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Lawyers Service Newsletter

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Editorial

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The close of the calendar year is fast approaching, it provides an important opportunity to reflect on the events of the last few months, it is clear that the clinical negligence lawyer's world is as fast paced as ever.

In October the National Audit Office (NAO) published its report on the "Costs of Clinical Negligence". The government's liability for clinical negligence claims stands at £60 billion which makes it the second largest liability on its balance sheet after nuclear commissioning. Very high value claims (obstetric claims involving cerebral palsy and brain damage) represent only 2% of all the claims made, yet account for 68% of the costs.

In September, the government announced the names of the Trusts to be included in the National Maternity Review. The announcement filled many clinical negligence lawyers with despair - what on earth can another maternity review teach us that we do not already know? **Vanessa Harris**, AvMA panel solicitor at Clarke Willmott writes "***Why Baroness Amos' National Maternity and Neonatal Investigation may succeed where others have failed***" highlighting the opportunity to draw together learning from previous investigations. **Sara Sutherland**, Barrister at Exchange Chambers together with **Anna Mills Morgan** of Mackenzie Jones Solicitors, also welcome the Amos Review. In "***Morecambe Bay – Opportunities to learn are still being missed***" Sara recalls evidence given at the nineteen day inquest into the death of baby Ida, which revealed not only an alarming lack of candour and honesty on behalf of the Trust but a lack of compassion and support for the family which only became apparent through the inquest process and the MNSI investigation.

The NAO report naturally focuses on the financial cost of high value claims. **Victoria Johnson** is an associate at Penningtons Manches Cooper, she looks at "***Birth Injury and the Psychological Impact on Families: What the Law Can do***" noting the significant psychological needs of families who bear the brunt of profound disability arising from negligence.

Leslie Keegan, barrister at 7 Bedford Row, has recently written several articles on anonymity orders. In this edition of the Lawyers Service Newsletter he writes of "***ABC (by her father and litigation friend, XYZ) v***

Gloucestershire Hospitals NHS Foundation Trust" and describes how he secured an anonymity order as well as damages for future care and assistance at critical points of the claimant's life where the risk of epileptic seizures were more likely. **Patricia Leonard**, also practising at 7 Bedford Row, explores "***Compelling medical testing; the £10 million question***" and considers the existing two stage test for whether claimants should have to undergo medical testing or whether this has moved to a three stage test looking at balancing the parties competing rights – the Court of Appeal is expected to clarify this in the near future.

Another significant development is the judgment in the case of ***Mazur and another v Charles Russell Speechlys LLP* [2025] EWHC 2341 (KB)** which has sent shock waves through many civil litigation practices. The decision confirms that mere employment by a person who is authorised to conduct litigation is NOT sufficient to allow an employee to conduct litigation. The difference between conduct and delegated tasks will be a question of fact in each case. CILEX has now been granted leave to appeal the decision.

This Newsletter contains several practice points for clinical negligence lawyers to consider. **Simon Brown KC**, of 12 Kings Bench Walk, focuses on "***Recovery of success fees in high value clinical negligence claims – A Practical Guide***". **Anthony Searle**, barrister at Serjeants' Inn, looks at "***Pleadings, Expert Evidence and QOCS: A Triple Warning***" arising from the recent judgment in the case of *Read v North Middlesex Hospital Trust* [2025] EWHC 1603 (KB). The case confirms that QOCS will not shield an unviable claim, expert evidence must come from the right disciplines and inadequately particularised claims will not survive.

Staying with practice points, what is the difference between factual evidence and expert evidence? **James Bentley** and **Alice Reeves**, both practising at Guildhall Chambers explore this in "***You can't say that! How to spot when the Defendant's witness evidence is inadmissible – and, what to do about it***". **Michael Rivlin**, barrister at St John's Chambers picks up the case of ***Man v St George's University Hospital NHS Foundation Trust* [2024] EWHC 1304 (KB)**, referred to in James and Alice's article, and explores the judgment in more detail, looking at what the case means in practice.

"***Informed consent: Who knows what's best?***" by **Kriti Upadhyay** and **Sophie Holme**, both of Guildhall Chambers, considers the current state of the law on informed consent within the context of the BMA's recently published toolkit on "**Consent and refusal by adults with decision making capacity**".

The NAO report also found that around three quarters of settled cases were for claims worth less £25,000. **Philippa Luscombe**'s article "***Clinical Negligence in the NHS and lessons not learned: A growing concern for patient safety and NHS sustainability***" examines some of the NHS data to identify any interesting trends in clinical negligence claims and opportunities to learn from these. **Paul Balen**, a well-respected clinical negligence mediator with Trust Mediation needs no introduction. His "***Dispute Resolution Update***" is included in this Newsletter and urges consideration of Alternative Dispute Resolution (ADR) at the end of the pre action protocol period as a means of facilitating early resolution of claims.

The apparent lack of, or slow pace of learning from adverse medical accidents and the ongoing failure of trusts to act is disappointing – AvMA urged that the **Clinical Negligence Claims Agreement** include a provision for Trusts to say sorry and set out the lessons learned – see paragraph 12 of the Agreement – to our knowledge no Trusts have complied with this to date. Please let us have details of your experience (good or bad) of trying to implement paragraph 12 by emailing **Norika@avma.org.uk**.

Earlier this year, AvMA was approached by **Barry Elsby**, of Justice4patients. Barry is one of several campaigners from the Falkland Islands seeking to draw attention to the fact that they do not have the benefit of a Data Protection Act or freedom of information legislation and the impact this has on individuals. We are pleased to include Justice4patient's story of "***A six year campaign for justice after repeated medical data breaches and a cover up...***"

Many within the legal profession willingly and tirelessly offer their time and expertise to support AvMA's aims and objectives, from senior and leading counsel providing verbal and/or written advice and holding conferences for us, to our Helpline Volunteers who enable us to help the public. We are proud to be part of Pro Bono Week, it is an important opportunity for us to say a very public thank you, to all of you who help us. We were also very pleased to receive the **Wyn Legal award** in recognition of the outstanding commitment AvMA and our clinical negligence legal community make in advancing access to justice.

As an example of the difference pro bono work can make, this year we featured one of our inquest clients, you might like to **see the video**. **Toby Brown**, Chair of Pro Bono Week UK, explains how free legal advice can change lives in "***Celebrating Pro Bono Week 2025***".

Jayne Nicol is AvMA's Panel Accreditation Manager, and we are delighted to advise that we have made some small, but significant changes to the Panel Reaccreditation process, details of which are contained in Jayne's "***AvMA Panel Reaccreditation Update***". Behind the scenes, work continues on trying to streamline the panel application process.

We are also pleased to confirm that following a six-month pilot with Irwin Mitchell solicitors we will be rolling out the **Certificate of Competence Scheme (CCS)** early in the New Year. CCS is aimed at junior solicitors and at some levels paralegals, it is important to say at the outset, it is not a passport to AvMA panel accreditation. It is intended to be a means by which more junior staff can track their progress and experience, which can be difficult to gage especially at a time when more of us are remote or hybrid working. We are organising a series of road shows to take place in Leeds, Manchester, Birmingham, London and Bristol in early 2026, when we will come and talk to you about the CCS process and how it is intended to operate. More details and road show dates are to follow, but we take this opportunity to thank all of the Irwin Mitchell applicants and panel members who were involved in the pilot.

It is with a real sense of loss and sadness that we must acknowledge the sad passing of **Professor Tim Draycott, MD, BSc, MBBS, FRCOG**; an exceptionally nice person, a great speaker, generous with his time and determined to improve maternity standards in England. From his Practical Obstetric Multiprofessional Training (PROMPT) programme rolled out in over 45 countries, to his more recent, Avoiding Brain injury in Childbirth (ABC) initiative, Tim was always looking for meaningful ways for maternity units to achieve safer births, his humour and contribution will be very much missed.

We look forward to welcoming you to the panel meeting and the very popular Holly Jolly event this Friday.

With very best wishes

Why Baroness Amos' National Maternity and Neonatal Investigation may succeed where others have failed

VANESSA HARRIS
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It is safe to say that we have been aware of issues with maternity care in England and Wales for many years. Up until recently these have been treated as isolated incidents involving failings at a particular Trust and have been investigated accordingly. Multiple Secretaries of State have ordered investigations into failings at different Trusts across the country; but to what extent have these investigations identified common themes in the barriers to delivering high standards of maternity care? Furthermore, what steps have been taken in the past to address issues in maternity care? With this in mind, why will Baroness Amos succeed where others have failed?

The Frances Inquiry

In 2013, the Frances Inquiry report[1] was published which considered the failings across all services at Mid Staffordshire NHS Trust between 2005 and 2009, which had led to the unnecessary deaths of many patients. Although the report did not single out maternity services for particular concern, the issues identified are ones which have been echoed in subsequent investigations into maternity services. The key recommendations were to increase standards of care, ensure sufficient levels of appropriately trained staff, ensure patient-centred care and to promote a culture of openness and candour within the NHS. It was considered to be a watershed moment in UK healthcare, however, issues in maternity services across England persisted.

Morecombe Bay NHS Foundation Trust

In 2015, the Kirkup Report[2] considered the unnecessary deaths of three mothers and sixteen babies between 2004 and 2013 while under the care of the maternity unit at Furness Hospital in Barrow, part of Morecambe Bay NHS Foundation Trust. The report was published in March 2015 and highlighted five problem areas within the Trust:

1. Working relationships between different groups of staff were extremely poor;

2. Midwifery care in the unit became strongly influenced by a small number of dominant individuals;

3. Clinical competence of a proportion of staff fell significantly below the standard require for safe, effective service;

4. Advice to mothers that it was appropriate to consider delivery at FGH was significant compromised by the failure to properly assess the risks;

5. A grossly deficient response from the maternity unit to serious incidents with repeated failure to investigate properly and learn lessons.

A year after the Kirkup Report the National Maternity Review published their report, Better Births, which set out a vision to make maternity services in England safer, more patient focused and more responsive to women's needs and choices. The key aims were to improve standards of care in maternity services, halve incidents of stillbirth by 2030 (which was subsequently changed to 2025) and introduce continuity of care in maternity services. The subsequent Saving Babies' Lives Care Bundle program set out five key areas of care to reduce stillbirth and neonatal death.

Shrewsbury and Telford Hospitals NHS Trust

In 2016 concerns were initially raised about 23 cases involving stillbirth, neonatal deaths, maternal death and brain injury at maternity services at Shrewsbury and Telford Hospitals NHS Trust. In 2017 health secretary, Jeremey Hunt, ordered an independent review and appointed Donna Ockenden to lead the review. After the launch hundreds of further families came forward raising concerns about care that they had received at the Trust. In the end Donna Ockenden and her team identified 1,862

1 The Francis Report *(Report of the Mid-Staffordshire NHS Foundation Trust public inquiry) and the Government's response - House of Commons Library*

2 Morecambe Bay Investigation: Report - GOV.UK

cases between 2000 and 2018 which required further investigation. The Ockendon Report was published in 2022 and concluded that 300 babies had died or been left brain damaged due to inadequate care at Shrewsbury and Telford NHS Trust from 2000-2019 and at least twelve mothers had died unnecessarily while giving birth in the Trust's hospitals. Donna Ockenden identified multiple failings at the Trust and in particular:

1. Failures in leadership and teamwork in maternity services. Poor working relationships, overstretched staff and a culture of 'them and us' between midwives and obstetric staff;

2. Failures to follow clinical guidelines;

3. Failures to learn and improve;

4. Failures to listen to patients

Cwm Taf Health Board

In April 2019 Vaughan Gething, Minister for Health and Social Services in Wales, confirmed that maternity services at Cwm Taf Health Board were to be placed in special measures following the Royal College of Obstetricians and Gynaecologists and Royal College of Midwives review into maternity services at Royal Glamorgan Hospital and Prince Charles Hospital[3]. The review identified significant issues with the leadership, culture and safety systems in place at in the maternity units at these hospitals between 2016 and 2018. They identified staff shortages and systemic failures in reporting when incidents did occur. It concluded that one in three babies stillborn at the two hospitals might have survived were it not for the issues which had been identified.

