genetic conditions, it carries with it, ethical conundrums. **Ben Collins KC** and **Emily Raynor**, both of Old Square Chambers consider the role of genetic testing in negligence cases where the results may be able to inform questions of causation and ask: "***Genetic testing – whose choice is it anyway***?". It is easy to see how genetic testing can be used as a tactic with defendants seeking a stay of proceedings if the claimant refuses to undergo testing, Ben and Sophie explore when the Court will exercise its discretion to make such an order.

Our thanks to **Georgie Cushing**, Senior Associate Solicitor at Irwin Mitchell LLP, for succinctly raising practical points for consideration in her "***PI Claims: Considerations when representing a claimant who lives outside of the jurisdiction***". Georgie highlights a number of areas which should be considered in this niche area, from asking whether tax is payable on compensation awarded in the country of residence to whether the Court of Protection has jurisdiction to manage the affairs of someone without capacity who resides outside of England and Wales.

A severely underfunded, ailing court system increasingly beset by delays and the rising cost of clinical negligence claims means that the impetus for finding alternatives to litigation grows ever stronger, Alternative Dispute Resolution (ADR) remains a powerful tool in the fight for more cost effective, restorative justice practices. **Paul Balen**, an experienced clinical negligence practitioner, Mediator and Director of Trust Mediation looks at "***How Churchill has turned us all into Dispute Resolution Lawyers***" and offers guidance on how to choose the right form of ADR for your case.

As clinical negligence lawyers we commonly lament the fact that we see the same healthcare mistakes repeated time and again. "***The inquest touching the death of Peter Mannheim***" was taken on by AvMA's **pro bono inquest service** in 2024, Denise Broomfield (Medico Legal Team Lead) assisted by Dr Hannah Davies had conduct of the case with **Alice Kuzmenko**, counsel at 1 Crown Office Row providing advocacy at the 1 ½ day hearing in December. Alice has detailed the facts and circumstances of Peter's death in her case report and set out some very helpful tips for practitioners to consider when faced with issues that go to the way risk assessments have been conducted, and how Continuing Healthcare Review Forms have been completed, alongside a reminder of what needs to be demonstrated for the coroner to consider neglect.

It is with sadness that we acknowledge the death of one of our long-standing panel members, Stephanie Prior, partner and Head of Medical Negligence at Osbornes Solicitors LLP, we have included a short obituary here.

As we all begin to navigate how best to address the complex issues and challenges facing the NHS and continued patient safety issues, AvMA is pleased to welcome to our team, Eleanor Riches, as our Policy and Campaigns Manager. Anna Devine is our Director Marketing, Fundraising and Communications who joined us in December 2024. Eleanor and Anna will both be at the ACNC in Bournemouth, and we look forward to seeing you there – fingers crossed for sunshine!

Best wishes

In Memoriam: Stephanie Prior

Osbornes | Law°

PARTNER AND HEAD OF MEDICAL NEGLIGENCE
OSBORNES LAW

Stephanie's work and achievements were recognised throughout the clinical negligence community, her professional impact was significant, she was much liked as a person and her loss will be keenly felt. Our thoughts are very much with her friends, professional colleagues and of course her children whom she lovingly spoke of often and of whom she was immensely proud.

Stephanie was a long standing AvMA panel member having been appointed to the panel prior to 2003. She was committed to access to justice, client care and achieving the right outcomes for her clients throughout her career, always professional and sensitive to her client's needs.

Stephanie will be very much missed.

Fundamental Dishonesty in the case of Cullen v Henniker-Major

CHRIS HOUGH
SERJEANTS' INN

SERJEANTS' INN

This article considers the decision of ***Cullen v Henniker-Major*** [2024] EWHC 2809, a clinical negligence claim against a GP arising out of a failure to refer a patient with signs suggesting cancer. Liability and causation were admitted in pre-action protocol correspondence. The assessment of damages hearing was listed for six days, commencing in February 2024. As might be expected, the respective experts had met, with a surprising degree of agreement. An RTM was scheduled for the week before trial. The seemingly smooth course was severely disrupted by the Defendant's decision to plead fundamental dishonesty.

On January 24th 2025, 48 weeks after the first day of trial, and after 12 days of hearing (both in trial, and discrete inter-trial applications), the judge awarded damages to provide 24 hour care, and indemnity costs against the Defendant. He found that it was unreasonable for the Defendant to maintain the allegations of fundamental dishonesty, and was highly critical of the manner in which the claim had been defended.

Background

Wilma Cullen was born on the 9th September 1957 and was aged 58 in 2015, the date of treatment. Prior to the events leading to her attendance with the doctor, she had a very full social and domestic life with her family and friends. She had many hobbies and interests (including cooking for her friends' parties, wild swimming and appearing as a stand-up poet).

In late 2015, she attended her GP with a worsening cough and sore throat. This was thought to be benign and nothing was done for a few months.

Unfortunately, her symptoms were in fact caused by throat cancer. The diagnosis was made in March 2016. She underwent a stormy period of treatment with radiotherapy and chemotherapy. Her cancer was cleared, but she had to have a total laryngectomy, bilateral neck dissections and severe complications of the chemotherapy.

In the Letter of Response it was admitted that her GP was negligent in failing to refer her under the cancer pathway, following the attendance in January 2016. This was plainly aggressive cancer, and it was further agreed that, with earlier referral, she would have avoided the laryngectomy and chemotherapy.

Condition and prognosis

In the main reports served, there was considerable agreement between the experts in describing Ms Cullen's condition.

Professor Homer was a fantastic expert. He provided an excellent report and his oral evidence was wonderful. In his report, Professor Homer described:

a. Ms Cullen speaks through a valve. Her speech is reasonably clear. It is difficult to raise her voice or to alter the pitch. She cannot raise her voice to cope with background noise. She has a loss of identity, but has retained her Scottish accent.

b. The speech valve need to be changed regularly: this is unusually problematic and has fluctuated from every few months to every few weeks. It is now required every two weeks.

c. She has a stoma which (she says) requires help to keep clean, inserting tubes, forceps and scissors. She carries a portable machine with her to help with suctioning.

d. She has a slow swallow. She finds it easier if food is cut up. Mark Williams watched Ms Cullen eat and described slow mastication, frequent swallow and frequent drinking of fluids.

e. She has stiffness and pain in her right shoulder and neck.

f. She suffers frequent chest infections.

g. She has no sense of smell.

The experts describe secretions and food blockages which cause choking and violent coughing, sometimes

leading to urinary incontinence. The experts witnessed carers helping to clear these blockages. Throughout the trial, Ms Cullen needed help. On every day, she had to leave the court for help in clearing her throat. The judge was asked before trial to allow hourly breaks: these were necessary.

The episodes of blockages and coughing/choking are unpredictable. The mornings were often bad, and food would often get stuck, so after meals – but it could be the smell of perfume, dust or fumes.

These symptoms have led to a marked deterioration in the quality of her life, affecting her independence, social life, hobbies and work. Professor Homer described the injuries as a significant deterioration in any patient's life.

Quantum issue

On behalf of Ms Cullen, Professor Homer, the SLT expert and the care expert supported a 24 hour care package. The claim was based on 24 hour nursing care. This was over-stated. There was no need for nurses to provide the care.

In fact, Ms Cullen had a team of friends and family who had received some training: the system worked.

Running in the background, Continuing Health Care had assessed Ms Cullen, and they agreed that she needed 24 hour care: they had provided funding for such care. Ms Cullen had put together a team of friends and her two sons to provide her with care. In her witness statement she said she wanted to pass the funding on to the tortfeasor and be relieved of the accounting commitments she had with Continuing Heath. She also went on she wanted to replace her friends with a nursing agency.

In October 2023, the Counter Schedule was served, with supporting expert evidence. For the first time, there was a serious challenge to the need for 24 hour care. The Defendant's care expert, Marie Palmer, advised that Ms Cullen could be given a short period of rehabilitation and regain her independence (possibly requiring a 999 emergency call, or attending Hospital through Accident and Emergency).

The ENT expert, Kate Heathcote gave evidence that nobody needed 24 hour care, and people were generally able to cope themselves. Her report was based on a short zoom call.

On the face of it, we had a "normal" dispute between experts on the assessment of future care.

The contemporaneous notes

In December 2023, everything changed. Updated records were obtained from Barts Hospital, describing Ms Cullen as *"self-changing"*.

The experts met on various dates in January 2024, the month before trial. The impact of the updated records was very significant. Both the care and SLT experts agreed that, if Ms Cullen was a self-changer, there was a minimal claim for future care. At best, the claim was limited to a period of intensive rehabilitation, and some emergency provision (amounting to about £150,000).

This led to the revision of the Schedule to reflect the joint statements.

In the background, the partner handling the case at Leigh Day left the firm to go elsewhere. It was intended that the case go with the partner to the new firm.

Fundamental dishonesty

The Defendant's response to the updated records was to investigate fundamental dishonesty. The key allegation was *"self-changing"* undermining Ms Cullen's witness evidence and Schedule that she needed care.

Running in parallel, the Defendant obtained video surveillance footage (taken in January 2024) and access to Facebook images (obtained in January 2024). They also obtained hundreds of pages of bank statements: days were spent pouring over those in support of allegations that Ms Cullen had paid carers when they were not actually caring for her (either because she was on holiday/ visiting friends or periods of Covid-related isolation). The judgment sets these out in great detail. These were later described by James Todd KC (who was brought in for the costs hearing) as *"hopeless"*. The judge agreed with this description.