East Kent NHS Trust

In October 2022 a further investigation into maternity services at East Kent NHS Trust was published[4]. Led by Dr Bill Kirkup the investigation considered maternity care provided at the trust between 2009 and 2020. The investigations considered 202 cases of death and harm. It found that in almost half of these cases the mother or baby would have had a different outcome if staff had provided appropriate levels of care. Once again Dr Kirkup highlighted the same issues in the maternity care provided at East Kent NHS Trust:

1. Failures in leadership and teamwork in maternity services. Poor working relationships with squabbling between midwives, obstetricians, paediatrician and others. Junior obstetricians and midwives being planned for errors by senior colleagues;

2. Inadequately qualified / experienced staff being given responsibility for managing the highest-risk mothers

3. Missed opportunities to recognise problems and implement solutions and a failure to be open and honest when issues occurred;

4. A lack of care and kindness. 'Victim blaming' mothers for their children's death and

5. Failing to listen to families

Nottingham University Hospitals NHS Trust

A further review into maternity care at Nottingham University Hospitals NHS Trust was established by NHS England in May 2022[5]. Again, this review is being led by Donna Ockenden who is considering nearly 2,500 cases where maternity care at the Trust has been brought into question. The review is due to conclude in summer 2026. However, in 2023 the Care Quality Commission brought charges against Nottingham University Hospitals NHS Trust following an investigation into three deaths which occurred in maternity services in 2021. Nottingham University Hospitals NHS Trust pleaded guilty to six counts of failing to provide safe care and treatment to babies and their mothers[6]. On 2 June 2025, Nottinghamshire Police announced that they had opened a corporate manslaughter investigation into maternity services at Nottingham University Hospitals NHS Trust[7].

The National Maternity and Neonatal Investigation

These failings in maternity services are shocking, however, they are far from unique. In September 2024, following a sixteen-month review of 131 units across the NHS, the CQC reported in the National Review of Maternity Services in England 2022 to 2024. The CQC found that 36% of maternity units that responded 'required improvement' while 12% were 'inadequate'. The CQC

3 Review of maternity services at the former Cwm Taf University Health Board: report | GOV.WALES

4 Maternity and neonatal services in East Kent: 'Reading the signals' report - GOV.UK

5 NHS England — Midlands » Independent Review of Maternity Services at Nottingham University Hospitals

6 NUH to plead guilty following deaths of three babies in 2021 | Latest news | NUH

7 Police investigate Nottingham trust for corporate manslaughter related to maternity deaths | The BMJ

once again identified issues as lack of staff, insufficient training, failing to appropriately assess risks, failing to act in a timely way and failing to report incidences and near misses. They concluded that preventable harm was at risk of becoming "normalised".[8]

On 23 June 2025, Health and Social Care Secretary, Wes Streeting, announced that the government would hold a national investigation into maternity care across England[9]. Baroness Amos was appointed to lead the investigation on 14 August 2025. The investigation will look at individual services alongside reviewing the maternity and neonatal system across England. It intends to bring together the findings of previous reviews into one clear set of national recommendations. On 15 September 2025 the government announced the terms of reference for the independent investigation were to be as follows:

1. develop and publish one set of national recommendations to:

a. drive the improvements needed to ensure high-quality and safe maternity and neonatal care across England

b. reduce inequalities and promote health equity in the delivery of those services

c. help bereaved and harmed families to receive justice and accountability in the future

2. ensure that the lived experiences of women, babies and families, including fathers and non-birthing partners, are fully heard and used to inform the development of the national recommendations

3. conduct and publish fourteen local investigations of maternity and neonatal services in NHS Trusts and use these alongside other sources of data and evidence gathered by the investigation to inform the development of the national recommendations[10]

This is on the backdrop of the MBRACE Report, Saving Lives, Improving Mothers; Care Report which was published on 11 September 2025[11]. While the rates of stillbirths and neonatal deaths decreased in 2023, there remain significant inequalities in maternity services in England. The report highlights persistent inequalities in maternal outcomes for women from black and ethnic backgrounds. Women from black and ethnic backgrounds are still more than twice as likely to die compared to white women. Black and Asian women also continue to face higher risks during pregnancy, childbirth and the postanal period.

The government confirmed that fourteen trusts that will be reviewed as part of the rapid, independent national investigation into maternity and neonatal services are as follows:

- Barking, Havering and Redbridge University Hospitals NHS Trust
- Blackpool Teaching Hospitals NHS Foundation Trust
- Bradford Teaching Hospitals Foundation NHS Trust
- East Kent Hospitals Foundation NHS Trust
- Gloucestershire Hospitals Foundation NHS Trust
- Leeds Teaching Hospitals NHS Trust
- Oxford University Hospital NHS Foundation Trust
- Sandwell and West Birmingham Hospitals NHS Trust
- The Shrewsbury and Telford Hospital NHS Trust
- The Queen Elizabeth Hospital, King's Lynn NHS Foundation Trust
- University Hospitals of Leicester NHS Trust
- University Hospitals of Morecambe Bay NHS Foundation Trust
- University Hospitals Sussex NHS Foundation Trust
- Somerset NHS Foundation Trust

In order to ensure an accurate picture of maternity services across England these Trusts have been chosen for investigation based on a range of criteria including the CQC maternity patient survey, MBRRACE-UK perinatal mortality rates, Trust type, geographic coverage and provision of care to individuals from diverse backgrounds. Shrewsbury and Telford, East Kent and University Hospitals of Morecambe Bay have also been chosen due to the previous investigations which have taken place at these Trusts and the learnings from these investigations which will be incorporated into the new investigation.

Why could Baroness Amos succeed?

Following previous investigations and reports there have been promises of permanent change in the way maternity care was delivered and to significantly improve

8 National review of maternity services in England 2022 to 2024 - Care Quality Commission

9 National maternity investigation launched to drive improvements - GOV.UK

10 National maternity and neonatal investigation: terms of reference - GOV.UK

11 Saving Lives, Improving Mothers' Care 2025 - *Lessons learned to inform maternity care from the UK and Ireland Confidential Enquiries into Maternal Deaths and Morbidity 2021-23 | MBRRACE-UK | NPEU*

the outcomes for women and babies. Ultimately the various governments and the NHS have failed to deliver on their promises. Despite an intention to halve stillbirth rates by 2025, recent data published by the ONS in May 2024 showed that stillbirth rates were 3.9/1000 births in 2022 in England, while Wales had actually seen an increase in stillbirth rates to 4.4/1000 births[12]. This is miles away from the 2.6/1000 target set out in the Better Births Report and illustrates the mountain left to climb in order to significantly improve standards and outcomes in maternity care.

This mirrors what I see within my own caseload. At present around a third of the cases I am instructed on involve negligent maternity care. While the nature and extent of the injuries vary, I see the same issues arise again and again. There are frequent failures to recognise issues and to escalate situations; repeated failings to follow guidelines; a lack of experienced staff to manage high risk patients; poor working relationships between midwifery and obstetric staff; a grossly deficient response to failures or near misses which prevents learning from mistakes; a failure to listen to women and their families and to ensure patient-centred care; a culture of victim blaming and a failure to be open and honest when things go wrong.

Given the failings of the previous investigations, I was initially sceptical about a further review into maternity services. However, the investigation proposed by Baroness Amos does strike me as being different. Instead of considering incidents at one Trust in isolation, she will be drawing together learnings from previous investigations while also considering maternity care in a broad range of geographical locations, trust types and with focus on Trusts who provide care to individuals from diverse backgrounds. In this way they she will be able to identify common themes and barriers to providing maternity care. Furthermore, her investigation will also highlight where maternity care is of a high standard and use this to inform and influence national guidelines. Ultimately, the success or failure of Baroness Amos' national recommendations will be determined by the extent to which she is able to identify the core issues which prevent high standard maternity care and to address these core issues within the recommendations.

12 Child and infant mortality in England and Wales - Office for National Statistics

Morecambe Bay – Opportunities to learn are still being missed

SARA SUTHERLAND, EXCHANGE CHAMBERS
ANNA MILLS MORGAN, MACKENZIE JONES

The news that there is to be an independent investigation by Baroness Amos should be welcomed, but with caution. Have we been here before? The Francis Inquiry, the Kirkup Inquiry, the Ockenden Inquiry, the East Kent Inquiry, Nottingham Inquiry...the list goes on. Will this investigation achieve more than the inquiries have done?

In February and March of this year we were involved in a nineteen day inquest into the death of Ida. Ida had died in late 2019 but through obfuscation and delays largely on the part of Morecambe Bay Trust, we did not resume the inquest until March 2025. By that point, there were more than 30,000 pages of disclosure during the course of which there were significant issues identified with the Trust, the governance processes and the clinicians.

It is important to recognise that the NHS, when it works, is a truly remarkable thing. For millions, it has been the difference between life and death. We also recognise the restrictions on resources and expertise and that many clinicians, despite these difficulties provide exceptional care to those in need. However, Ida did not receive the care or treatment that she deserved and neither did her parents.

There were many twists and turns to the chronology, but some of the key evidence included:

Following the traumatic labour and birth the mother was told that her placenta was observed to be 'gritty' and she was asked '*was she a smoker*', despite it being clear from her medical records she was a lifelong non-smoker. Until the conclusion of the inquest the mother was left wondering, did her daughter die because of something she had done?

The family were never told of the ineffectual resuscitation and that pressures on the machine had been turned to a dangerous level.

Following the death of their daughter, the family were told by the Trust that '*we did everything we could, we couldn't have done anything else.*'

When they requested to speak to the bereavement nurse to try and understand how their daughter had come to die the family were guided onto a delivery suite on the labour ward. Upon the family expressing their concern they were taken to another room near the day assessment unit, handed the notes and left to review them alone. They were without guidance and surrounded by women in labour; something that, at best, lacked empathy.

They were involved in an HSIB (now MNSI) investigation after which the report concluded there were numerous findings of concern. It is of some note, you may think, that the midwife whose records were found to be inaccurate during the course of that investigation complained about the interview she underwent, although scrutiny of the transcript of the interview discloses only professionalism and courtesy by the MNSI investigators.

The Trust's own Root Cause Analysis (RCA) sent to the family failed to identify any substantive failings. This RCA was the first of four with various named lead investigators who, it transpired, had limited involvement in the compilation of the document. During the course of the inquest the then Ward Manager, now Head of Midwifery told the learned Coroner that she had conducted the investigation although she had no training and the document '*wasn't worth the paper it was written on*.' Her evidence to the Coroner was that she had learned a lot through the inquest process; demonstrating the inquest was essential.

There were multiple missed opportunities to identify this incident and refer the matter for further investigation to the CQC, which was described by the Head of Midwifery as a '*grave failing*'.

About six months after the death of her daughter the family sent a seven page letter to the Trust setting out their concerns and requesting a meeting. There was a meeting with the Clinical Director and the Head of Midwifery and the family were told that '*there were lapses of care… there are things that we absolutely should have done differently…I'm not going to sit here and make excuses… it wasn't right and that's not right. So what we can do is redo the RCA.*' At that time the family did question the integrity of the RCA if the clinicians intended to amend it simply on their word however they welcomed any further information about how their daughter came to die.

Time passed and the family received no further RCA. Within documentation disclosed to the Coroner there was a document in which it said '*on reflection the maternity group have concluded that they are not undertaking a further RCA.*'

The family had never wanted to involve lawyers. They did not want litigation. They simply wanted to understand how their daughter had come to die.

Despite advice from another hospital and the MNSI to report the matter to the Coroner, the Trust did not. Finally, it was the family's lawyers who had no other option but to take that step.

Thereafter the stance adopted by the Trust was aggressive, confrontational and obstructive. Despite their Head of Midwifery and Clinical Director confirming there were lapses of care and the thorough and detailed report from the MNSI (who of course had spoken to the clinicians themselves shortly after Ida's death) the Trust instructed independent medico legal experts to comment on the case. They subsequently refused to disclose those reports until ordered by the Coroner. It is of some note, you might think, that the Coroner said of this:

'*This approach also produced the somewhat surreal situation where the Department of Health, through its arm's length organisation NHS Resolution, was obtaining expert reports to disagree with the Secretary of State for Health's independent panel of experts at the HSIB*'.

The Trust filed a position statement which did not accept the conclusions of their own Clinical Director and Head of Midwifery or the MNSI. This was amended only two weeks before the final hearing, the cynic might think that was a tactical move (some six years after Ida had died) to prevent legal representation at the final hearing because with admissions of liability the family would not be able to recover their costs.

The findings of fact and conclusion are attached hereto, but some of the key issues identified were:

- The investigation process was deficient, defensive and reached inadequate conclusions (with the Coroner recording that the Rapid Review and RCA were inadequate).
- The midwifery records were inaccurate.
- The midwives involved in the care of Ida may not have undergone mandatory training, although this was not clear.
- The Head of Clinical Governance said '*were it not for the HSIB report, the failures in Ida's care would not have been brought to light by the Trust.*'

Dr Kirkup, who had led the inquiry into care at the same Trust, concluded that the RCA '*report showed nearly all the same features as identified in his 2015 report. Some of the issues highlighted in the 2015 report were that "*investigations were flawed, relying upon poor-quality records that conflicted with patients' and relatives' accounts*". The report also identified features of investigations as being superficial, protective, brief and failed to identify problems due to a lack of a multidisciplinary approach*'. Dr Kirkup said that reports from a midwife, neonatal nurse, obstetricians and paediatricians did not constitute a multidisciplinary approach as this required a discussion and coming to a single overall conclusion. Dr Kirkup also said that an investigation should be inclusive of the family as it was important to hear what they had to say, understand their views and concerns so that any subsequent report answered the questions

At no point did the family receive communication from the Trust to explain the failings in care.

This is just a summary of some of the issues but many, in our experience, are not unusual. As clinical negligence lawyers who represent families we are endlessly disappointed with the lack of compassion, communication and transparency displayed by Trusts.

It is of note that although this relates to a death which occurred in 2019, the inquest in 2025 illustrated that there had not been any reflection by the Trust as to why their investigation into Ida's death had fallen short, what had gone wrong and how investigations should be undertaken; it took the coronial process to achieve transparency.

The MNSI in this case shone a light in a dark tunnel of despair for that family. The only organisation to explain

what had happened. Without the MNSI the family would have been left in the dark. What is worrying is that the current funding of the MNSI does not appear secure. As far as we are concerned, this independent organisation is crucial for the safety and wellbeing of pregnant women, women in labour and newborn babies. Our experience is that they hold a wealth of experience and knowledge that is so very helpful in identifying what has taken place. Their curiosity is necessary.

It is our opinion that hospitals, as demonstrated by this Trust, are not equipped or able to self-regulate. To reduce the funding for the MNSI poses a very real risk to those in maternity units and is likely to result in many more serious injuries and deaths. We can only hope that Baroness Amos takes steps to secure funding for the MNSI to enable them to continue with their vital role.

This article has been written by Sara Sutherland of Exchange Chambers and Anna Mills Morgan of Mackenzie Jones Solicitors. The views and opinions expressed in this article are our own and do not reflect the official position of any organisation, employer or individual with whom we are affiliated. All information is provided for general purposes only and should not be taken as professional, legal or financial advice. While we have taken every effort to ensure accuracy and completeness, we cannot guarantee that the content is free of errors or omissions. Any reliance you place on the material is at your own discretion.

Birth Injury and the Psychological Impact on Families: What the Law Can Do

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PENNINGTONS MANCHES COOPER

PENNINGTONS MANCHES COOPER

Severe brain injury at birth is one of the most devastating outcomes of clinical negligence. The consequences are not only medical but profoundly personal for the families involved. Part of our role as clinical negligence solicitors is to ensure that families are supported in the aftermath, within the framework that the law allows.

Even in successful claims, the law only provides for financial compensation for the person directly harmed by the negligence, which does not truly recognise the wide-reaching effects on the family members of the injured person. This means that family members are often surprised by the limits of what they can recover, particularly when it comes to psychological harm. However, there is some scope for such support for families.

How Brain Injuries Occur

Common causes of brain injury in babies include:

- Oxygen deprivation before birth, typically occurring in the mother or birthing parent's late pregnancy or during labour
- Delayed or incorrect treatment of neonatal conditions such as hypoglycaemia (low blood sugar)
- Delayed diagnosis of infections like meningitis or encephalitis during the neonatal period or early years

Children's and babies' brains are still undergoing critical developmental processes. Indeed, brain development continues well into our twenties. An injury sustained in infancy can disrupt cognitive, emotional, and physical growth in ways that may not be immediately apparent. Symptoms evolve over time, often surfacing as developmental delays, behavioural changes, or learning difficulties. This complicates both diagnosis and the legal process and, of course, a claim will only succeed if it can be shown that there were failings in the mother or child's care that caused the brain injury.

The Financial and Practical Reality

The financial reality of a brain injury at birth is often misunderstood. When claims settle for large sums, the media may portray them as a "win" or "windfall". In truth, compensation is a mechanism to restore, as far as possible, the quality of life lost due to negligence. No amount of money can undo the harm or restore the life that would have been.

As anyone with a disability will know, disabled households have huge financial burdens that other families do not have. For children with brain injuries, this often translates into:

- Specialist housing adaptations
- Professional care and case management
- Equipment and assistive technologies to support communication and mobility
- Educational support and therapies

Families also face a significant administrative burden, managing appointments, coordinating care, and navigating complex medical, legal, and social systems. They require not only legal support but also access to multidisciplinary rehabilitation, educational advocacy, and financial planning advice if compensation is secured. This hidden labour is emotionally and physically draining and often falls disproportionately on parents already coping with trauma.

The Emotional Impact on Families

The effects of a birth-acquired brain injury extend far beyond the hospital walls. Parents often face emotional strain, financial pressure, relationship challenges and difficulty managing the effects on siblings. Many families feel isolated, overwhelmed, and uncertain about the future. They must become advocates, caregivers, and experts in their child's condition, often with little guidance or support.

Litigation in complex brain injury cases usually takes years, often because the child's prognosis needs to become clear before the claim can be accurately valued. There is therefore an additional long-term requirement for the family in dealing with the legal process itself.

For many families we work with, the birth that has not been managed appropriately follows a previous complicated pregnancy or birth. The birthing parent's medical needs in these situations may be more complex, increasing the risk of something going wrong. It is therefore not uncommon for families to have experienced miscarriage or stillbirth before having a child who suffers a brain injury at birth, compounding the trauma and emotional toll.

As lawyers, our role is primarily to try to secure financial compensation to cover the child's needs for life. However, what families require often extends beyond the financial, as they have significant psychological needs as well. While damages can be claimed for the pain, suffering and loss of amenity caused to the child, including for psychiatric damage, there is very limited ability to claim the same for the family.

Psychiatric Injury and Legal Limitations

One of the most difficult aspects of these cases is the limited scope for psychiatric support within legal claims. Although the claim is usually managed by one of the parents, it is brought on behalf of the child. This means that there is no automatic right to compensation for losses incurred by the parents themselves. Parents can be compensated for items purchased for the child and for some of the time spent caring for them, but the law does not fully recognise the psychological impact.

If the injury to the baby occurred before their birth (i.e. during pregnancy or labour) the mother or birthing parent is considered a "primary victim", as she has suffered a direct physical injury herself. This means that psychiatric damage caused by the injury can be claimed. If the mother has suffered PTSD or another recognised mental health condition, therefore, she may be able to seek compensation for this injury and to cover the costs of her treatment.

However, there are strict time limits: the mother has three years from the date of her injury to bring a claim. (For the child, the three-year period does not begin until their 18th birthday or may never begin if they lack mental capacity to litigate.) Compensation for the mother does not cover any previous trauma nor the day-to-day impact of having a child with a disability itself: only the damage that was caused directly to her by the failings during her labour.

If the injury to the child occurred after their birth, e.g. during the neonatal period, the mother is not deemed a primary victim. She, like the father or any other person psychologically affected by witnessing the child's injury, is considered a "secondary victim". In 2024, a Supreme Court ruling made it virtually impossible to bring a clinical negligence claim for secondary victims. Fathers, siblings, and extended family members, despite being deeply affected, are therefore generally not eligible for any psychiatric damages at all.

The limitation of the law in this area is frustrating for injured people, families and their legal teams. In some cases, however, we are now seeking to claim for family therapy, if it is deemed to be in the best interests of the child. While this does not fully cover the gaps in the current law's position on psychiatric claims, it does go some way to recognising the broader emotional impact of a brain injury, and the need for collective healing.

About the author

Victoria is an associate in the Penningtons Manches Cooper clinical negligence team and specialises in complex, high-value cases for children who have been severely injured at birth. Victoria qualified in 2018, is a member of APIL and has been ranked in **Chambers UK** for the past three years.

ABC (by her Father and Litigation Friend, XYZ) v Gloucestershire Hospitals NHS Foundation Trust

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On 3rd September, the Cardiff County Court made an anonymity order and approved a final settlement reached between the parties in the sum of £550,000 in this claim.

C. Was born in June 2012 and is therefore now thirteen years old. She suffered a Neonatal Hypoglycaemic Brain Injury (NHBI) due to a failure to monitor her blood sugar levels adequately. C was a very low birthweight baby, with her weight being on the 2nd centile. This meant that her ability to mount a ketogenic response to any fall in blood sugar levels was significantly restricted and therefore her blood sugar needed to be monitored carefully. It was not monitored carefully and as a result she sustained the NHBI. The only apparent consequence of the NHBI was that she suffered seizures. She suffered three seizures in the neonatal period but remained seizure free without medication and her neurodevelopment was not in any way atypical. At the age of five following a long-haul flight she had two further seizures. This led to her being placed on anti-epileptic drugs (AED). She continued to develop normally and progressed very well both at home and at school. There were no signs of her having any long lasting problems resulting from the NHBI other than the seizures which were very well controlled by a low dose of AED.

However, in 2024 as the matter was progressing towards trial, C. was diagnosed with a brain tumour. An application was made to Court to stay the proceedings whilst evidence was obtained from paediatric neurologists and from paediatricians as to whether there was any link between the NHBI and the brain tumour. Following extensive investigations, the agreed response was that these were not linked. C underwent appropriate resection of the tumour. She continued to progress very well both academically and socially. In the course of having treatment for her tumour, her anti-epileptic medication was stopped and for period of eighteen months prior to settlement she remained seizure free. The agreed consensus amongst the medical experts was that she was most likely to remain seizure free without medication but that if she did develop any further seizures these would be controlled by a return to the very low dose AED that she had been on.

The dispute between the parties centred on whether there should be any provision for C. so that she should receive care and assistance at critical points in her life such as when she left home to live independently and when she had children of her own to avoid triggering further seizures. C's argument was that it is an accepted fact that tiredness can be a trigger for seizures and that consequently C. Would need support in the form of care and assistance at these times.

There was also a dispute as to whether any provision should be made to account for the fact that C could be more restricted in her working life due to a resurgence of epilepsy. There was agreement that provision should be made for C. to have advice from a specialist nurse in epilepsy during any future pregnancies to advise regarding the effects of taking or not taking AED during pregnancy and there was also agreement that C. should have some counselling to help her deal with the anxiety that she developed regarding epilepsy.

We vigorously advocated for the Claimant's future care and assistance, emphasising that fatigue and stress may trigger seizures. By providing support at identified key points, these can be mitigated to better address the Claimant's needs. It is also clear that epilepsy can affect somebody's earning capacity and choice of career. Following a detailed discussion in conference we emerged with good support from our medical and care experts in relation to the need for these provisions and this enabled us to pursue these aspects of the claim at the Joint Settlement Meeting (JSM).

Although no breakdown of figures was agreed at the JSM, apart from general damages in the sum of £124,470, the following is a suggested breakdown - Past care £100,000, Future advice during pregnancy £3,600, Future counselling £8,000, Future Earnings £50,000, Future Care & assistance £263,930. Leslie Keegan Counsel for Claimant was instructed by Spencer Collier at Geldards.

Compelling medical testing; the £10 million question

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Until recently, it appeared the legal principles around compelling Claimants to undergo medical testing were fairly settled. The accepted test was a two-stage test, set out by Lord Justice Kennedy in *Laycock v. Lagoe* [1997] PIQR 518:

"...a two-stage test. 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 of 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 and 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."

Under this approach, the balance generally favoured the claimant where substantial reasons existed for refusing testing. This approach was followed in cases involving genetic testing (*Paling v Sherwood Forest Hospitals NHS Foundation Trust* [2021] EWHC 3266) and early expert assessment (*Read v Dorset County Hospital NHS Foundation Trust* [2023] EWHC 367 (KB)) and has been endorsed in the White Book commentary.

The Two-Stage Test: Legal and Practical Considerations

Stage One requires the Court to assess factors such as the probative value of the proposed test, whether the test will resolve a disputed issue, whether there is credible evidence that the Claimant may have the condition in question, and the potential impact on quantum. In some cases, Defendants have sought genetic testing in brain injury cases based on speculative assertions—where no specific syndrome has been identified, but a genetic cause is merely hypothesised. Scrutiny should be undertaken as to whether the Defendant will concede the issue of causation once the outcome of testing is known. Even where a genetic link is established, causation may remain unresolved due to the complex interplay between genetic predisposition and environmental factors, and the often minimal contribution of certain genes to the condition.

When looking at the second stage, factors such as the invasiveness of the test, the physical/psychological risks of testing and potential mitigation strategies. The Defendant should clarify whether further testing of the claimant or family members may be required depending on the results. Additionally, the possibility of incidental findings—such as information about adult-onset conditions or carrier status—must be considered as a Claimant will be forced to live in the shadow of this knowledge. As Master Sullivan noted in *Paling*, there is a qualitative difference between choosing not to undergo genetic testing and being compelled to do so but opting not to receive the results.

Genetic testing may also reveal risks to family members, raising complex questions about confidentiality and potential legal duties. In rare cases, a duty of care to relatives may arise, potentially requiring a breach of the claimant's confidentiality. Genetic testing may also reveal genetic issues for family members, raising complex questions about confidentiality and potential legal duties. In rare cases, a duty of care to relatives may arise, potentially requiring a breach of the claimant's confidentiality[1].