On the 8th February 2024 the Defendant served the Amended Counter Schedule pleading fundamental dishonesty.

Meanwhile, the "new firm" returned the case to Leigh Day, who despite the risks associated with this allegation and the fact the barrister originally instructed in the case withdrawing, accepted it.

A little over two weeks before trial, a completely new team was put together (including me). Ms Cullen was lucky that Leigh Day "backed her". A team of four solicitors was assembled who worked incredibly hard to review the evidence. We were lucky with Ms Cullen: she was a feisty woman who gave as good as she got.

Permission was granted on the 20th February 2024 by Mr Justice Soole, the week before the warned period. An RTM was scheduled for the afternoon after the hearing to amend the Counter Schedule, but the Defendant said that no financial offer would be made: we could discuss the terms on which we could discontinue. We didn't attend.

Mr Justice Soole directed that the costs of considering fundamental dishonesty were outside the budgeted costs. Fortune favours the brave: Leigh Day have recovered unbudgeted costs on an indemnity basis.

Yet further evidence

In conference with Ms Cullen it became clear that "something was wrong". She seemed to be a transparently honest woman, given help by her sons and carers. All of these witnesses were vociferous that the contemporaneous records were wrong. She had never changed the valve by herself.

But, facing the combination of contemporaneous records and agreed expert evidence seemed a formidable/ impossible hurdle.

Within the Leigh Day team was the supercharged assistant solicitor, Camilla Browne. She went to the SLT department of Barts Hospital to get a witness statement. She came back, waving a witness statement, and achieved a correction of the medical records. "*Self-changing*": did not mean that Ms Cullen could do it herself. The SLT team said that she couldn't: but she could do valve changes at home with a carer. Self changing meant that she didn't have to come into the Department.

We served the witness statement on the 23rd February, one week before the trial was scheduled to start.

After receipt of the factual SLT evidence, Ms Cullen's experts all produced revised reports, essentially going back to their original positions.

'Phew', we thought. I advised Ms Cullen that the Defendant would now settle. Not quite the most useless advice I have given.

Response?

The Defendant found another treating SLT – who confirmed the meaning of self-changing. Double-phew.

The Defendant served nothing from their experts.

On the 28th February, HHJ Ambrose asked for a PTR. He was given assurances by the Defendant that:

a) The time estimate of 6 days was safe

b) Cross-examination of Ms Cullen would be a day and

c) the Defendant's experts would comment on the new SLT evidence (as the judge reminded the Defendant, required under CPR Part 35). Even at the early stage of a PTR, the judge could not understand the silence.

d) The judge identified the lack of an expert response on the first morning of the six day case and was again assured that it was "in hand".

All of these assurances were broken. No just breached of promises made to the court, but also breaches of the CPR.

The Trial

Most of the time in court turned on whether Ms Cullen had been fundamentally dishonest. She spent nearly four days being cross-examined in an aggressive and hostile manner. Had the Defendant succeeded, Ms Cullen would have recovered nothing in damages, would have been liable to return an interim payment, and probably faced committal proceedings for contempt of court. Her legal team would have recovered nothing in costs. There was the risk of public humiliation through exposure and photographs which might feature in the tabloid press. The stakes were high.

Despite the evidence from the treating SLT, the Defendant attacked Ms Cullen about how much she was able to do. Slowly, the expert evidence changed – the expert SLTs agreed she needed 24 hour care, Ms Heathcote (who the judge said was "*all over the place*") seemed to agree.

Despite the SLT agreement, the Claimant's excellent SLT expert, Samantha Holmes, was cross-examined with hostility and derision. Part of the background relied on to award indemnity costs.

There were other lines of attack apart from "*self-changing*", but these allegations were later described by the replacement legal team as "*hopeless*". The judgment sets out the lines of attack. Poor Ms Cullen. It was a dreadful ordeal to be put through days of aggressive, unnecessary cross-examination.

Eventually, the Defendant's ENT and SLT expert agreed that Ms Cullen needed 24 hour care. Ms Palmer stuck to her guns, but was on her own (and discredited).

Indemnity costs

The judge found that the Defendant acted unreasonably in continuing with the allegations of fundamental dishonesty after the evidence from the treating SLT was obtained.

Not surprisingly, he was also disappointed by the failure to comply with CPR part 35, and the breach of the assurances he had been given.

Other points of interest

Double recovery

The care experts agreed that agency care could be provided for about £96,000 pa. After the award, Ms Cullen approached agencies and found that she needed more (probably £140,000 pa). With permission of the judge, she sent the draft judgment to Continuing Health to explain that she might need continuing support. The Defendant demanded very complicated orders (including two versions of a PPO, an order requiring the damages to be in a nominated bank account and the expenditure to be supervised by the court). We offered a simple 6 line undertaking to tell Continuing Health and let them decide whether to "top up" or replace if the damages ran out. The judge accepted our simple solution (which James Todd described as "*sensible*").

Disclosure of judicial criticism

Secondly, in *Manna v Central Manchester NHS Trust* 2017 EWCA 12, the Court of Appeal recorded the trial judge's criticisms of Marie Palmer (the Defendant's care/OT expert in both Manna and Cullen) as "*wholly unrealistic*", "*extraordinary … and wholly out of kilter with awards made in this area*". The judge asked whether an expert should disclose such strong judicial criticism. He said that such disclosure was normal in criminal cases. In the event, he simply ignored her proposals that Ms Cullen rely on 999 and A&E.

Should there be such an obligation to disclose in civil cases?

Finally, the judge commented that an application made in April 2024 (heard in May 2024) for further specific discovery, weeks after the conclusion of factual evidence was a step too far: this was a fishing expedition which would have required Ms Cullen to be recalled. It was dismissed.

He also completely disregarded the unsolicited supplementary written submissions referring to an unreported County Court case in Liverpool.

And, in the end, dismissed the allegations of fundamental dishonesty as hopeless and awarded indemnity costs. And, most importantly, Ms Cullen received damages to pay for 24 hour care.

Representation

Christopher Hough was instructed by Leigh Day (Suzanne White, Kirsten Wall, Camilla Browne and Sarah Gray) for the Claimant.

Farrah Maladad KC and William Wraight were instructed by Kennedys (Sarah Lord and Tom Armstrong) for the Defendant. James Todd KC instructed for the costs/indemnity hearing.

Are anonymity orders involving protected parties in peril?

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The very detailed judgment on 22nd November 2024 in the case of *PMC (a child by his mother and litigation friend FLR) v A Local Health Board* [2024] EWHC 2969 (KB) citing the extensive caselaw in this area could have very important implications for what solicitors should do when issuing proceedings and particularly those proceedings involving protected parties.

I know that most people are aware that with UK Dockets on Westlaw, people can create daily alerts on new cases, specific courts or parties, and other events, track individual cases and be alerted to any changes, access every step of the case journey from a claim being filed to judgment and through to the appeals process.

The availability of this information occurs as a direct result of the publication of this information on the Court's electronic filing system (CE-File) and the availability of relevant documents from the records of the Court, under CPR 5.4C(1), following the filing of the Acknowledgement of Service.

However, in *PMC* Nicklin J. deals in detail with the implications of this for those seeking anonymity orders after the Claim Form and Particulars of Claim are filed. He points out that because these details have been published in this way that if the anonymity order is not sought at the outset of proceedings this could make it very difficult for those seeking anonymity orders after this stage to establish that there is a need for such an order.

All of us as practitioners acting on behalf of protected parties are aware of the model PF 10 Order and of the guidance given by the Court of Appeal in the case of *JX MX v Dartford & Gravesham NHS Trust* [2015] 1 WLR 3647 [34] regarding dealing with approval hearings means that (i) the hearing should be listed in public unless by the time of the hearing an anonymity order has been made (ii) because the hearing will be held in open court the press and public will have a right to be present (iii) the press will be free to report the proceedings, subject only to any order made by the judge restricting publication of the name and address of the claimant, his or her litigation friend and restricting access by non-parties to documents in the court record other than those which have been anonymised. (iv) Whether the claimant has formally applied for an anonymity order or not, the judge should invite submissions from the parties and the press as to whether such an order should be made. (v) Unless satisfied after hearing argument that it is not necessary to do so, the judge should make an anonymity order B for the protection of the claimant and his or her family. (vi) If the judge concludes that it is unnecessary to make an anonymity order he should give a short judgment setting out his reasons for coming to that conclusion. (vii) The judge should normally give a brief judgment on the approval application (taking into account any anonymity order)

What practitioners may not be aware is that there is a view, as now clearly expressed by Nicklin J. in the *PMC* case, that by failing to seek an anonymity order (involving the withholding of the details of name address etc and corresponding prohibition of publication) it could well be too late to do so once his name has become "*embedded in the public domain*".