1 ABC v St George's Healthcare NHS Trust & Ors *[2020] EWHC 455 (QB)* Yip J found that there may be a legal duty of care towards third parties, this duty being a duty to balance a third party's interest in being informed of genetic risk against the patient's interest in

Any adverse results could have long term consequences; a Claimant may have to disclose the results for health or life insurance or to future employers. It may impact future family or reproductive plans.

A Shift in Interpretation: *Clarke v Poole* [2024] EWHC 1509 (KB)

In *Clarke*, the Claimant sustained a severe brain injury in a road traffic accident, resulting in profound physical and cognitive impairments. Her provisional schedule of loss exceeded £22 million. Her mother had previously been diagnosed with asymptomatic myotonic dystrophy (MD), a hereditary condition.

Experts agreed the Claimant exhibited symptoms potentially indicative of active MD. There was a 50% chance she carried the relevant gene, though possession of the gene does not guarantee symptomatic manifestation. It was also agreed electromyographic neurophysiological (EMG) would determine whether the Claimant had active MD and the Defendant argued the presence of MD would significantly reduce the Claimant's claim.

Unlike in *Paling*, the Claimant in *Clarke* presented with at least one symptom of MD, and the proposed testing was more targeted. Notably, the Defendant pursued EMG testing rather than genetic testing— this was likely a strategic decision following the unsuccessful attempt to compel genetic testing in *Paling*. While a positive EMG result would strongly suggest the presence of the gene, it would lack the definitive certainty of genetic testing and offers limited insight into future clinical deterioration.

The Claimant refused EMG testing, citing (i) the significant implications of a diagnosis, (ii) personal autonomy, and (iii) concerns about mental health deterioration. She had previously declined EMG testing when her mother was diagnosed.

The Legal Debate: Two Stages or Three?

The parties agreed the *Laycock* two-stage test applied and was satisfied. However, the Defendant argued there should be a third stage which requires the court to perform an evaluative exercise of both party's respective interests to determine the just and proportionate outcome in all the circumstances.

HHJ Gargan decided, notwithstanding Kennedy LJ's explicit reference to a 'two-stage test', a true reading of *Laycock* required this third stage. This interpretation drew upon *Starr v National Coal Board* [1977] 1 WLR 63 (not cited in *Laycock*) but argued to be consistent with its underlying reasoning. HHJ Gargan held that *Laycock* must be read in the broader context of earlier authorities, including *Prescott v Bulldog Tools Ltd* [1981] 3 All ER 869 and *Hill v West Lancashire Health Authority* (unreported, April 1996). He reasoned that the two-stage formulation in *Laycock* was intended merely to '*summarise and simplify*' the test, and that the balancing exercise had always been an integral component of the analysis.

HHJ Gargan described the third stage as a balancing of "*competing rights, namely (i) the defendant's right to defend itself in the litigation; and (ii) the claimant's right to personal liberty.*" Particular weight should be given to the Claimant's objections if "*the test is invasive and/or involves pain/discomfort and/or the risk of physical/psychological harm. He also held the terms of the stay should "do no more than is reasonably required to enable the defendant properly to defend the claim.*"

He stayed part of her claim for future losses (with a value of £10m) unless she consented to EMG testing/conceded the issue of MD. The first two stages were answered positively and in relation to the balancing exercise, he opined that the EMG results would have a material bearing on the determination of the dispute, any physical risks posed by the test were limited, there were potential "therapeutic" advantages (not identified), her anxiety could be alleviated by home/local testing and a negative test would provide significant comfort.

Awaiting Clarity from the Court of Appeal

Permission to appeal was refused by Nicola Davies LJ. However, a successful application (via a rarely-used CPR 52.30) to reopen the refusal of permission was heard by Underhill LJ and Whipple LJ on 24 February 2025 and permission to appeal was granted on all five grounds. The five grounds argued that the correct approach in law was a two-stage test and the judge erred in the way he carried out the third stage.

The Court of Appeal is expected to clarify the correct interpretation of *Laycock* and its relationship to *Starr*.

Underhill LJ expressed tentative support for HHJ Gargan's analysis, stating he was "inclined to think" it was correct. Whipple LJ, while not expressing a definitive view, noted:

> *"...there is at least a respectable argument that Laycock is correct, not because it suggests a two-stage instead of a three stage test (although it may be correct for that reason) but because it implicitly recognises that a*

preserving confidentiality in relation to his diagnosis and the public interest in maintaining medical confidentiality generally (para 188).

claimant who objects to undergoing a test or investigation, in circumstances where that objection is not imaginary or illusory, is likely to be objecting on grounds of personal autonomy which will weigh heavily in the balance and may well be determinative of the outcome."

Whipple LJ's comment that personal autonomy *"may well be determinative of the outcome"* provides hope for Claimants navigating these complex and deeply personal decisions.

Recovery of success fees in high value clinical negligence claims: A practical guide

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Introduction

Over the last few years Claimant solicitors undertaking work for clients through both conditional fee arrangements and other retainers have become increasingly aware of the need for the Claimant (or Claimant's representative) to have informed consent as to the fee arrangements involved.

Even if the client care aspect is thoroughly fulfilled there remain a number of potential pitfalls which may affect recovery of costs, and particular additional liabilities out of the recovered damages.

This is particularly so in high value catastrophic cases where the claimant is (a) a child and or (b) a protected party and the recovery of success fees and ATE premiums from the recovered damages has to be approved by the Court.

If a Solicitor has agreed with the client to take a "success fee" and/or ATE premiums (typically up to 25%) from any damages agreement, the Court needs to approve this deduction from the final damages settlement otherwise the deduction is unlawful.

Judicial Guidance and Approach

Such approval of costs recoveries as stated above can be a complicated process. It is usefully explained by the Practice Note of the then Senior Costs Judge, Master Andrew Gordon Saker, in December 2021. A copy of this Practice Note follows this article. It has attached useful Appendices of Draft Orders.

Nevertheless, there remains trepidation on the part of many solicitors applying for approval of deduction of additional liabilities from damages that, even in cases where the client's litigation friend agrees to the deductions, the Court may side with the client and try and restrict deductions from damages. One solicitor has stated *"it is like having your homework marked and if there are mistakes you lose out."*

Certainly, it is a process which is undertaken to protect the best financial interests of the recipient of the damages. Nevertheless, speaking to Costs Judges in the Senior Court Costs Office ("SCCO"), it is far from the truth so say they are obstructive or even unsympathetic.

The starting point is that they understand that solicitors representing Claimants are entitled to, and deserve, recompense for taking risks; this is particularly so in difficult and complicated catastrophic injury case for children and/or protected parties. The Judges are also aware that there are many cases they do not see which fail and the solicitor recovers no fees.

Nevertheless, they are also there to ensure that the client is not paying more out his or her damages than is reasonable. The largest proportion of cases where the solicitor fails to recover the sums claimed are those where the Practice Note and Directions from the Court are not followed. Adherence is required to produce the relevant documents, explain the levels of risk, the advice given which results in the success fee sought from the damages.

The whole purpose of the guidance and directions from the Court is to furnish the Costs Judge with material upon which an assessment can be made. Indeed, it is not uncommon that the Costs Judge may deal with the matter on the papers if they are all in order and the relevant information on which to make aa decision is provided.

Directions of the Court

As to procedure, even if the Practice Note is of use, there will be a Directions Order upon lodging the papers containing disclosure paragraphs similar to those set out and discussed below. Whereas these may be directions often used in the SCCO, they provide a good working guide as to what should be provided to any Judge considering such applications.

The Costs Judges will not necessarily deny an application if the material falls short of what is required, but may adjourn the case off to another date, which with listing may be months. This affects cash flow and can be expensive to prepare yet again for another hearing.

(1) The Claimant's solicitors shall at least seven days before the hearing file in either paper or electronic form (i) a note / skeleton argument as to the reasonableness of the Success Fee sought and (ii) the following documentation (to the extent that it has not already been provided,

As to the Skeleton Argument I suggest this should be comprehensive and cover:

• What is being applied for and under which CPR rules and statutory provisions (e.g. CPR 21.12 and the court will undoubtedly have regard to CPR 46.9 and the case law)

• What evidence is being provided in support (e.g. witness statement from the solicitor and possibly from the costs lawyer who negotiated costs recovery)

• Summary of the relevant provisions in the CFA and the discussions with the "client" surrounding the same

• Whether the solicitor is pursuing both success fee and ATE premium and relevant factors such as whether the solicitor is seeking also to recover shortfall in costs recovery,

• Whether the solicitor has funded expert reports and their attendance (these factors will affect the success fee as to the risks taken)

• Reasonableness of the additional liabilities claimed

• The calculation of the success fee with regard to recovered costs, percentage uplifts, and level of the 25% cap.

(a) Pleadings and relevant documents in relation to the substantive proceedings, including Letter of Claim, Letter of Response and Counsel's advice on approval of damages together with relevant quantum assessment.

These should be provided in full. Counsel's advice on approval of damages is critical regarding the 25% cap. Counsel's advice should state the suggested or approved level of the settlement sum for each head of claim and not simply what the pleaded case was (e.g. there may have been a pleaded case for past care at £175,000 but Counsel advised settling that head of claim for £115,000). It is the latter figures which is relevant.

(b) Conditional Fee Agreement/s and the risk assessments/s

These are critical. Risk assessments may be elsewhere so those documents should also be attached. Please note that risk assessments may also be handwritten in attendance notes so ensure the critical documents are typed up for ease of reference.

(c) All attendance notes or other documents relevant to the issue of the risk undertaken by the solicitors at the time the CFA was entered into, to include all documents on file setting out the facts and matters known to the solicitors at the time they entered into the CFA.

The points about handwritten records being typed is again essential. The information therein and also given to the client by way of information, is crucial and should form the basis of reasoning to arrive at the level of the success fee. ALL relevant documents should be provided. If there was, for example, an NHS Trust initial report into the incident which was considered in the setting of the success fee this should be attached.

If there was further consideration of the risks and success fee following the issue of breach of duty / causation being resolved, evidence as to this should be disclosed. If the solicitor started with a 100% success fee and succeeded on liability and causation and proceeded to assessment of damages certain Costs Judges will be considering an overall success fee in the region of 35%-40%.

The important matter for assessment is what the solicitor was the thinking at the time and whether that was reasonable. By way of further example, it may be that case that a Legal Aid solicitor had previously had the file, expressed views as to success and was denied further funding. Such factors are extremely relevant if, for example, the new solicitor then took the case over on a CFA where prospects were fairly low, succeeded and claimed a high success fee (albeit capped).

(d) Papers relevant to Inter-Partes Costs settlement (Including the Bill of Costs or any breakdown of costs which formed the basis of negotiations between the parties).

This can often be covered by the costs lawyers who conducted negotiations in a witness statement with exhibits. All relevant information should be disclosed.

Other Judicial Guidance

Finally, note should be had of the appeal judgment of the judgment of HHJ Simon Monty KC in the Central London County Court in the case of *Duffield (a minor, by his mother and Litigation Friend Ms Sandra Matuleviciute)*

v. - and – W M Morrison Supermarkets Ltd. in the Central London County Court (Neutral Citation Number: [2025] EWCC 35) handed down on 1st July 2025.

He had been informed that there was inconsistency amongst the judgments of the District Judges on such applications and the DJs were falling into error. HHJ Monty KC was concerned and therefore provided a reasoned written judgment which might assist those who have to deal with similar issues in other cases. He acknowledged that whilst each case will, of course, turn on its own facts, the matters of principle with which he was concerned on this appeal are of general application.

Experience shows that some Costs Judges in the SCCO have noted his judgment but were not particularly assisted by it as they were aware of the correct legal principles.

The author Simon Browne KC, of 12 Kings Bench Walk, is notably ranked in the directories in Band 1 of two separate practice areas, namely "Costs and Litigation Funding" and "Catastrophic Injury".

Pleadings, Expert Evidence and QOCS: A Triple Warning

ANTHONY SEARLE
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Clinical negligence specialist **Anthony Searle** analyses a recent decision on pleading deficiencies, expert evidence missteps, and costs consequences.

Introduction

In *Read v North Middlesex Hospital Trust* [2025] EWHC 1603 (KB), Master Thornett delivered a judgment that should make clinical negligence practitioners pause. The case offers a triple warning for those undertaking claimant work:

1. Inadequately particularised claims that lack a counterfactual causation case will not survive.

2. Expert evidence must come from the right disciplines and must be obtained prior to serving pleadings.

3. QOCS protection is no shield for substantively unviable claims.

The decision illustrates how failures at every stage — from expert instruction to pleading to compliance with unless orders — can culminate in both strike out and the disapplication of QOCS, exposing claimants to adverse costs orders. This article analyses the judgment and offers practical guidance for claimant practitioners.

A claim in trouble: procedural background

Mr Read's claim stemmed from two A&E attendances in November 2016 and January 2017 following a fall that allegedly caused severe spinal compression. He underwent surgery later in January 2017, said to have been only partly successful, leaving paraesthesia in both feet and a kyphotic deformity.

He initially brought the claim as a litigant in person. The central allegation was that earlier investigation and treatment would have improved his outcome.

The procedural history reveals both drafting inadequacies and fundamental misjudgements in case preparation:

- Initial Particulars of Claim (June 2020): The Claimant drafted the PoC himself. They were sprawling and unfocused, and they relied on impermissible 'loss of a chance' arguments.

- Unless order (October 2020): The Court required the Claimant to provide proper particulars, failing which his claim would be struck out. He appealed the order and further applications followed.

- Appeal compromise and further unless order (November 2023): The appeal did not go ahead because the Claimant, by then legally represented, agreed to serve Amended PoC with 'further and better particulars' of breach and causation by 15/12/2023, plus a condition and prognosis report, failing which the claim would be struck out.

- December 2023: Amended PoC, together with a C&P report, were filed in intended compliance with the order. The PoC were a complete rewrite of the original [19-20].

Expert evidence missteps

Two problems emerged relating to (i) timeline concerns and (ii) expert disciplines.

The Claimant's solicitor's witness statement revealed they were instructed in October 2023 '*for the limited purpose of obtaining expert medical evidence from a consultant neuro/spinal surgeon*' [25]. Yet at the November 2023 compromise, the Claimant represented — through his Counsel — that he had obtained supportive expert evidence on breach and causation [12].

Master Thornett found this representation '*material to the Defendant*' in agreeing to the compromise [13], noting that the Defendant '*not unreasonably assumed any amended Particulars of Claim would not only be more comprehensive and coherent in pleading terms but had the support of independent considered expert opinion*' [12].

The expert discipline mismatch compounded the problem. Despite alleging breaches in A&E management, the

Claimant had only instructed a Consultant Neurosurgeon: '*It is difficult to follow how opinion from a Neurosurgeon and Spinal Surgeon could ever be appropriate to the question how the Claimant should clinically have been considered and processed in the Accident and Emergency Department(s)*' [14]. This fatally undermined the case.

Inevitably, the Defendant applied for strike out and/or summary judgment. The Court had to address whether the Amended PoC complied with the November 2023 unless order or whether the claim was already struck out. Master Thornett's judgment grappled with three key issues.

Issue One: the counterfactual imperative

Pleading failures: the Court's forensic analysis:

The Amended PoC alleged negligence across two A&E attendances:

• First attendance: Negligent triage (category 3 instead of urgent) and loss of chance of earlier diagnosis and '*full, alternatively better recovery*.'

• Second attendance: Negligent failure to investigate/ examine, misdiagnosis, and negligent discharge.

However, the causation allegations operated at an unacceptably high level of generality, lacking the essential counterfactual matrix. The PoC simply stated that '*The Claimant suffered spondylodiscitis ("the condition")', copied directly from the neurosurgeon's report. This was a 'self-explanatory state of the Claimant's health*' without temporal context [47].

Critically, without knowing when the Claimant developed spondylodiscitis or '*its aetiology and hence state of progress or manifestation as at the operative dates relied upon,*' the allegations of breach became '*devoid of relevant clinical context*' and '*unacceptably present in a vacuum*'. The Defendants' clinicians '*did not cause "the condition"*', and any actionable claim must show they '*either made matters worse or at least made a material contribution to the continuance of "the condition" between specified dates*' [ibid]. These are elementary points of pleading in clinical negligence litigation.

The ten unanswered counterfactual questions:

Master Thornett's analysis crystallised the pleading deficiencies through ten fundamental questions that remained unanswered in the Amended PoC [51]:

1. When should the Claimant have been seen by a doctor?

2. What grade or type of doctor should have seen him?

3. What assessment should have been performed?

4. What would the likely findings have been?

5. How and why would those findings have led to an MRI scan?

6. When and where would the MRI scan have been performed and reported?

7. What action would have been taken in response to that MRI scan?

8. What treatment would the Claimant have received?

9. When, what and where would that treatment have occurred?

10. What is meant by 'better recovery'?

These questions '*naturally arise and as one would expect to be explored and answered as part of the fundamental burden of any claimant pleading such a claim*' [52]. Helpfully, they provide a practical template for all practitioners drafting clinical negligence pleadings.

Master Thornett delivered a robust rejection of the Claimant's submission that subsequent expert opinion could expand on what should have taken place [36]. This represented an '*inappropriate attempt to pass the burden of proof onto a defendant instead to identify, propose and justify what it contends should (or might) have happened*' [37].

The Court emphasised that '*stating what did not happen is rarely if ever sufficient proof of what should have happened if the events relied upon are acts of omission*' [36]. Pleading a counterfactual matrix is not optional: it is fundamental to establishing causation.

Issue Two: the failed re-amendment

The Claimant had cross-applied for permission to re-amend the PoC. Despite narrowing the claim to a single attendance and deleting '*loss of chance*' language on causation — only to reintroduce it under the guise of quantification [70] — fundamental defects remained uncured.

The proposed amendments included allegations of failure to provide pain relief and an opportunity to lie down. Although important to patient comfort, Master Thornett characterised these as '*collateral and comparatively minor episodes*' more suited to '*a Small Claims Track claim*' rather than multi-track clinical negligence [72].

Even after re-amendment, core questions remained unanswered, and there remained a failure to articulate

a positive counterfactual case. Both the Amended PoC and the proposed re-amended pleading '*would present any defendant and their representatives with an almost impossible task unless the burden of proof were to shift to expecting them as defendants to offer and discuss the range of possibilities that might have eventuated had the Claimant not voluntarily chosen to leave A&E on his first attendance*' [79]. The Court refused permission to re-amend and went further: even with the re-amended allegations, the claim would still have no real prospect of success.

Issue Three: QOCS and the '*substance over form*' approach

Automatic strike-out:

Unsurprisingly, Master Thornett found the claim was automatically struck out for non-compliance with the November 2023 unless order [80-81]. A Part 18 request would not be able to remedy this and, in any event, should not '*facilitate a party wholly to re-plead their claim.*' As the Claimant did not apply for reinstatement, '*this has to be the end of the claim*' [82].

Crucially, the Court noted that unless the order was designed to avoid the wrongs contemplated in CPR 3.4(2)(a) and (b), and failure to comply meant those substantive defects remained [89].

QOCS arguments:

On costs, the strike out for non-compliance with the unless order raised the question: was QOCS protection lost? The Claimant argued that non-compliance with an unless order falls under CPR 3.4(2)(c) (failure to comply with a rule/order) and CPR 44.15 disapplies QOCS only where strike-out is on grounds (a)/(b) (no reasonable grounds/abuse).

However, Master Thornett agreed with the Defendant that the underlying reason for non-compliance was a failure to plead a viable case, i.e. grounds (a)/(b). The Court adopted a 'substance over form' approach. The word 'grounds' in CPR 44.15 refers to the substantive reasons for strike-out: '*"grounds" in rule 44.15 refers to, no more and no less, than the underlying reason [or] explanation why a claim came to be struck out*' [97]. Agreeing with the Claimant's restrictive interpretation would have led to unjust and absurd consequences: '*Such as the example provided of a claimant who egregiously fails to comply with an unless order obliging them to preserve documents by instead destroying them*' [98].

Even if wrong about automatic strike-out, Master Thornett found that the Amended PoC should be struck out under CPR 3.4(2)(a) and/or (b) as disclosing no reasonable grounds and/or constituting an abuse of process [100]. Either way, QOCS protection was lost.

Practical implications

Claimant practitioners cannot afford to ignore Master Thornett's judgment in *Read*. The following practical guidance emerges from the case:

- Instruct the right experts early — from the correct disciplines, before serving the PoC.
- Never represent that supportive expert evidence exists unless it has actually been obtained.
- Plead the temporal relationship between the condition's development and the alleged negligence.
- Build a complete counterfactual causation case, especially in claims involving omission allegations. Use Master Thornett's ten questions as a checklist.
- For obvious conditions (e.g. '*a claimant had two legs before the wrongful amputation of one of them*' [47; see footnote 6]), detail may be unnecessary; for progressive conditions (e.g. infection), temporal context is essential.
- Non-compliance with unless orders risks both strike out and QOCS disapplication.
- Courts look to substance, not technical procedure — defective claims will not be rescued by labels.

Conclusion

Master Thornett's triple warning underscores a judicial intolerance for speculative or underprepared clinical negligence claims. For claimants, the risks extend beyond strike out to adverse costs exposure. Be aware that this judgment now provides defendants with both a template for challenging defective pleadings and reassurance that QOCS protection is not a safety net for unviable claims.

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You can't say that! How to spot when the Defendant's witness evidence is inadmissable...

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...and, what to do about it

The issue

What is the difference between factual evidence and opinion evidence? When is a witness of fact entitled to give an opinion in evidence? How do the rules of evidence operate when the Defendant serves statements from clinicians in support, giving their own opinions, despite not being Part 35 reports?

This article seeks to explain the difference between factual and opinion evidence, what is and is not allowed, and what steps can be taken if the line is crossed.

Factual and opinion evidence – what's the difference?

There is an important distinction between evidence of fact and opinion evidence, albeit sometimes it is difficult to distinguish between the two. An example might assist. Imagine a case involving an alleged failure to diagnose sepsis. In that case there may be a statement from the clinician who is being criticised, and that statement may say something like:

'When I saw the patient, whilst she had a temperature, there was no reason suspect sepsis.'

The phrase '*she had a temperature*' is more fact that an opinion, but the phrase '*there was no reason to suspect sepsis*' is certainly more opinion than fact. Indeed, it is probably the key issue in your case. There will be breach of duty experts on both sides and yet on the Claimant side you will now be faced with another clinician giving evidence as to what was or was not reasonable. And yet, that clinician is entitled to give his or her opinion, but why?

The Civil Evidence Act 1972

The admissibility of opinion evidence is governed by the Civil Evidence Act 1972 (hereon 'the 1972 Act').

Section 3 of the Act states that:

(1) Subject to any rules of court made in pursuance of this Act, where a person is called as a witness in any civil proceedings, his opinion on any relevant matter on which he is qualified to give expert evidence shall be admissible in evidence.

(2) It is hereby declared that where a person is called as a witness in any civil proceedings, a statement of opinion by him on any relevant matter on which he is not qualified to give expert evidence, if made as a way of conveying relevant facts personally perceived by him, is admissible as evidence of what he perceived.

(3) In this section "relevant matter" includes an issue in the proceedings in question.

Going back to the above example and looking at it through the lens of Section 3, saying that '*there was no reason to suspect sepsis*' can be seen as an attempt to convey a relevant matter (i.e., were there reasons to suspect sepsis – the key issue in proceedings) that was personally perceived by the said clinician. It is therefore admissible opinion evidence. Furthermore, one has to be realistic and not artificial about such things. Whilst it might cause difficulty for those representing Claimants in proving negligence, in the words of Mr. Justice Holman in *ES v Chesterfield, North Derbyshire Royal Hospital NHS Trust* [2003] EWCA Civ 1284:

'It is, in my view, not only inevitable but appropriate, for no professional person can explain or justify his or her actions and decisions save by reference to his or her training and experience.'

What about clinicians not directly involved?

Things are of course rarely as straightforward as the above example. It is often the case that one is faced not just with

the single statement from the clinician being criticised, but perhaps another (or several) more statements from clinicians who whilst they did not deal with the Claimant directly, would have treated him or her but for the negligence, and/or (more broadly) were employed by the trust at the time. If they were to say '*there was no reason to suspect sepsis*' would that be admissable?

Clinicians who would have treated the Claimant 'but for' the negligence:

Having proved some breach of duty, the Claimant will then have to prove what would have happened but for the accident. This is sometimes referred to as '*the Bolitho question*', and is quite straightforward (at least in principle):

a) What would have happened in fact, and why?

b) Would what have happened be considered negligent?

If the further statements are from the pool of doctors that would have treated the Claimant, then their evidence on what they would have done, what would have happened generally, and why (which will necessarily involve opinion evidence) is perfectly admissible.

It is true that the question of what would have happened is, given its hypothetical nature, to some degree an opinion. However, that opinion is only being expressed as a way of conveying the question of fact (i.e., causation) and because those clinicians were there at the time (i.e., they have '*personal perception*') they are entitled to give that evidence. Furthermore, as Mr. Justice Holman observed, in those circumstances it is artificial to pretend that evidence of fact and opinion either could or should be separated from one another.