> *"55.....If a party to litigation has not taken steps to seek a withholding order and corresponding reporting restrictions at the outset of the proceedings, s/he is highly likely to find that – whether for want of jurisdiction to make the order or on the basis that the Court refuses to make an order – it is simply too late to do so once his/her name has become embedded in the public domain as a result of the natural (and entirely predictable) incidence of reporting of court proceedings."*

As a clinical negligence practitioner, I consider that if a protected party fails to apply to withhold name, address and other details at the commencement of the proceedings it is an unduly rigid interpretation of the Court's powers under section 11 of the Contempt of Court Act 1981 if s/

he were to be deprived of an Order which enables him to withhold their details and to prohibit publication of those details simply because the party's details are "*embedded in the public domain*." This would mean that in the hundreds of claims involving protected parties, where the Claim Form has been issued and served, Defences served, Orders of the Court made, some of which will be orders approving interim payments and there has not been an application made to withhold the names and addresses of the protected party, that these applications are likely to fail. This is not only an unduly restrictive interpretation of the Court's power but is likely to frustrate or render impracticable the administration of justice or would damage the interests of protected parties whose interests the HRA provides the power to the court to protect.

Nicklin J. in this detailed judgment considers where the wording of PF10 is wrong and needs improvement; whether a statutory power exists to grant orders in the suggested format and what that statutory power is; whether the court should be granting orders with retrospective effect and whether the Court of Appeal in the *JX MX* case failed to consider s.11 of the Contempt of Court Act 1981 and other relevant appellate authorities. We have been granted permission to appeal because (a) this is an area of significant wider importance and (b) that the Court of Appeal decision in *JX MX*, conflicts with several other appellate level authorities.

Genetic testing – whose choice is it anyway?

OLD SQUARE CHAMBERS

BEN COLLINS KC AND EMILY RAYNOR
OLD SQUARE CHAMBERS

It has become increasingly common in recent years for Defendants to seek permission for a Claimant to undergo genetic or other testing in order to inform questions of causation – for example to assist with the question whether symptoms of brain injury arise from a congenital condition or are consequent on negligence, perhaps in the form of perinatal asphyxia or a traumatic brain injury.

Where a dispute arises as to the appropriateness of such testing, a Defendant may invite the Court to order that some or all of the proceedings be stayed if the Claimant will not consent to undergo testing. It can readily be seen that this is a potentially very powerful weapon. The effect of a stay in relation to some or all of the Claimant's case on quantum may be self-evidently devastating.

CPR 3.1(2)(g) provides that the court may stay the whole or part of any proceedings either generally or until a specified date or event. The same power existed before the enactment of the CPR by virtue of the inherent jurisdiction of the Court (*Starr v National Coal Board* [1977] 1 WLR (CA)). When will the Court exercise its discretion to make such an order? A number of cases have considered this question.

In Starr, the Claimant refused to be examined by the expert witness instructed by the Defendant. The objection was not to examination per se, but rather to the particular expert. Scarman LJ identified the need to balance "*two fundamental rights*": the Claimant's right to personal liberty and the Defendant's right to defend himself. It is the balance between those rights which is at the heart of any application of this kind. In order to balance those rights, the Court held that the proper approach was:

(1) To start by asking whether the Defendant's request for the Claimant to be examined by the expert was a reasonable one; if that answer was yes, then:

(2) To ask whether the Claimant's refusal of the request was unreasonable.

These two questions were to be asked by reference to "*the necessity, so far as the court can assess it, of ensuring a just determination of the cause*" – something like a pre-CPR reference to the overriding objective.

In *Aspinall v Sterling Mansell Ltd* [1981] 3 All ER 866, the Defendant sought permission to undertake 'patch testing' on the Claimant's skin. The procedure involved a small risk of injury. Hodgson J considered that the distinction between an examination (as in *Starr*) and a procedure (as in *Aspinall*) was important: "*In my judgment the difference between medical examination, including as it must manual interference with the patient's body and such procedures as patch testing, the use of hypodermic syringe, the administration of a drug or anaesthetic and, at the far end of the scale, exploratory operations is one of kind not of degree.*"

Having considered *Starr*, the Judge held that the Claimant's right to personal liberty must prevail: "*I do not think it can ever be unreasonable for a plaintiff to refuse to undergo a procedure which carries with it a risk, however minimal, so long as it can be called real, of serious injury.*"

In *Laycock v Lagoe* [1997] PIQR P518, the Court considered whether the Claimant should undergo an MRI scan, in circumstances where he suffered from schizophrenia and would be (as an expert psychologist advised) at risk of undergoing an acute psychotic episode. The Claimant declined to undergo the scan and the Defendant applied for a stay. At first instance the stay was refused but the Court of Appeal disagreed. Kennedy LJ expressed the proper approach as follows:

> "*First, do the interests of justice require the test which the defendant proposes? If the answer to that is in the negative, that is the end to the matter. If the answer is yes, then the court should go on to consider whether the party who opposes the test has put forward a substantial reason for that test not being undertaken; a substantial reason being one that is not imaginary or illusory.*

In deciding the answer to that question, the court will inevitably take into account, on the one hand, the interests of justice in the result of the test and the extent to which the result may progress the action as a whole; on the other hand, the weight of the objection advanced by the party who declines to go ahead with the proposed procedure, and any assertion that the litigation will only be slightly advanced if the test is undertaken. But, if the plaintiff, for example, has a real objection, which he articulates, to the proposed test, then the balance will come down in his favour."

The White Book (3.1.8.1) suggests that *Starr* is the applicable authority in relation to an ordinary examination, and that *Laycock* provides the approach to be adopted where the examination involves a procedure giving rise to discomfort or risk of injury.

A number of recent interlocutory decisions have brought this issue to the fore. In *Paling (A Child) v Sherwood Forest Hospitals NHS Foundation Trust* [2022] Med LR 51 Master Sullivan refused an application for a stay pending genetic testing in a clinical negligence claim involving a serious brain injury. In doing so, she held that she should apply the two-stage test in *Laycock*. And in *Read v Dorset County Hospital NHS Foundation Trust* [2023] EWHC 367 (KB) the Defendant applied for a stay pending a neurological examination by its expert witness to determine whether the Claimant's cauda equina symptoms were attributable to any breach of duty. The parties agreed that the *Laycock* approach was applicable.

In *Clarke v Poole and others* [2024] 1 WLR 5149, the adult Claimant was involved in a road traffic collision which caused devasting injuries leaving her with a range of physical and cognitive impairments. She had a family history of muscular dystrophy ("MD") which gave rise to a 50% chance that she had the gene for MD, and the Defendants' expert neurologist suggested that some of her symptoms might be consequent on MD rather than the collision. He recommended that the Claimant undergo EMG testing to offer greater certainty as to the presence of MD.

EMG testing is undertaken by inserting needles through the skin into the muscle. It can be painful. The Claimant had always declined diagnostic testing and did not wish to know whether she had the MD gene, for both practical and psychological reasons. Her expert psychologist concluded, and the Judge accepted, that "*any pressure on the claimant to undergo such testing would be likely to have a detrimental impact on her mental health*".

HHJ Gargan, sitting as a Deputy High Court Judge, concluded that the proper approach was to apply a three-stage test:

(1) The starting point is to determine whether it is in the interests of justice for the testing to be carried out.

(2) If it is, the next question is whether the Claimant has put forward a substantial objection which is more than imaginary or illusory.

(3) If she has done so, it is necessary to balance the competing rights – the Claimant's right to personal liberty and the Defendant's right to defend itself.

He concluded that the balance should be weighed in favour of the Defendant. "*It does not seem to me to be just that the claimant should be entitled to pursue her claim in full if the defendant is to be deprived of the opportunity of carrying out tests which will identify whether or not she has active symptoms of MD*."

The Claimant sought permission to appeal to the Court of Appeal. HHJ Gargan's decision has received some attention and seems likely to affect the approach taken to stay applications by those representing Defendants.

It seems at least arguable that the *Clarke* approach is inconsistent with *Laycock*, and in particular with Kennedy LJ's dictum that if the Claimant has a "*real objection… then the balance will come down in his favour*". That weighting of the balance in favour of the Claimant's entitlement to object to interference with her bodily integrity, even at the expense of the Defendant's ability to defend the litigation, might seem consistent with the more modern *Montgomery* approach to the concept of personal integrity.

What is clear is that any Claimant faced with an application of this sort will need to focus on the provision of evidence to the interlocutory judge – as to the nature of and reasons for the Claimant's objection, as to the likely physical and psychological effects of the testing, and as to any limitations in the test results - for example as to whether they will entirely resolve a question between the parties or only lend weight to one party's case; or as to the significance in quantum terms of the issue which the testing addresses. It cannot be overlooked that an application of this sort will give rise to an exercise of a discretion which is particularly fact-sensitive. In the meantime, it remains to be seen whether the Court of Appeal will consider this interesting question.

PI Claims: Considerations when representing a Claimant who lives outside of the Jurisdiction

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In England and Wales, we have a very well-established compensation system designed to meet the financial needs of individuals who have suffered injury at the fault of another. Some of these well-established principles can be taken for granted when quantifying claims for individuals who live in England and Wales, but what happens when the claimant moves to reside in another jurisdiction?

This article is designed to raise some of the issues that need to be considered when representing a claimant who was injured in England and Wales, but no longer lives in this jurisdiction.

Tax

It is established by statute (Section 51 (2) TCGA 1992) that compensation awarded as part of a PI claim isn't taxable in the hands of the individual. But this might not necessarily be the case in other jurisdictions, especially those with alternative compensation systems. Is your client potentially liable to pay tax on the lump sum award and / or any annual periodical payments that might be agreed upon settlement? If so, how can this potential tax liability be mitigated? This is an issue which requires expert evidence and should be considered before directions are set.