Clinicians who would not have treated the Claimant, but were employed by the relevant institution:

Again, it is not unheard of to receive evidence from those who neither treated the Claimant nor would have treated the Claimant but for the negligence. They can still give some evidence, but that will be limited to the systems and policies that were in place at the time.

So, going back to the example, you might have somebody speaking to the system that the unit had in place in time for dealing with sepsis in your particular circumstances. They may say something like '*the system at the time would be that we would look for x/y/z, and if the patient had two of those three criteria then this is what our policy says we should have done.*' If the evidence were limited to that, and to explanations of how the system would work in practice, then that evidence is likely admissible.

However, it is important to pay particular attention to the wording used. If the above went onto say that, '*and under our system at the time it is unlikely that the Claimant would have been considered at risk of sepsis*', then that is inadmissible. The 'systems' witness was not dealing with the Claimant, nor would have been one of the pool of doctors treating him or her.

Clinicians who were not working at the relevant institution:

Another important point to note is whether or not the witness was employed on the unit at the time. That can often be the case where the clinicians involved were working as locums. Indeed, whilst there is no agreed estimate, there is broad agreement that the number of locums working in the NHS is high and is on the rise, and so that is a situation that many representing Claimants are increasingly facing.

In the case of the above, the systems evidence is admissible because it comes from that witnesses' direct knowledge. They have that direct knowledge because they were employed by the relevant institution. This is where the Practice Direction to CPR 32 comes to the fore and is worth remembering. CPR 32.8 makes it clear:

'A witness statement must comply with the requirements set out in Practice Direction 32.'

Paragraph 18.2 of the Practice Direction requires that:

A witness statement must indicate:

(1) Which of the statements in it are made from the witness's own knowledge and which are matters of information or belief; and

(2) The source for any matters of information or belief.

It follows that if the witness was working on the unit at the time, in whatever capacity, much of the evidence will come from his or her own knowledge. However, if not working on the unit, then it follows that any statements about the systems will be either from information and belief. That might be from policies that were current at the time, conversations with colleagues etc. However, as per the Practice Direction, the source of that information must be stated, and if it is not, then the consequences may be severe.

The importance of pleadings

The (extempore) Judgment of Master Sullivan in *Man v St. George's University Hospital NHS Foundation Trust* [2024] EWHC 1304 (KB) is a neat example of all the above principles being applied in practice, as well as an

important reminder of how important the pleadings are when it comes to considering the above issues.

In that case, the Claimant had alleged that she presented to the nurse practitioner in '*extreme pain*'. That was not made explicit within the medical records but nevertheless was her case. Furthermore, one of the allegations was that the Nurse had failed to give consideration to a soft tissue infection being a cause of that pain.

The Defendant responded that:

1. In respect of the aversions re: extreme pain, it was '*admitted insofar as they are consistent with the entries made in the medical records.*'

2. If not in those records, then it was outside of the Defendant's knowledge, and therefore the Claimant was required to prove it.

3. Negligence was admitted, but in relation to the specific allegation mentioning extreme pain, there was no response (given a prior admission).

That all seems straightforward. However, the Defendant then served a statement from Nurse Jabeen saying that, '*I can see that the Claimant states...that she told me she was in extreme pain. I cannot recall this phrase being used and if she was in pain, I would have administered pain relief....Additionally, if she had been visibly distressed from pain, then I would have recorded this within the notes. But in fact, my record says she was not distressed.*'

The Claimant's position was that there was no denial of extreme pain within the pleadings, and insofar as there was a denial, then the Defendant was obliged to set out a different version of events (CPR 16.5 (1) and (3)), which they had not done. Furthermore, this was not a case, it was said, where there was a good reason for not admitting nor denying, since they could have spoken to the Nurse, and there was no suggestion that they were unable to do so. If the Defendant wished to put the issue of pain in dispute then it would require an amended defence, and without an amended defence the Nurse's evidence was inadmissible because it did not go to a matter that was in issue.

The Master agreed. The complaint that the aversion of extreme pain fell outside of the Defendant's knowledge was not a proper pleading. Had the Defendant spoken to the nurse then they would have been able to answer the question and put it in issue. The language of non-admissions is only for where a Defendant can truly not admit nor deny, and is not an excuse to provide, '*a stonewalling defence with indiscriminate non-admissions.*' (see *Henderson LJ in API v Swiss Post International (UK) Ltd* [2019] EWCA Civ 7).

A summary

a) In order for any witness to give opinion evidence, it must be an issue that is in dispute. If there is a non-admission, then the Defendant is not entitled to lead evidence on that point. It is important to check the pleadings. One may want to think about the value of putting in a Part 18 request, or whether tactically it makes more sense to not do so.

b) Those who are being criticised are entitled to give opinion evidence on why they did what they did, as well as the systems and policies in place at the time, and how those systems and policies worked in practice.

c) Those who would have been one of the pool of clinicians who would have seen and/or treated the Claimant but for the negligence can give evidence on what they would have done and why. Again, they too can give evidence on systems and policies as per above.

d) Those who are neither of the above can give evidence on systems and policies in place at the time. However, they must state whether that is from their own knowledge, information or belief. If they were not employed on that unit at the time, one cannot assume that they have direct knowledge of the systems etc., and so it is imperative that they cite where their information or belief comes from.

e) If the evidence that has been served does not conform to the broadly stated principles above, then there may be some merit in applying to strike out parts of that evidence. If that is going to be done, then it is important to make clear by way of redacted statements which sections you are applying to strike out, and which you are not.

f) If successful in that application, then it might be worth thinking about how that impacts the expert evidence (if at all).

Man v St George's University Hospital NHS Foundation Trust [2024] EWHC 1304 (KB)

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Clinical negligence defences frequently adopt a boiler plate approach of non-admissions and putting claimants to proof. In this article I will be focusing on *Man v St George's* [2024], and how claimants can capitalise on these defences.

In *Man v St George's University Hospital NHS Foundation Trust* [2024] EWHC 1304 (KB) the claimant alleged, in part, that the defendant's nurse ("Nurse Jabeen") had failed to act on the claimant's reports of extreme pain.

It appears from the judgment (because we do not get to see the pleadings themselves) that the allegation of severe pain was included within the particulars of claim twice. First during the factual background, second during the allegations of breach.

The defendant pleaded in response to the factual background that it admitted the facts which were consistent with the medical records but that otherwise it could not admit or deny the allegations as they were outside of the defendant's knowledge and put the claimant to proof. This will be very familiar to those dealing with clinical negligence cases.

In response to the allegations of breach, the defendant made one admission, but not to extreme pain. The defendant did not plead further to breach of duty but put the claimant to proof of the other allegations made.

Fast forward to the case management stage, and the defendant sought to rely on a statement from Nurse Jabeen as evidence that the claimant was in fact not in extreme pain. The claimant applied to have that statement excluded on the basis that the claimant's extreme pain was not in issue - it had been admitted. The judge acceded to that application, applying the following reasoning:

• The defendant's pleading was defective. Per CPR 16.5, it was only open to the defendant to "*put to proof*" if either (a) the defendant was unable to admit or deny the allegation, or (b) the nature of the defendant's case was set out in the defence.

• The latter plainly was not the case; it appears the defendant had put forward a relatively bare defence. As to the former, Master Sullivan held that it was not open to the defendant to say it was "unable" to admit or deny. Nurse Jabeen was presumed to have been available to provide comment because she had in fact done so in 2016 (and there appeared to be an understanding that she still worked for the defendant).

• Further, Nurse Jabeen was the one alleged of being negligent; she was not a "third party" who the defendant could reasonably delay seeking information from. Consequently, the defendant had no good reason for its lack of knowledge.

• There are only three options available to a defendant in a defence – to admit, to deny, or to put to proof. The defendant had failed to properly put to proof because it was not unable to admit or deny. Nor had it set out its case, nor sought to deny the allegation. As such, the allegation that the claimant was in extreme pain must be taken to have been admitted. Therefore, it was not in issue and the defendant was not entitled to put forward evidence on the matter.

• In any event, even if it was not admitted, putting the claimant to proof means just that. It was not open to the defendant to put forward a positive alternative case of its own, along with evidence to that effect, having not done so in its defence.

What does this mean in practice?

A corporate defendant like an NHS Trust has the knowledge of its employees, agents, and officers etc, and it is taken to have that knowledge for the purpose of pleading its defence. Beyond that, enquiries need not be

made of "third parties" (per *SPI v Swiss* [2019][1]) at this early stage of litigation.

Of note, Master Sullivan refuted the idea that Nurse Jabeen was a "third party" on the basis, in part, that she was the one alleged to have been negligent. It seems to me that whether she was the one who was negligent or not is not strictly relevant if she was in fact still employed by the defendant. The information held by any current employee, per *SPI v Swiss*, should be held to be within the defendant's knowledge. If we took the view that the defendant has some kind of enhanced obligation to seek the comments of the clinician at the heart of the allegations, that would have significant consequences. It would presumably mean defendant NHS Trusts needing to contact former employees before serving a defence.

However, even if this is just a restatement of existing principles of the knowledge of corporate defendants, it is clear that NHS Trusts will need to be more proactive in seeking the comments of their employees. Further, where a defendant puts a claimant to proof, they should not then be allowed to put forward their own positive evidence if they have not pleaded a positive case. At the case management stage, claimants should keep the defence in mind and identify which issues are properly in play and then attempt to prevent the defendant relying on evidence otherwise.

In *Man* the claimant argued that not only would the defendant need to apply to amend, but it would need to apply to resile from an admission. This was explicitly not dealt with by Master Sullivan, but it does appear to follow logically.

One final point worth mentioning is that the claimant in *Man* had argued that if pleading a non-admission in a defence, the defendant is required to set out a good reason for being unable to admit or deny. I am unsure about that. It is one thing to require a defendant to have a good reason, but another to require that it be pleaded in. It is often apparent why the defendant is unable to admit or deny, and in my view, it would be draconian to hold that all such non-admissions are admissions unless the reason is given. I would be slow to advise a claimant to attempt to have a court apply that approach.

What next?

1) One would expect defendants to be more proactive in seeking information from witnesses of fact prior to serving a defence. That might cause yet further delay to claims that are already routinely extended by months or years.

2) Further, one would expect a shift in the way defences are drafted, which are often relatively formulaic. I would expect to see a reduction in the number of defences which put to proof without giving a good reason, albeit I am doubtful that this is strictly necessary. Additionally, if defendants have gone to the trouble of seeking evidence from employees, we may see these being incorporated into defences more commonly, with a corresponding reduction in the use of "*unable to admit or deny*".

3) A consequence of the above might in fact be that claimants face more robust defences. However, in the meantime, claimants have an opportunity to capitalise on boiler plate defences which are all too common in clinical negligence claims, by ensuring the courts see inadequate non-admissions as admissions.

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Man v St George's and other related cases were also discussed on the St John's Chambers **Personal Injury Podcast** by Sophie Howard and Lauren Karmel.

1 SPI North Ltd v Swiss Post International (UK) Ltd and another *[2019] EWCA Civ 7*

Informed Consent: Who knows what's best?

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Earlier in 2025, the British Medical Association published an updated Ethics Toolkit, titled *"Consent and refusal by adults with decision-making capacity."*[1] This toolkit provides comprehensive practical guidance to clinicians across the UK about the process of obtaining consent from adult patients, and is intended to apply any time the doctor wishes to initiate any examination, treatment or intervention. The guidance also covers situations such as sharing information with patients, consent in emergency situations and consent for medical research.

This article considers the BMA toolkit in the context of the current case law on consent, particularly following the Supreme Court decision in *McCulloch v Forth Valley Health Board* [2023] UKSC 26.

The law on materiality: from *Montgomery* to *McCulloch*

It is necessary, before turning to the BMA Toolkit, to first consider the current state of the law on informed consent, and three key decisions from the last decade: *Montgomery*, *Duce* and *McCulloch*.

Readers will be very familiar by now with the Supreme Court's decision in *Montgomery v Lanarkshire Health Board* [2015] UKSC 11, which put forward the correct approach for clinicians to adopt when consenting a patient for treatment, including the discussion of risks and alternative treatment options.

The Supreme Court considered the history of the law in respect of consent and breach of duty, including the application of *Bolam v Friern Hospital Management Committee* [1957] 1 WLR 582 ('the *Bolam* test') and the approach endorsed in *Sidaway v Board of Governors of the Bethlem Royal Hospital and the Maudsley Hospital* [1985], to determine whether a doctor's failure to warn a patient of the risks of treatment was a breach of her duty of care, and was normally to be determined by the application of the *Bolam* test.