In a case concerning a child who resided in New Zealand, tax wasn't payable on the capital lump sum but might have been on any annual periodical payment (APP). Consideration therefore needed to be given as to how to best mitigate that risk. Considerations included, but were not limited to:

1. Would the Defendant agree to a tax indemnity?

2. Could you gross up the APPs?

3. Could you capitalise the APPs using a more advantageous discount rate to compensate the claimant for the risks associated with an uncertain life expectancy?

4. Is there a tax authority which could give a binding ruling on the issue in advance of any settlement / trial?

Discount Rate

In England and Wales, we apply the England and Wales PI discount rate when quantifying all future losses in personal injury claims. This discount rate is set by the Lord Chancellor in a way that reflects the current economic climate and costs of investing in England and Wales.

If your claimant lives outside of England and Wales, could it be argued under Section 1A(2) of the Damages Act 1996 that it is '*more appropriate*' in the case in question to take a different rate of return into account?

This is an issue which requires expert evidence from actuarial and economics experts, who will have to grapple over what methodology to use in determining the '*more appropriate*' discount rate. Should you be going back to first principles of full compensation (*Wells v Wells*) and restitutionary damages? Or should you, and is it even possible to, attempt to follow the approach taken by the Lord Chancellor when setting the PI discount rate in England and Wales?

Indexation of the PPO

In England and Wales, if a PI settlement is agreed by way of a lump sum, plus annual periodical payments for (usually) care and case management, those annual payments are linked to an index which ensures the payments increase over the years in line with inflation. In England and Wales cases, ASHE 6115 is usually the index to which the PPO is linked pursuant to Section 2(8) of the Damages Act 1996. Section 2(9) of the same Act however allows that to be disapplied.

If a claimant residing outside of the jurisdiction is paying for care and case management, then you should be considering whether an index which relates to price / wage increases in that country should apply. Again, this is an issue which requires expert evidence from an economist.

Currency Issues and Exchange Rate Risk

With claimants residing outside of the jurisdiction, there are likely to be different currencies at play. It is important to consider whether there is an exchange risk associated with converting money from GBP to an alternative currency and determine ways to mitigate that risk. Do you need to plead your Schedule in the currency in which the losses have been and will continue to be incurred? Should your settlement agreement / Order be based on payment in the currency of the country where the money is designed to be spent? Will you need to plead your schedule in two or more different currencies and convert it all into one currency at settlement?

Should an exchange rate be agreed at the point of settlement?

CPR Rule 16 and its Practice Direction sets out the requirements where a claim is for a sum of money expressed in a foreign currency.

Issues could potentially arise when making and receiving Part 36 offers where a claim is in GBP but an award is in a foreign currency, in particular issues around whether the award is more or less advantageous than a previous offer.

Managing Property and Finances when the Claimant Lacks Capacity

In England and Wales, when a claimant lacks capacity, or is likely to lack capacity at the age of 18, a Deputy is appointed by the Court of Protection to make decisions on their behalf and manage their property, finances and affairs. But if you have a claimant who resides outside of England and Wales, the question arises as to whether the Court of Protection in England and Wales has the jurisdiction to appoint a Deputy for the claimant.

If the Court of Protection in England and Wales doesn't have jurisdiction, it becomes necessary to explore the closest equivalent mechanisms available in the country in which the claimant resides. It turns out that in New Zealand, this was in the form of a Professional Trustee (a bit like a PI Trust in England and Wales) or a Property Manager.

This is an issue which requires specialist expert evidence, and the Court will have to approve any mechanism identified to manage the claimant's funds on an interim and final basis.

Experts Outside of the Jurisdiction

When representing a claimant who resides outside of the jurisdiction, expert evidence from foreign experts is likely to be required. It will then be necessary to ensure that any reports obtained are compliant with CRP Part 35 and that the expert understands the litigation process in England and Wales. This can be taken for granted when using experienced experts in England and Wales.

A further consideration relates to the rules around summonsing experts in alternative jurisdictions. Any attempt to serve a witness summons outside England and Wales will not be binding. Instead, a process set out under CPR Rule 34 must be followed which involves the Court sending a Letter of Request, which is a request made by a judicial authority of one contracting state to the Hague Convention to the competent authority of another contracting state either to obtain evidence or to perform some other judicial act. The contents of the Letter of Request are set out in Article 3 of the Hague Convention.

The RCJ have a foreign process department who can advise on summonsing witnesses outside of the jurisdiction and the Foreign Commonwealth Office can advise on what restrictions / requirements there are for witnesses giving evidence via video link in a Court in England and Wales, from other jurisdictions.

If your case does end up going to trial, do you need to apply for and arrange for witnesses to give expert evidence via video link?

Losses in other Countries

If the financial losses of the claimant are to be incurred in another country, it is important that your experts provide an opinion of the likely costs of meeting the claimant's needs in that country. Your experts are going to have to do their research on local accommodation and adaptation costs, care rates, the cost of aids and equipment, any local VAT equivalent taxes and additional employer costs.

Case Managers

It is well established that in cases in England and Wales concerning severe injury that Case Managers are usually appointed to advocate for the claimant and to help organise and facilitate the necessary rehabilitation package. Case Managers exist in England and Wales because of our PI compensation system, but this might not necessarily be the case in other countries.

In a case concerning a child in New Zealand, it became apparent that Case Managers didn't really exist due to their No-Fault Compensation System. As such, a Case Manager based in England, who happened to be from New Zealand, was appointed on an outreach basis.

Life Expectancy

Does your life expectancy expert need to consider any adjustments to their life expectancy estimations based on the county in which the claimant lives?

Practical Considerations

In addition to the legal and procedural considerations set out above, there are also practical issues to consider:

1. Is there a language barrier? Do you need to work with a translator and have key documents translated? Any witness whose first language is not English will have to give their evidence in their first language and the CPR requirements in this area will have to be followed closely. These issues will cause substantial increases in costs and will have to be budgeted for in full. Consideration also needs to be given to whether this means your client / witness is classed as vulnerable for the purposes of proceedings.

2. Should you be seeking out Leading Counsel / Counsel who has experience in the issues which arise in these sorts of cases?

3. Are there other legal advisors from whom you can seek advice on issues which fall outside of your area of expertise? Court of Protection Lawyers? International Personal Injury lawyers? Trust lawyers?

4. Do you or anyone in the firm have connections in other countries, which you could use to get recommendations for experts or a steer on where to look?

5. Is there a time difference you have to work with? For New Zealand, it meant early morning or late evening conferences, and a Joint Settlement Meeting across different time slots first thing in the morning and in the evening / into the night.

The list of considerations above is not designed to be exhaustive and there may well be other issues that have arisen in your cases where claimants have resided in other jurisdictions. I would be interested to hear from you if that has been the case. I hope at least that this article has provided food for thought on some of the things to consider when your client says to you: '*I'm thinking about moving to Australia*'.

How *Churchill* has turned us all into Dispute Resolution lawyers

PAUL BALEN
TRUST MEDIATION

"It is acknowledged that dispute resolution assists the parties in avoiding litigation and unnecessary costs and resources, which benefits the claimant and NHS healthcare professionals. The parties agree to explore the use of relevant dispute resolution methodologies and work together to promote the judiciaries' ambitions of avoiding unnecessary litigation."[1]

So said the latest **claims handling agreement** negotiated by AVMA and SCIL with NHS Resolution.

This article explores what are the *"relevant dispute resolution methodologies"*; how the lawyers representing the parties are supposed to choose between them and what happens when they have been *"explored"* or if they have not been *"explored"*.

Genesis

I am old enough to remember the times when medical records were only supplied, if at all, fourteen days after the conclusion of an inquest; witness statements and expert evidence were not exchanged and parties arrived in court for a trial without much, if any, idea what exactly the issues were. Bereavement damages were £3,500 and legal aid was available for trials even where the amount in issue was little or nothing. Patients or relatives were frequently only looking for information or apologies and had little more information after a trial - win or lose - than they had before. Concepts such as "closure" "disclosure" and "candour" were unknown. If settlements were to be discussed this took place in the court corridor just before the judge made his grand entrance. That was the extent of dispute resolution in clinical negligence cases. There was no concept of co-operation either between parties or even amongst fellow claimant lawyers who regarded each other as opposition. AvMA and APIL were yet to be formed, and, when they were, had to overcome widespread opposition/suspicion from other claimant lawyers.

Strangely in retrospect, the personal injury industry was more advanced. Settlement days when the insurance claims manager popped round to discuss and hopefully resolve the book of cases a claimant firm was running against its insured were commonplace but that was as far as alternative dispute resolution got.

Numbers

In 2001, as the world became more litigious, the then Government indicated that preferentially all claims against it should be mediated. This led in 2002 to a mediation pilot run by the NHS for small value claims but even after that there was little or no take up. I, like many fellow lawyers never experienced a health defendant accepting an offer of mediation. It was only after pressure from the Department of Health that a further mediation pilot study was run in 2016 leading to the creation of what is now the NHS Resolution Mediation Scheme following which mediation in clinical negligence cases really got off the ground.

Even this successful scheme, which so far has involved around 2,500 cases since January 2017, has barely scratched the surface although there is no doubt that it has fuelled the acceptance of other forms dispute resolution.

Judges

It seems strange but true to describe the current Master of the Rolls, Sir Geoffrey Vos, as a disruptor but if the definition of a disruptor is someone unafraid to shake up how things are done it is undoubtedly he who has led the revolution. It is his view, frequently expressed in a variety of speeches since 2021, that courts are there to assist the parties find a resolution to their dispute and (A)DR is to be viewed as an integral part of that process not an opt in and not really *"alternative at all"*. Appearing before a judge and taking up valuable and scarce judicial resources is in his view a last resort. Hence, parties' lawyers are primarily

1 *Clinical Negligence Claims Agreement - AvMA SCIL NHSR-26.8.24 para 13.*

dispute resolution lawyers not adversarial litigators. Over recent years fellow judges across the civil litigation arena have increasingly picked up the baton and penalized a party for not negotiating out of court[2] even in some instances when that party had won at trial.[3]

Encouraged by the Master of the Rolls' example his fellow judges saw their roles as part of their case management powers to cajole and if necessary coerce parties to resolve cases out of court[4]. The reasons given for avoiding sanctions in the clinical negligence case of *Halsey*[5] were one by one dismembered so, for example, the strength of a party's case was no longer a valid reason for failing to attempt out of court resolution.[6]

Some considered this was going too far and effectively prevented parties exercising their right of access to the courts. The Master of the Rolls saw it differently and seized the opportunity in the *Churchill*[7] case to make the position clear.

In that case the Council was seeking a stay in view of the existence of its complaints process which the claimant had not utilised. The Master of the Rolls, however, pointed out that the complaints process did not provide what the claimant was seeking - i.e. compensation. He ruled that: *"The court can lawfully stay proceedings for, or order, the parties to engage in a non-court-based dispute resolution process provided that the order made does not impair the very essence of the claimant's right to proceed to a judicial hearing, and is proportionate to achieving the legitimate aim of settling the dispute fairly, quickly and at reasonable cost."*

He declined *"to lay down fixed principles as to what will be relevant to determining the questions of a stay of proceedings or an order that the parties engage in a non-court-based dispute resolution process."* Refusing to order a stay for the complaints process to be followed he stated that *"the parties ought to consider whether they can agree to a temporary stay for mediation or some other form of non-court-based adjudication."*

Following publication of this judgment Lady Chief Justice Carr, spoke about the court's case management powers stating that: *"... judges are increasingly likely to be called upon – further to the requirement to manage cases – to consider whether to mandate the use of ADR. And not just to consider the question of whether to do so, but also the broader question of which form of dispute resolution to mandate."* She emphasised that the judiciary and legal practitioners will need to become familiar with the different forms of ADR explaining:

"Here the parties will need to play their role. They will need to consider, constructively and further to the CPR's overriding objective, which process might best suit their circumstances. They will need to inform the court of this view. And, as importantly, judges will need to be familiar with the different forms and their features, so that they can properly assess which is best-suited."[8]

Subsequent judgements have echoed this and emphasised that out of court dispute resolution obligations continue throughout the litigation process. Just because the first attempt may fail does not means to say that the obligation is discharged.[9]

In the meantime, judges continue to penalise parties for not mediating[10]; and as well as the updated AvMA/SCIL/NHS Resolution handling agreement; proposals have been made to update the pre-action protocols to reinforce the requirement to adopt dispute resolution[11]

2 PGF II SA v OMFS Co *2013 EWCA 1288*

3 Laporte v The Commissioner of Police of the Metropolis *2015 EWHC 371.* Marsh v Ministry of Justice *2017 EWHC 1040*

4 *For example: "it was ordered that at all stages the parties must consider settling this litigation by any means of Alternative Dispute Resolution (including mediation). I was told that no mediation has yet taken place. Any party not engaging in ADR in some form may expect to be heavily punished in costs irrespective of the outcome of the claim and counterclaim. I would urge that following the determination of this application both parties will re-evaluate the strength and weakness of their respective cases"* Thandi v Saggu *2023 EWHC 1379 (Ch)*

5 Halsey v Milton Keynes General NHS Trust *[2004] EWCA Civ 576*

6 *See* Griffiths J in DSN v Blackpool *[2020] Costs LR 359 EWHC 670(QB)*

7 Churchill v Merthyr Tydfil CDC *[2023] EWCA Civ 1416*

8 *(Lady Chief Justice Carr speaking at London International Dispute Week in June 2024, (***https://www.lawgazette.co.uk/news/lady-chief-justice-calls-for-united-front-on-adr/5119891.article***)*

9 Heyes v Holt *[2024] EWHC779(CH) summary judgment application dismissed-claim stayed foe second mediation (Estate dispute);* Francis v Pearson *[2024] EWHC 605 (KB) Failed strike out after failed mediation - judge strongly recommends the parties re-consider some form of ADR process (libel)*

10 Bell v Commissioner of Police of the Metropolis *(2) 2024 EWHC 650 (KB) Hill J;* Stoney-Andersen v Abbas *[2023] EWHC 2964 (CH)*

11 *CJC Consultation Amending Pre-Action Protocols 2024*

- *Litigation is to be a last resort*
- *Compliance with the PAPs is to be mandatory*
- *Parties should co-operate to resolve complaints or disputes before resorting to litigation, – to be incorporated in the overriding objective in an amended CPR 1;*
- *Formal offers may be made;*
- *Adverse costs sanctions for disproportionate, and severe sanctions for dishonest conduct;*
- *If negotiation fails it will be obligatory to use a dispute resolution process, but settlement is not mandatory(!) and parties will be free to go to court if the dispute is not settled.*

and the Civil Procedure Rules have been amended to formalise the court's case management and enforcement powers.[12]

There has now been the first reported High Court Judgement since *Churchill* which emphasises the judges' determination to give priority to dispute resolution generally and mediation in particular even if one or both parties objects[13]. In that commercial case the claimants' application for the court to order mediation was resisted by the defendant.

In ordering the parties to mediate, the judge ruled that:

• even where the parties' positions seem diametrically opposed with each requiring a judicial determination, mediation has been shown to be successful;

• while there was some force in the defendant's submission that mediation was too late as the parties were preparing for trial there can be an advantage in the parties' positions having been crystallised through pleadings and witness statements

• although the parties were represented by experienced solicitors who had been unable to resolve the case mediation can often overcome an entrenched reluctance of parties to negotiate

• the range of options available to the parties to resolve the dispute through mediation went beyond the binary answer a court could provide;

• the mediation was likely to be 'short and sharp' since little documentation would be required and there was no suggestion that a mediation would significantly disrupt the parties' preparations for trial;

• on the material available to the court it seemed possible for the parties to find a workable date for the mediation, despite the defendant's contention that it had very limited availability prior to trial.

The lesson from this is clear. Resolving cases out of court is a priority. There can be no valid objection to attempting dispute resolution and if the parties cannot agree either on the principle of using ADR or on the type of ADR suitable for the particular issues in the case the court will order ADR and if necessary choose the form of dispute resolution to be applied.

The Dispute Resolution Toolbox.

So what dispute resolution options are available now for the clinical negligence lawyer to utilise?

1. Direct negotiation

It is a shame that modern IT has led to the phone being removed from desks and turned into an internet communication which all too often discourages human vocal discussions losing the nuances that oral communication can provide during one to one discussions. Emails and WhatsApp seem to be preferred to human contact!

2. Joint settlement meetings

Familiar to most these can be very successful. Lawyer led without ground rules other than their implicit "without prejudice" nature they tend to err on the adversarial side with the client sometimes confined to a broom cupboard. With goodwill from both sides they can and have worked very well. They tend to be held late on in the litigation cycle and be lawyer centric, sometimes failing in circumstances where a more considered approach would have ironed out misunderstandings and avoided lawyers grandstanding.

3. Mediation

There are two forms of mediation – facilitative, where the mediator as an independent neutral is simply there to help the parties resolve the case themselves and evaluative, where the mediator as a specialist in the field being litigated is asked to express an informal non-binding opinion on an issue or the whole case. The current NHS Resolution Scheme has only covered facilitative mediation but it is understood that NHS Resolution, which is increasingly promoting alternative forms of dispute resolution, is now prepared to agree to evaluative mediation in suitable cases.

Experience from the first eight years of NHS Resolution Scheme shows that around 80% of cases resolve at or immediately as a result of mediation and that that resolution rate does not differ whenever in the litigation cycle the mediation takes place. This suggests that mediation which takes place early in the cycle with compensation and costs being paid earlier to claimants and lawyers has a lot to commend it and this is borne out by the Trust Mediation experience in which now well over

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12 *CPR amendments from 1st October 2024*

- *The overriding objective updated to promote the use of ADR*
- *CPR 1.4 and 3.1- may order ADR*
- *Pt 28 and 29 –must consider whether to order or encourage ADR*

Pt 44 expressly defines failure to participate in ADR as relevant conduct issue when considering costs

13 **DKH Retail Ltd and others v City Football Group Ltd [2024] *EWHC 3231 (Ch) Miles J***

50% of mediations take place pre-issue and well over 70% pre-CCMCs.

Run by the independent neutral, with the claimant involved as little or as much as he/she wants to be, helps not only bring resolution but also personal closure to both parties. The process is underpinned by a formal mediation agreement (in the case of a NHS Resolution Scheme mediation, a standard agreement) which also stresses the confidentiality of mediation as well as its "without prejudice" nature. There are no rules other than confidentiality, so the process is flexible and in each case, with experienced mediators guiding the way, adapted to the needs of the parties in the case in question. Misunderstandings can be uncovered and ironed out; extra-judicial remedies such as apologies and lessons learnt often play a key part and there is often no need for either party to prepare to trial standard. Indeed, parties' lawyers are often now skilled enough to rely on their own experience of similar cases to assess the risk and valuations involved at a very early stage.