In *Montgomery*, the Supreme Court noted that the reality of the doctor-patient relationship implicit in the time of decisions such as *Sidaway* has shifted. The court considered in detail the more recent clinical guidance, including the GMC's '*Good Medical Practice*' and guidance on consent, which focused (by the date of the judgment) on a "*basic model of partnership between doctor and patient*"[2], as opposed to the more paternalistic relationship of old. Lord Kerr and Lord Reed pointed out that the GMC advised that clinicians must tell patients if treatment might result in a serious adverse outcome, even if the risk in question was objectively very small, and that patients should be told about less serious complications if they occur very frequently.

Considering the social and legal developments that have taken place since the earlier decisions, including developments in human rights law, the Supreme Court unanimously held that there is a duty on the part of doctors to take reasonable care to ensure that a patient is aware of material risks of injury that are inherent in treatment:

> *"This can be understood, within the traditional framework of negligence, as a duty of care to avoid exposing a person to the risk injury which she would otherwise have avoided, but it is also the counterpart of the patient's entitlement to decide whether or not to incur that risk."*[3]

The court drew a distinction between on the one hand, the doctor's role in considering the possible investigatory or treatment options which should be offered to the patient, and which are an exercise of professional skill and judgment on the part of the clinician, and on the other hand, the doctor's role in discussing with the patient any recommended treatment and the possible alternatives as well as the risks of injury which may be involved. The

1 https://www.bma.org.uk/media/txrnpo3s/consent-and-refusal-by-adults-with-decision-making-capacity-guidance-updated-2025.pdf

2 Montgomery, *per Lord Kerr and Lord Reed at [78]*

3 *Ibid, at [82]*

court rejected the suggestion that the latter role is solely a matter of the exercise of medical skill, ignoring entirely the patient's right to decide the risks to her health that she is willing to run, which is a decision that could be influenced by non-medical considerations.

The fundamental principle endorsed by the court in *Montgomery* was that an adult of sound mind is entitled to decide which, if any, forms of treatment to undergo, and her consent must be obtained before treatment interfering with her bodily integrity is undertaken. The doctor is therefore under a duty to take reasonable care to ensure that the patient is aware of any material risks involved in any recommended treatment, and of any reasonable alternative or variant treatments.

The test of 'materiality' was defined as "*whether, in the circumstances of the particular case, a reasonable person in the patient's position would be likely to attach significance to the risk, or the doctor is or should reasonably be aware that the particular patient would be likely to attach significance to it.*"[4]

The next key decision when considering the case law on informed consent is *Duce v Worcestershire Acute Hospitals NHS Trust* [2018] EWCA Civ 1307. Mrs Duce brought a claim for damages following a total abdominal hysterectomy and bilateral salpingo-oophorectomy, which left her with nerve damage and serious and permanent chronic post-surgical pain ('CPSP'). The Court of Appeal considered the claimant/appellant's case that she was not adequately warned of the risk of pain in relation to the procedure when she was consented for it.

At trial, the judge had considered the decision in *Montgomery*, and the test of materiality, but found in respect of breach of duty that the claimant had been well aware of the alternative treatment on offer; that as both sides' expert gynaecologists agreed, there was no duty to warn her of the risk of developing CPSP in particular; that at the relevant time, in 2008, there was in fact no duty to warn a patient such as the claimant of the risk of developing either short term or long term chronic or neuropathic pain; and that the claimant understood, at the point where she was asked to consent to the procedure, that the operation would cause her some pain, and was specifically warned of the risk of 3-6 months of numbness or pain.

In respect of causation, the trial judge considered the history of the claimant's condition, and the attempts by clinicians to steer her towards other treatment options prior to this procedure and rejected the case put forward on her behalf that if she had been warned of a risk of chronic pain or 'nerve pain', she would either have decided not to have the operation, had second thoughts, sought a second opinion, or at least put things off. The judge concluded that it was more likely than not that she would have proceeded to the operation on the day.

In their judgment on appeal, the Court of Appeal considered the application of *Montgomery* in respect of breach of duty to the claim, as well as the relevant principles on causation, including the test of causation set out in *Chester v Afshar* [2004] UKHL 41.

The appeal failed, with the court considering that the judge was correct to find that in 2008 there was insufficient understanding among gynaecologists of the existence of a risk of '*chronic pain, or of neuropathic (or nerve) pain, whether that was long term or short term*', to justify the imposition of a duty to warn of such a risk. This was held to be consistent with the *Montgomery* approach, because *"a clinician is not required to warn of a risk of which he cannot reasonably be taken to be aware."*[5] The question of materiality therefore only arises if the risk was one which was known.

The Court of Appeal interpreted *Montgomery* as creating a twofold test[6]:

1. What risks were or should have been known to the medical professional: this is a question for the experts;

2. Whether the patient should have been told about such risks by reference to whether they were 'material'. This is a question for the court to determine, and not the subject of the *Bolam* test.

The court also rejected the claimant's arguments in respect of causation. It was argued on behalf of the claimant that Chester created essentially an '*alternative pathway to causation in consent cases*,' subject to three requirements, which were said to be satisfied in the present case: (i) the injury was intimately involved with the duty to warn; (ii) the duty was owed by the doctor who performed the surgery to which the patient had consented; and (iii) the injury was the product of the very risk that the patient should have been warned about when they gave their consent.

The Court of Appeal did not agree that *Chester* amounted to a departure from 'but for' causation, emphasising instead from that decision the need for proof that (i) there was a failure to warn of the relevant risk which did arise; and (ii) as a matter of fact, if the claimant had known of

4 *Ibid, at [87]*

5 Duce v Worcestershire Acute Hospitals NHS Trust *[2018] EWCA Civ 1307, per Lord Justice Hamblin at [43]*

6 *Ibid, at [33]*

the actual risks of the proposed surgery, she would not have consented to the procedure on the relevant date. The approach in *Chester* was said to be a modification to the normal approach to causation, rather than a '*free-standing test*'.[7]

The Supreme Court then had reason to revisit the issue of consent more recently in *McCulloch v Forth Valley Health Board* [2023] UKSC 26. In this appeal, the court considered what legal test should be applied to the assessment as to whether an alternative treatment is reasonable and requires discussing with the patient. Where a doctor fails to make a patient aware of an alternative treatment, in a situation where the doctor's opinion is that the alternative treatment is not reasonable, and that opinion is supported by a responsible body of medical opinion, does that fall below the required standard of reasonable care?[8]

Applying the principles set out in both *Montgomery* and *Duce*, the court emphasised that the identification of which treatments are reasonable alternatives, i.e. clinically appropriate, is as much a matter falling within medical expertise and professional judgment, and hence governed by the *Bolam* test, as the identification of risks associated with any treatment. The court noted that both are closely linked, and the risk of any given treatment will be a significant part of any analysis of alternative treatment options[9]. Once reasonable alternative treatment options have been identified, the doctor is required at the second stage to inform the patient of the reasonable alternative treatments (which have been identified by the professional as clinically appropriate), and of the material risks of those alternative treatments.

The court was at pains to stress that "*it is not being suggested that the doctor can simply inform the patient about the treatment option or options that the doctor himself or herself prefers. Rather the doctor's duty of care, in line with Montgomery, is to inform the patient of all reasonable treatment options applying the professional practice test.*"[10]

The Supreme Court considered that this approach would be consistent with both *Montgomery* and *Duce*, and rejected the appellant's submissions that the duty to take reasonable care to ensure that the patient is aware of '*any reasonable alternative or variant treatments*' means all such treatments, or that what constitutes a reasonable alternative treatment is to be determined by the court, "*unshackled from the professional practice test.*"[11]

Both the BMA and the General Medical Council intervened in the appeal, emphasising the importance of clinical judgment in determining reasonable alternative treatment options. The BMA further pointed out, and the court accepted that, the doctor's duty is not fulfilled by 'bombarding' the patient with every possible treatment option for every potential diagnosis, potentially 'obstructing' patient understanding[12].

The Supreme Court also considered that rejecting the *Bolam*/professional practice test in determining reasonable alternative treatments might lead to an unfortunate conflict in the exercise of a doctor's role, where the law might require a doctor to inform a patient about an alternative medical treatment which the doctor exercising his professional skill and judgment, and supported by a responsible body of medical opinion, would not consider to be a reasonable medical option[13].

Practical guidance: the BMA Toolkit

The 2025 BMA Toolkit on consent sits alongside the GMC's '*Decision making and consent*' professional standard[14], but helpfully incorporates the key guidance from the GMC. At twenty-one pages long, it is a comprehensive document.

The toolkit emphasises that doctors can apply their own professional judgement about the most appropriate way to seek consent, which will be dependent upon the specific circumstances of each decision, including:

a. the nature and severity of the patient's condition and how quickly the decision must be made;

b. the complexity of the decision, the number of available options and the level of risk or degree of uncertainty associated with any of them;

c. the impact of the potential outcome on the patient's individual circumstances;

d. what the clinician already knows about the patient, and what the patient already knows about their condition, the potential options for treating or managing it;

e. and the nature of the consultation.

7 *Ibid, at [51]-[66]*
8 *McCulloch v Forth Valley Health Board [2023] UKSC 26, per Lord Hamblen and Lord Burrows at [3]*
9 *Ibid, at [64]*
10 *Ibid, at [58]*
11 *Ibid, at [60]*
12 *Ibid, at [73]*
13 *Ibid, at [71]*
14 **https://www.gmc-uk.org/-/media/documents/gmc-guidance-for-doctors---decision-making-and-consent-english_pdf-84191055.pdf**

While consent does not always need to be in writing, the patient's records should 'usually' include discussions about the treatment options, including potential harms and benefits of any treatment, any specific concerns the patient had and any other information that was given to them. Doctors are reminded that consent should be a continuing process rather than a one-off decision, giving patients continuing opportunities to ask further questions and to review their decisions.

If a patient asks for treatment that the clinician does not think would be clinically appropriate for them, their reasons for requesting it should be discussed with them. *"Any significant factors for the patient should be explored further, including non-clinical factors such as their beliefs or views. Following this, if you still consider that the treatment is not clinically appropriate, you do not have to provide it."* However, the reasons for the refusal should still be explained clearly to the patient, as well as other options available to them including seeking a second opinion.

The toolkit also sets out a very comprehensive list of matters that the doctor should provide them with '*sufficient, clear and accurate information*' about, in respect of any proposed course of action or treatment. This includes the purpose of the investigation or treatment, details and uncertainties of the diagnosis, options for treatment, including the option of no treatment, the likely benefits and probabilities of success of each option, the risks and potential side effects or adverse outcomes, the name of the doctor with overall responsibility for their care, and their reasons for any recommended treatment options. The discussions should be tailored according to the nature and complexity of the proposed course of action, the level of risk associated with it, and the individual's own concerns, wishes, values, and their understanding of their condition and prognosis.

Information should only be withheld from the patient in the very limited scenario where the doctor has a reasonable belief that providing the information would cause the patient serious harm, but the exception should not be abused.

Doctors should take all reasonable steps to maximise the patient's ability to understand, consider options and make a decision. This includes steps such as taking time to understand the patient's values, wishes, preferences and knowledge of their own condition, using clear and consistent language when discussing risks of harm and potential benefits, encouraging patients to ask questions, supporting patients with additional needs to have the time and any reasonable adjustments they need, giving the patient time to reflect, before and after they make a decision, providing the opportunity for patients to discuss their options with others, and considering whether the patient might need more time with the doctor or others in the healthcare team.

Essentially, the main takeaway from the toolkit is that one size does not fit all when it comes to the process of obtaining consent from a patient for a particular treatment/procedure, or indeed when discussing the available options with the patient before a particular option is ultimately consented to. The toolkit attempts to put forward a series of comprehensive guidelines to assist clinicians with the process, in a way that reduces the risk of paternalism and promotes greater equality within the doctor-patient relationship.

From the patient's perspective, however, one might be concerned that there is no particular hierarchy of factors: it would appear to be for the clinician to determine which factors they prioritise above the others. One clinician, when considering the specific circumstances for a particular decision to be made, might prioritise the severity of the patient's condition and the need for urgent treatment, while another might be more persuaded by the patient's concern that they cannot afford a lengthy recovery period. In practice, even the same treatment options might be presented to the patient in a very different way, depending upon what each clinician chooses to prioritise.

The other practical difficulty with the toolkit is the fact that all of these discussions realistically require sufficient time, if the doctor is to genuinely comply with the guidance. That may be more available in the hospital context, particularly for non-urgent surgical procedures where there is a consent form to be signed, and/or long courses of treatment where a patient might be seen by the same consultant on an ongoing basis. Unfortunately, a busy locum NHS GP, seeing a patient in a 5-10 minute appointment, is likely to have limited opportunity to properly get to the know the patient, or to be able to give them enough time to ask questions or reflect.