Virtually all cases are suitable for mediation and, as we have seen, if necessary, more than once. Mediation is undoubtedly particularly successful where logjams have occurred; parties wish to play a central part; where the litigation may have become aggressive or where relationships whether lay or legal have broken down; and where issues are particularly sensitive.

Mediation can also be used to narrow the issues and be specially set up for that purpose. This in the presence of the mediator as an independent neutral may lead to recognition either that the claimant's case is stronger than previously perceived by the defendant team leading to earlier resolution albeit at a later date, and, conversely, the claimant team realising that the claim is no longer viable and advising the claimant accordingly. If the mediation is set up purely for this purpose it is critical that this is stipulated by the defendant team from the outset.

Experienced mediators facilitate the exchange of information; keep the parties engaged in thinking resolution; diffuse emotion and adversarial posturing whilst encouraging venting if appropriate and assisting the parties in case and risk analysis as well as managing expectations.

Increasingly a lot of preparatory work takes place before the mediation day with the mediator holding pre-mediation discussions with each party separately and providing encouragement to parties to exchange documentation and information. This includes encouraging parties to reflect on how they see the case being resolved and to set down and share those thoughts in a short document known as a position statement. For those who have not experienced a mediation before, the mediator will provide guidance on the production of documentation, exchange of information and on the process to be adopted on the day. Choreographing discussion of extra-judicial remedies and offers of settlement are key skills of mediators involved in these sensitive cases.

4. Neutral Evaluation

Sometimes also known as Early Neutral Evaluation an independent specialist evaluator is appointed by the parties to provide an assessment of the merits of their respective submissions on a particular issue or the whole case. The evaluation is non-binding and "without prejudice", so no reference can be made in any proceedings to what happened in the evaluation process unless otherwise agreed by the parties. Trust Mediation provide specialist legal and medical evaluators whose evaluation may then be used as the basis for settlement negotiations either direct or in a subsequent facilitative mediation.

Usually, once appointed, the evaluator will give administrative directions for submissions (whether oral or written or both) to be provided with supporting documents. Already some parties are on occasions agreeing that such an evaluation should in the individual case under consideration be treated by them as binding – in other words effectively an adjudication.

5. Adjudication or Arbitration

With the delays and lack of investment in the court service why not effectively privatise the process so that parties can secure a binding decision cheaper and quicker than going to court? Already we are seeing this trend with online arbitration of smaller personal injury claims[14] and conceptually there is no reason why that process cannot be used for small value clinical negligence claims and indeed, if the parties agree, for higher value claims.

6. Mix and Match

As can be seen from the above parties are increasingly embracing the flexibility of the out of court dispute resolution processes. So, for example, facilitative mediation can be followed by evaluation or vice versa; and mediation of either kind or evaluation could be followed or converted into adjudication/arbitration. It is also apparent that AI is going to play an increasingly

14 *Using the Trust Arbitration scheme for road traffic claims below 25k for which over 50% of RTA insurers and major bulk handling claimant law firms now use*

valuable role in both in case preparation and evaluation or adjudication.[15]

Conclusion

Every litigation lawyer needs to be able to advise their clients on the appropriateness of each of the many dispute resolution options before issuing any court proceedings and throughout any case. It is wise to provide in client care documentation some initial guidance on dispute resolution out of court to avoid clients having the misapprehension that they are inevitably heading for court and feeling they have been robbed of their day before a judge if you later recommend mediation or evaluation be attempted first.

Opportunities abound now for exerting pressure on the opponent to resolve the claim out of court and to do so early. The stocktake at the end of the pre-action protocol is increasingly seen as the most important stage of the case. If resolution is not achieved, then opportunities arise throughout the litigation circle. Ducking involvement in dispute resolution is not an option. Judges are already ordering parties to participate in mediation and other forms of dispute resolution. Participation means active participation. Attending as part of a "tick-box" exercise with no intention of exploring resolution may be treated as non-participation and may also be penalised. Ignoring offers of an opportunity for dispute resolution such as mediation risks incurring financial penalties and judicial intervention and opprobrium.[16]

Paul has practised as a solicitor in the clinical negligence field for over 45 years. Although now a very part time consultant to his old firm Freeths he remains an AVMA specialist panel member now with Honorary status.

Paul qualified as a mediator in 2004 and has conducted approaching 350 mediations mostly, but not exclusively, clinical negligence and personal injury cases. He is a director of Trust Arbitration and of Trust Mediation, one of the two mediator providers contracted to NHS Resolution. He has also mediated cases involving NHS Wales, the MDU, MPS and in Jersey. He is also a panel mediator for Sport Resolutions.

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

15 *For information and help with all methods of out of court dispute resolution contact* **registrar@trustmediation.org.uk** *or* **paul.balen@trustmediation.org.uk**

16 *See e.g.* Evans v R&V Allgemeine Veriscerung *[2022]EWHC 2688;* TMO Renewables v Yeo *[2022] EWCA 1409;* Moradi v Home Office *[2022] EWHC 3125;* Wales v CBRE *[2020] EWHC 1050;* BXB v Watch Tower *[2020]EWHC 656*

The inquest touching the death of Peter Mannheim

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An inquest in November 2024 heard evidence concerning a care home resident dying after eating inappropriate food. Regrettably, this is not an uncommon subject for inquests arising from care homes, and incidents have been reported from hospitals too. This article highlights points to consider when dealing with deaths following choking, and in particular as to the risk assessment of food and level of care.

Background to the inquest

Peter Mannheim suffered frontal lobe damage to his brain from a stroke suffered in 2019. This caused him oropharyngeal dysphagia (the loss of the ability to swallow solid food safely) and some behavioural changes, including the loss of ability to control the speed with which he would eat soft food. He was hospitalised three times across 2019 due to aspirational pneumonia. He satisfied a full NHS Continuing Healthcare assessment, which indicated the need for a more supportive environment to reduce the risk of non-compliance with his swallowing recommendation, supervision when feeding, and to prevent further hospital admissions.

As a result, Peter was transferred to a placement at a care home. He was shortly thereafter placed on 1:1 care at 24 hours per day, as the care home were unable to meet needs. The clinical rationale on the Additional Care Request form listed some concerns regarding Peter's impulsive behaviour towards other residents, but also the following concerning swallowing risks:

"presents with moderate oropharyngeal dysphagia and required modified diet to reduce risk of aspiration due to delayed swallow initiation, pharyngeal residue and laryngeal penetration. [...] PM lacks metal capacity to understand and retain relevant information regarding the risks attached to him eating regular diet. PM needs a regular support to prompt swallowing and to stop him from putting more food in his mouth or eating the food that is recommended for him [...]"

Consequently, the Coroner found that it was well documented and recognised that Peter had a high risk of aspiration due to an impaired swallow, and impulsively sought inappropriate food items.

The 1:1 care was reduced to 10 hours per day in December 2020, to reflect low risk at nighttime.

In May 2023, a review of Peter's 1:1 care was undertaken by the Integrated Care Board (ICB). However, unlike previous reviews, Peter's family were not consulted. If asked, Peter's family would have raised concerns about the removal of the 1:1 care as there was a foreseeable risk due to the ongoing (and permanent) oropharyngeal dysphagia and impulsive behavioural difficulties. Peter's lead carer at the care home gave evidence that she did not consider the removal of 1:1 care appropriate either, and if asked as part of the review by the ICB, would have raised concerns as Peter was "*an opportunistic food thief*". Nevertheless, the ICB removed 1:1 care. Peter's family were notified after the event by the care home and told that there was "*nothing to be done*".

Following the removal of 1:1 care, Peter's carers at the care home conducted an informal 1:1 as they felt they had to observe Peter constantly.

On 1 February 2024, an activity day took place on Peter's Unit. Peter did not usually participate in these, but was never excluded from them. If there was food involved, he would be interested in the event. At the event, another resident had marshmallows on his plate. While residents had their own feeding risk assessments, dictating the food prepared for those individual residents, there was no risk assessment of the activities themselves, and what risks they would pose on other residents of the Unit that were free to enter.

Peter took marshmallow sweets from another resident's plate, walked out from the room, ate them while walking back to his room, and choked. Immediate good quality first aid was not able to remove the airway blockage before a hypoxic brain injury was sustained. He died on 8 February 2024 as a result of this incident.

The Coroner reached a shortform conclusion of "*accidental death contributed to by neglect*", with the medical cause of:

Ia. Hypoxic-ischaemic encephalopathy

Ib. Asphyxiation associated with chronic dysphagia

II. Aspiration pneumonia, dementia, cerebral vasculitis, previous stroke.

Risk assessments

Risk assessments are processes by which hazards are identified and assessed, and considerations are given on how to control or minimise those risks. By their nature, they need to be bespoke and dynamic.

However, the following are pertinent questions to consider when reviewing whether a risk assessment concerning a person with feeding needs is sufficient and appropriate:

• Are risk assessments of a specific resident's eating/drinking needs informed by evidence from the relevant experts (e.g. SLT?)

• Do these risk assessments cater for all opportunities in which food may be available – ie: not just formal mealtimes, but snack times and activities/events where food is easier to carry out from dedicated eating spaces?

• Do risk assessments account for potential periods (even if brief) where residents are unsupervised, such as when staff are involved in clearing up after an event?

• Is there suitable communication taking place between the activity planners, nurses, and kitchen staff in setting up activity days to ensure appropriate information sharing of risks?

• If members of staff are not clinical practitioners, are they sufficiently trained to ensure knowledge and understanding of care plans in place?

• If there are known concerns of impulsivity (such as opportunistic food grabbing), what measures are in place to account for opportunities to access inappropriate food?

• Is there sufficient communication in place between the staff on the ground and those in management as to appropriate level of nursing care required for residents (ie: constant monitoring versus close monitoring)?

ICB reviews

This case dealt with issues concerning the process of the ICB removing 1:1 care.

It was recognised by the witness on behalf of the ICB that there was a failure to involve Peter's family in the decision reviewing 1:1 care, and errors in the review form. The errors included the omission of risk of aspiration pneumonia, failure to identify a DOLS in place, and incorrectly stating that the next of kin were spoken to and had no concerns with the outcome.

It will be important to families to feel that they have been heard, and their views accounted for in any such review.

More importantly, the appropriate carer's views would also have been pertinent at the review stage. In this case, the Coroner identified that the carers' concerns were sufficient to the extent that they were carrying out an informal 1:1 by keeping an eye on Peter when he left his room.

When reviewing Continuing Healthcare Review forms, careful consideration ought to be given to:

• The documentary basis for the assessment, and whether this includes known risks (such as disordered eating);

• Changes between annual reviews, and any explanations behind those changes;

• The extent to which the resident in question is spoken to or observed – for example, in this case, no mention is made of whether Peter was seen at a time of the day involving food;

• A robust reflection of the family's views; and

• Consideration of the views of carers, who will be well apprised of the reality of the risks involved.

Neglect

The Coroner was invited to consider the neglect rider as part of her conclusion. In so doing, she returned to the judgment of Lord Bingham in *R v North Humberside and Scunthorpe Coroner, ex parte Jamieson* [1995] QB 1, in particular at general conclusion (9) (emphasis added):

> *Neglect in this context means a gross failure to provide adequate nourishment or liquid, or provide or procure basic medical attention or shelter or warmth for someone in a dependent position (because of youth, age, illness or incarceration) who cannot provide it for himself. Failure to provide medical attention for a dependent person whose physical condition is such as to show that he obviously needs it may amount to neglect. So it may*

be if it is the dependent person's mental condition which obviously calls for medical attention (as it would, for example, if a mental nurse observed that a patient had a propensity to swallow razor blades and failed to report this propensity to a doctor, in a case where the patient had no intention to cause himself injury but did thereafter swallow razor blades with fatal results). In both cases the crucial consideration will be what the dependent person's condition, whether physical or mental, appeared to be.

As the Coroner identified, replacing "*razor blades*" with "*marshmallows*" would create a direct and compelling correlation to the example given in *Jamieson*.

She further noted that the carers realised the risk of access to food and were taking informal (albeit insufficient) steps to minimise such risks in the absence of 1:1 care. However, she was of the view that this was a case with a "*total and complete*" failure to undertake any risk assessment of the activity day itself.

In these ways, the care home allowed Peter to be exposed to a recognised risk. The omission of this risk assessment created a clear and causal link to Peter's death.

Consideration should be given to the nature of care being provided (or not, as the case may be) and whether this is analogous to the example given in *Jamieson*.

Conclusion

Practitioners will need to be live to the minutiae of changes in risks, particularly as residents may have worsening functionality as they age.

This will assist in recognising any failures occurring in the process of assessing their safety within the care home, and identify any changing need in the level of supervision or care.

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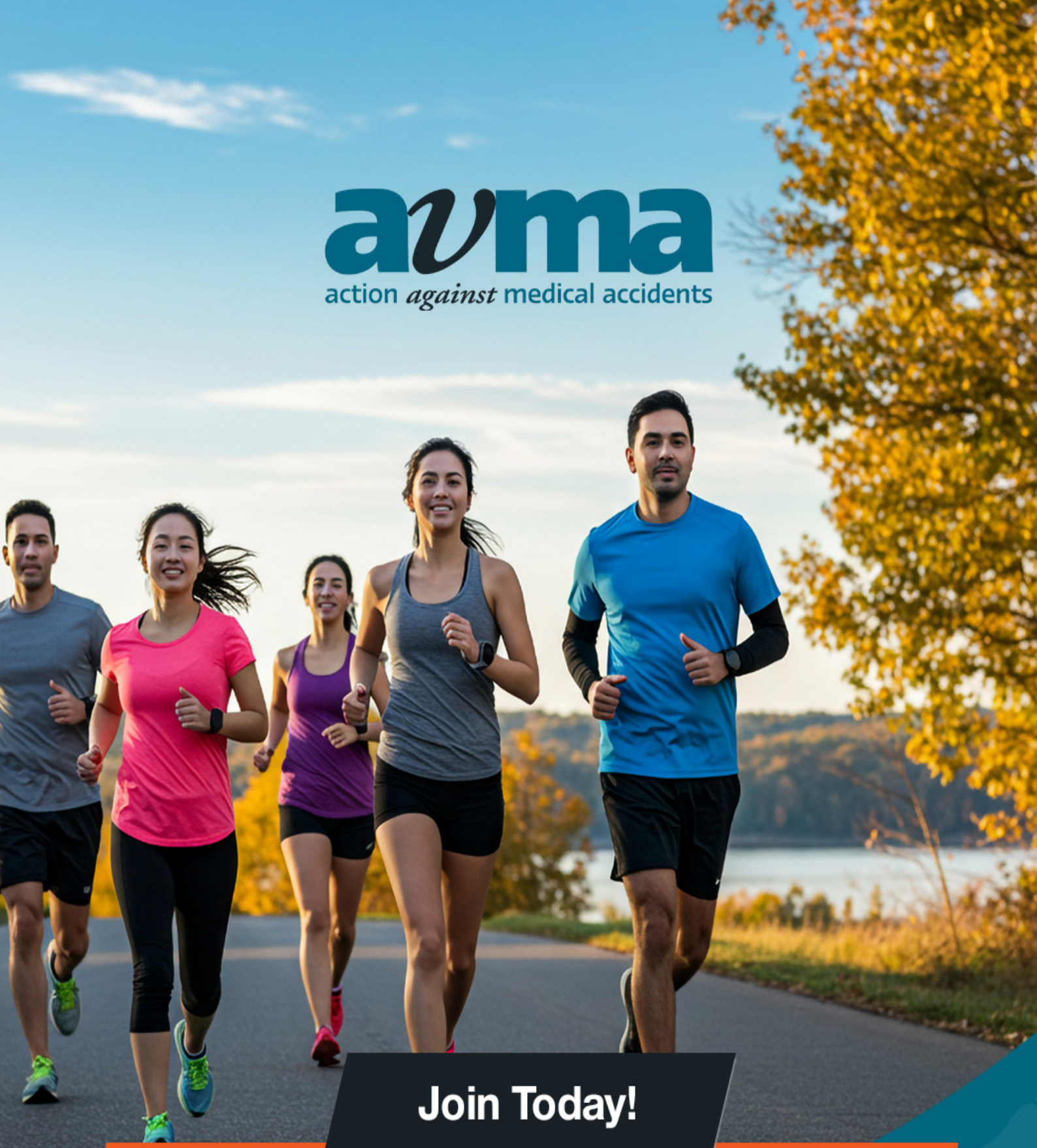

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50 Miles *in* May for Patient Safety

This May, AvMA is calling on **lawyers, legal professionals, and firms** to take on **50 Miles in May** – our first, fully online challenge that fuels our vital work supporting harmed patients and advocating for safer healthcare.

Every year, thousands of patients suffer due to medical negligence, and many turn to legal professionals for justice. By taking part in **50 Miles in May**, you can show solidarity with your clients, make a real impact, and help ensure no one is left without the support they deserve.

Why Take on the Challenge?

✅ **50 Miles – One Month – One Purpose:** Walk it, run it, or wheel it—wherever and whenever it suits you. Track your progress online and see how every mile helps make healthcare safer.

✅ **Make a Bigger Impact:** An estimated **13,500** deaths each year in the UK are linked to avoidable medical harm. AvMA's strategic plan aims to **reach more communities, signpost more people to expert legal advice, and ensure that harmed patients get the guidance they need to seek justice**.

✅ **Full Support Every Step of the Way:** When you sign up, you'll receive a **training plan, fundraising toolkit, and ongoing motivation** to keep you going throughout May.

✅ **Team Up for Justice:** Rally your firm, chambers, or legal department to take part as a team—boost camaraderie, encourage well-being, and raise funds together.

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Sign Up Today - Make Every Mile Matter

Join us and **be a champion for patient safety**. Whether you go solo or form a team with colleagues, **your participation will help AvMA expand its support, signpost more people to legal advice, and ensure harmed patients get the justice they deserve.**

Are you ready to step up for change?

Sign up today at www.avma.org.uk/50MilesInMay and take the first step towards a safer healthcare system!

Network, Engage, and Support Justice - Join an AvMA Fundraising Event!

The AvMA/Circle Case Management 5K

19 March 2025 | Bournemouth
📍 **Meyrick Park** |
🕕 Arrive **4:15 pm** | Warm-up **4:45 pm** | Race starts **5:00 pm**

Lace up and join us for the third AvMA/Circle 5K on Wednesday, 19 March! Whether you're a keen runner or a casual walker, this friendly event is open to all.

We're thrilled to welcome **15-year-old aspiring Paralympian James Scammell**, who will be officially opening the event.

🏆 **Prizes for the fastest finishers** + a special reward for the **Top Fundraiser!**
📢 **Sign up now!** www.avma.org.uk/5krun

This exciting event is organised by Circle Case Management and proudly supported by Enable Law and Clarke Willmott.

AvMA/PIC Curry Nights – A Feast for a Good Cause!

Enjoy a **three-course meal with a welcome** drink (champagne or soft drink), great company, and plenty of networking—all while supporting AvMA's work to improve patient safety.

📍 **Birmingham – 15 April | Rajdoot**
78–79 George Street, Birmingham, B3 1PY
🕕 **6:00 pm – 9:00 pm**

📍 **Cardiff – 10 June | Spice Quarter**
St Mary Street, Cardiff, CF10 1FG
🕕 **6:00 pm – 9:00 pm**

📍 **Manchester – 8 July | eastZeast**
Blackfriars Street, Salford, M3 5BQ
🕕 **6:00 pm – 9:00 pm**

✉ **Book your place or explore sponsorship opportunities!** Email: Emma Woolley at emma.woolley@pic.legal.

AvMA/Fletchers Tapas Night– Save the Date

24 April 2025 | 5:30 pm

📍 **Casa Leeds, 6 Grand Arcade, Leeds, LS1 6PG**

Organised by Fletchers Solicitors, this evening promises delicious tapas and great company, all in aid of AvMA.

✉ **For more information**, email Tara Evans at taraevans@fs.co.uk.

AvMA/Kain Knight Curry Night

22 May | Exeter
📍 **Ganges Restaurant, 156 Fore Street, Exeter, EX4 3AT**

Hosted by Kain Knight in aid of AvMA.

Enjoy a three-course meal with a welcome drink, all while raising vital funds for AvMA's work to improve patient safety.

✉ **Book your place!** Email: Adrian Hawley at Adrian.Hawley@kain-knight.co.uk

AvMA/Prosperity London Curry Night

29 May | London
📍 **Gunpowder Restaurant, 4 Duchess Walk, London, SE1 2SD**
(Just 2 minutes from Tower Bridge Station)

Hosted by Prosperity Insurance and supported by Kain Knight and 3PB in aid of AvMA.

Enjoy a three-course meal with a welcome drink, all while raising vital funds for AvMA's work to improve patient safety.

📢 **Reserve your seat now!** Book here

AvMA/Fieldfisher Manchester Charity Quiz Night [SOLD OUT]

1 May 2025 | 6:00 pm
📍 **The Courts Club, Manchester**

Think you've got what it takes to be a quiz champion? Get your team together for a brilliant night of trivia, laughter, and fundraising.

Missed out? Join the wait list! email Paula Santos at paulas@avma.org.uk

Generously hosted by Fieldfisher Manchester, and drinks sponsored by Byrom Street Chambers with all proceeds going to AvMA.

OR ORGANISE AN EVENT...

Get in touch

Inspired to organise a fundraising event to show solidarity with your clients, make a real impact, and help ensure no one is left without the support they deserve, please contact Paula Santos for an informal chat.

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

Forthcoming conferences and events from AvMA

Look out for details on more AvMA events coming soon! For further information on our events:
go to www.avma.org.uk/events
or email conferences@avma.org.uk

35th Annual Clinical Negligence Conference (ACNC) Update: Booking is now CLOSED

20-21 March 2025 (Welcome Event 19 March),

Bournemouth International Centre

If you've not already booked your place, make sure you don't miss out on the 35th AvMA Annual Clinical Negligence Conference (ACNC), the event for clinical negligence specialists! The very best medical and legal experts will ensure that you stay up to date with all the key issues, developments and policies in clinical negligence and medical law, whilst enjoying great networking opportunities with your peers.

AvMA End of Summer Social

Evening of 12 September 2025,

The Royal Liver Suite, Liverpool

Introducing a brand new social event for the clinical negligence and medico-legal community! Join us at the iconic Royal Liver Building on Liverpool waterfront on the evening of Friday 12 September for an evening of great food, fun, entertainment and networking in fantastic surroundings. Bookings for tables and individual tickets will open soon but please e-mail conferences@avma.org.uk for further details and sponsorship opportunities.

Medical Negligence & Access to Justice in Ireland Today Conference

6 November 2025,

Dublin

We will be making a fond return to Dublin in November! Booking will open soon but please e-mail conferences@avma.org.uk for further details and sponsorship opportunities.

AvMA Specialist Clinical Negligence Meeting

Afternoon of 28 November 2025,

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 28 November 2025,

Grand Connaught Rooms, London

AvMA Holly Jolly Christmas returns on the evening of 28 November! The evening will commence with a drinks reception followed by a fantastic three-course meal with wine, live music and dancing. It will be the perfect event to entertain clients, network with your peers and reward staff. Bookings for tables and individual tickets will open soon but please e-mail conferences@avma.org.uk for further details and sponsorship opportunities.

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

5 February 2026,

Doubletree by Hilton Bristol City Centre

This popular AvMA conference is returning to Bristol in February 2026 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. Full details available soon.

AvMA Medico-Legal Webinars

For more information, if there are topics you would like to be covered, or have any speaker suggestions call 02030961126
or please email Kate at kate@avma.org.uk

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

At AvMA, our medico-legal webinars give you immediate access to leading specialists speaking on subjects ranging from interpreting blood test results to medico-legal issues in surgery and many more besides!

When and where you need

The webinars can be watched at a time convenient to you, all without having to leave your office. You can watch the video as many times as you want, and you can download the slides and any extras materials to aid your learning.

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You can purchase three different webinar licences to fit your needs:

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Purchase only: www.avma.org.uk/learning

Our latest webinar titles include:

- Pre-Eclampsia during & after Birth
- Wounds – Prevention, Management & Healing Strategies
- AI & The Future for Lawyers
- Medico-Legal Issues in Invisalign Treatment
- Medico-Legal Issues in Dental Implants
- Arts Therapies within Neurorehabilitation

And more.... **Download our 2024 – 2022 Webinar List**

AvMA Live Webinars in 2025

Consent: A Clinician's Perspective with Mr Amar Alwitry, Consultant Ophthalmologist, Cataract & Refractive Surgeon at Spire Nottingham Hospital for a live and interactive webinar on Wednesday 2 April 2025 @ 14:30pm discussing Consent, a clinicians perspective.

Over the course of the hour Mr Alwitry will cover:

- The clinical application of montgomery
- Consent conundrums
- Q & A using Slido

Book now: www.avma.org.uk/events/avma-live-webinar-consent/

Neonatology with Dr Ranganna Ranganath, RCPCH Tutor, Deputy Regional Lead for Paediatrics and Consultant Neonatologist, St Mary's Hospital for a live webinar on Monday 19 May @ 10:30am

Book now: www.avma.org.uk/events/neonatology-live-webinar/

Radiology with Mr Jayaratnam (Jay) Jayamohan, Consultant Paediatric Neurosurgeon on Friday 6th June 2025

Bookings will open in early April 2025, for now please save the date!

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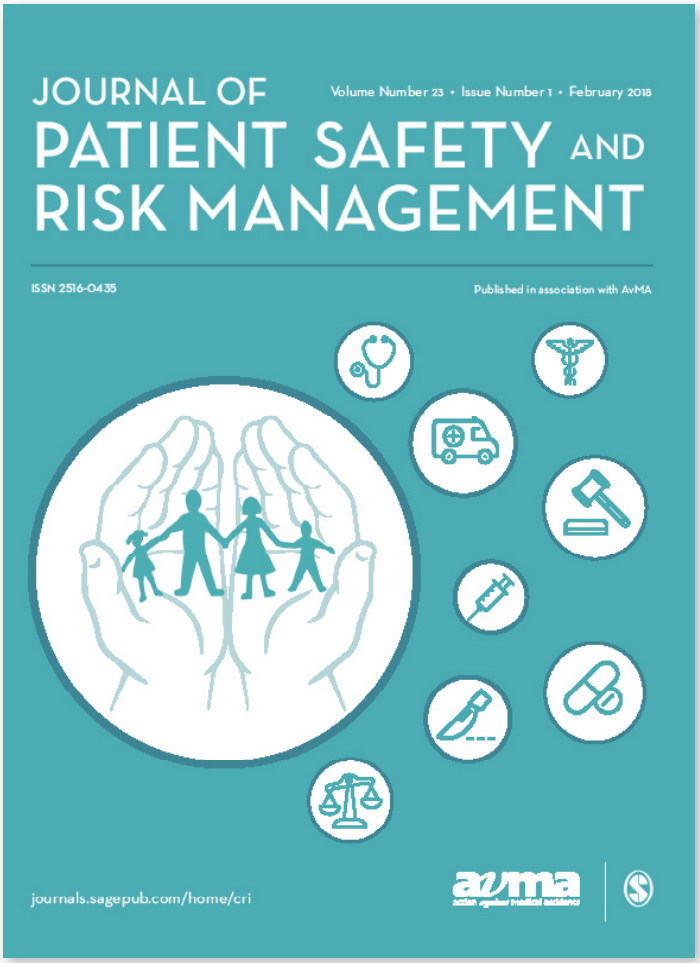

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