It might be suggested that the '*nature and complexity*' of GP consultations is not on the same level as a surgeon discussing proposed surgical procedures with a patient, so the lack of time is less significant in that context. However, given that GPs are often managing and treating a range of conditions within the community, and that for many patients, the majority of their clinical interactions will be with their GP, the importance of an effective and inclusive consent process even within the busy and

time-limited general practice consultation should not be underestimated.

Similar concerns may well apply to other clinician interactions where consent needs to be obtained from a patient under some time pressure, such as in the middle of labour: to what extent is the need for a swift decision to be made going to be allowed to override many of the more patient-centred aspects of the guidance?

Overall, while the toolkit is to be commended for its comprehensive and detailed guidance that appears to cover all the key points arising from recent case law, it remains to be seen how effectively in practice the already overstretched clinicians in many parts of the NHS are going to be able to apply its principles.

Clinical Negligence in the NHS and lessons not learned

PHILIPPA LUSCOMBE
PENNINGTONS MANCHES COOPER

PENNINGTONS MANCHES COOPER

A growing concern for patient safety and NHS sustainability

When I first started out as a clinical negligence solicitor I wondered if it was a field of law destined to wipe itself out – it seemed to me that as the number of clinical negligence claims pursued increased there could be no doubt that the cost of that would trigger improvements in care and in due course a downturn in claims.

Twenty-five (or so!) years later and it's been anything but - recent figures from NHS Resolution reveal an ongoing rise in clinical negligence claims across the NHS, with some Trusts facing significantly higher volumes and payouts than others. In 2024/25, according to their annual report **NHS Resolution annual report and accounts 2024 to 2025** the NHS paid out over £3.1 billion in claims and legal costs, with 14,428 new cases filed – many involving maternity care, emergency medicine, and surgery. This was an 11% increase in the number of claims year on year.

Cynics might say this is all driven by ambulance chasing solicitors – but I don't think that's the reality – clinical negligence claims are (rightly) hard to prove – negligence is establishing significant failings in care and injury caused, not just poor care, the costs rules make it ever more difficult for claimants to get proper access to justice and most clinical negligence lawyers think very carefully before advised a concerned patient or family member to proceed. My view therefore isn't that these numbers are a reflection of this area of law being promoted or actively growing – the cold hard facts are that the number of patients injured by unacceptable failings in care is growing. One can't help but think that these figures show an absolute failure to look at the causes of such high numbers of claims and take steps to improve processes, training , communication etc to reduce the number of claims brought, rather than publication of these numbers being used to suggest a compensation culture – which frankly in my view doesn't really exist.

In my experience (and I am sure I am not alone in this) many people bring claims reluctantly and only because injuries caused have had a significant impact on their day-to-day abilities, work capacity etc and they need the compensation. Many others only bring claims because their concerns have been dismissed or no one has sat down to explain what has gone wrong or just provide an apology – despite things such as duty of candour. Very few people are bringing claims just to get some money and, as above, a claim will only ever succeed if there have been serious failings in care. The figures are not therefore a reflection on the general public and NHS patients but on the standard of care that is being provided – and the number of claims suggests that lessons are not being learned.

One of the things that always surprises me is when over time you see the same failing happen at the same Trust over and over again and end up bringing a succession of quite similar claims against the same Trust. In any normal commercial enterprise if there was a point of failure that resulted in multiple similar claims over time, that would be identified, and steps would be taken to ensure it didn't happen again. We as clinical negligence lawyers never know quite what analysis is done in the background, but what we see would suggest that this often isn't happening because change doesn't happen and more patients suffer avoidable injury. This is particularly frustrating when often only fairly simple things need changing – ensuring that policies and guidelines are publicised and followed for example.

What does the data show?

There is a part of me (the geeky part that really likes analysing numbers) that would absolutely love to get into the weeds of NHSR claims statistics, find the trends and point out things that could be done that would improve patient care and safety and reduce the number of claims – a true win / win.

In the absence of being able to do that, I instead thought I would do some analysis of clinical negligence cases in

the Courts at the moment and see whether those show any interesting trends.

I used Solomonic – a litigation analytics platform – to pull some data to review. Whilst it goes without saying that litigated cases form only a small proportion of clinical negligence claims instigated and settled and it is also relevant that issued cases often represent care that has happened some time previously, I thought the numbers of cases brought against various Trusts might show some interesting trends. For this purpose I:

- Looked only at claims issued from 1 January 2025 to 30 September 2025 (although also at total claims logged against individual Trusts)
- Focused on claims issued against NHS Acute Hospital Trusts – not including private hospitals, GP practices, community healthcare or mental healthcare trusts
- Looked at NHS Trusts in England and Wales only

Based on this analysis I identified the following:

Currently there are around 200 NHS Trusts in the UK of which 132 are acute hospital Trusts

To the end of September 2025 a total of 319 clinical negligence cases were issued in the High Court against NHS hospital Trusts (these figures therefore don't include lower value clinical negligence claims not brought in the High Court)

Twelve NHS Trusts have had seven or more claims issued against them this year.

These twelve NHS Trusts account for 98 of the total number of issued claims this year i.e. approximately 31% of total claims (despite, as above only forming about 10% of the number of acute hospital Trusts in the UK)

Those twelve Trusts were:

- Barking, Havering & Redbridge University Hospitals NHS Trust
- Leeds Teaching Hospitals NHS Trust
- Barts Health NHS Trust
- Aneurin Bevan University Health Board
- Cwm Taf Morgannwg University Health Board
- University Hospitals Bristol & Weston NHS Foundation Trust
- Guys & St Thomas' NHS Foundation Trust
- Lewisham & Greenwich NHS Trust
- Medway NHS Foundation Trust
- Blackpool Teaching Hospitals NHS Foundation Trust
- Manchester University NHS Foundation Trust
- Mid & South Essex NHS Foundation Trust

One logical explanation for this would be that the bigger NHS Trusts are bound to have more claims against them because of a higher volume of patients. Manchester University NHS Foundation Trust is regarded as probably the largest UK NHS Trust and does feature on this list – Barts also is a very large Trust and features BUT this list of twelve Trusts by no means represents the twelve largest NHS Trusts. However, size / number of patients is bound to have some impact.

I also looked at the total number of High Court clinical negligence claims logged against these Trusts – were the figures from this year indicative of a pattern? In the main the figures did show some consistency – most of the Trusts above generally had high numbers of total claims lodged against them – but not all. Barts by some way had the highest number of current claims against them and the claims issued this year are a small proportion, whereas for some of these Trusts the number of cases issued this calendar year forms a significant proportion of their overall claims. That in itself raises an interesting question – is there any mechanism in place to use notification of potential clinical negligence claims to prompt review of whether there is a developing problem at a particular Trust with a view to stepping in early to address it? That would seem a simple and effective way of using information to try and stop problems before they build – a sudden increase in notified claims may well be an indicator of an underlying problem.

Solomonic also enables you to look at which hospitals overall have had the highest number of litigated claims – and that data would suggest that the top three are all London hospital Trusts:

- Barts Health NHS Trust
- Kings College Hospital NHS Trust and
- Royal Free London NHS Trust

Protecting patients, restoring trust, and safeguarding NHS resources

Clinical negligence claims are more than just legal and financial burdens—they can in my view be reliable indicators of systemic issues in patient care and offer an opportunity to identify change needed. When an NHS Trust faces a high volume of such claims, it signals a need for review and opportunities for improvement. The stakes

for patients are too high to ignore and commercially this analysis makes sense – address the root cause of the claims and the cost of claims will reduce.

Some progress has been made – in September for the first time league tables were published on NHS acute Trusts - **NHS England » NHS Oversight Framework – NHS trust performance league tables process and results**. These weren't focused specifically on claims records but looked at various performance indicators – so work is being done to look at performance and compare Trusts. It is worth noting that none of the top ten ranked Trusts in this report feature as a Trust having a high number of claims against them either this year or generally. Of the twelve Trusts I noted with the high volume of claims, one (Medway) is in the bottom ten of the league table and another two (Blackpool and Mid & South Essex) fall within the bottom twenty of the league table. This would suggest that there is (unsurprisingly) a clear link between overall performance and number of claims. The issue is what is done to use this data for change.

In my view Trusts must move from reactive litigation management to proactive care improvement. With billions spent annually on negligence payouts, improving care is not just a moral imperative – it's a financial one. Reducing harm means preserving NHS resources for what matters most: delivering high-quality care to every patient, every time. If that does in the end do us clinical negligence lawyers out of a job, then we will have made a difference – but there looks to be a long way to go still.

Dispute Resolution Update

Trust Mediation

PAUL BALEN
TRUST MEDIATION AND TRUST EVALUATION

August 1st saw the commencement date for the new public procurement contracts awarded to providers for the NHS Resolution (NHSR) Mediation Scheme. The new four-year contracts awarded to Trust Mediation, Global and CEDR for the mediation contract contain subtle, but significant differences from the old contracts whilst the contract awarded to Trust Mediation and CEDR for the Neutral Evaluation contract is brand new. As mentioned below, details of the actual form of the NHSR Evaluation Scheme, however, are we understand still under development.

All this is in the context of the latest version of the Claims Handling Agreement between AvMA and NHSR; the recent amendments to CPR, and recent court judgments such as *Churchill*[1] and *DKH*[2], all of which emphasise out of court dispute resolution as being part of the overriding interest with in-court adjudication as a last resort. As recent statements by the Master of the Rolls and Lady Chief Justice emphasise, dispute resolution lawyers (the term litigation lawyers is out of date) are required to understand the different tools available in the dispute resolution toolbox and to be able to recognise and justify the tool most suited for the individual claim under consideration.

Court ordered mediation[3], whether by consent or over the heads of the parties, is now increasingly common as are penalties meted on parties who fail pro-actively to embrace dispute resolution. At Bristol County Court, for example, some cases are automatically stayed for dispute resolution upon a defence being filed[4]. Combining PT 36 and dispute resolution penalties is now an accepted feature in litigated cases.[5]

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

2 DKH Retail Ltd v City Football Group Ltd *[2024] EWHC 3231 (Ch)* Miles J stated:

**even where the parties' positions are diametrically opposed mediation has been shown to be successful;*

**while there was some force in the defendant's view that mediation was too late, there can be an advantage in positions being crystallised through pleadings and witness statements;*

** mediation can often overcome an entrenched reluctance of parties to negotiate;*

**the range of options available in mediation to resolve the dispute 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 mediation would not 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.*

3 *A typical order following a contested application for an order for mediation read: Pursuant to CPR 3.1 the parties must engage in Mediation which shall be completed b....The costs of the claimant's application for mediation dated.....shall be paid by the defendant and summarily assessed at the CMH.*

4 *The standard Bristol order includes the following:*

And upon the court considering that this case is appropriate for mediation

IT IS ORDERED THAT

1. The claim is allocated to the Multi Track and reserved to HHJ Ralton until the listing of any costs and case management conference;

2. The claim is stayed until [date} to enable mediation to take place;

3. Any party may apply to extend the stay to enable completion of the mediation provided such application is made no later than 7 days before expiry of the current stay.

4. Within 7 days of the expiry of the stay the parties shall jointly report to the Court whether mediation has taken place; and

a) If the mediation has not taken place, a note of the reasons why not;

b) If the claim has been settled or settled in part or one or more issues have been resolved, provide a schedule of the terms of settlement and a draft of any consent order required from the Court.

c) If the claim has not been settled a draft of the directions agreed or requested with an updated case summary.

5. This order has been made without a hearing. Any party may apply to the court for reconsideration of this order at a hearing provided such application is made within 7 days from service on them of this order.

5 *For example:* Barry v Barry 2025 *EWHC 819 (KB)*

The NHSR Mediation Scheme

As before, claimants have the choice of mediator from the panels from each mediation supplier, because each panel member has been pre-approved by NHSR. For non-NHS cases the choice of mediator has to be agreed by the parties and, absent agreement, by a third party such as a judge. In NHS cases NHSR fixes and pays the mediator provider reserving the right to reclaim one half of the mediator's fees in those cases which conclude without damages and costs being paid. This means that, in cases in which liability is not admitted, the risk carried (presumably by ATE insurers) will be one half of the mediator's fee for the relevant band.

What is new is that, whilst the eight-hour model is retained, the old four-hour model has been replaced by five-hour mediations and, for the first time, the Scheme expressly now includes both Facilitative and Evaluative mediations.

Facilitative mediation is the most common form of mediation and the form used in the two previous NHSR Schemes. The mediator is there to facilitate the discussion between the parties; to reality test where necessary and explore solutions but expressly not to pass an opinion or advise.

Evaluative mediation adds to the facilitative process the ability of the mediator, with the agreement of both parties, to provide a non-binding evaluation of the issue or issues upon which the parties require guidance. This may be expressed as an opinion of the likely outcome at trial or a recommendation of the potential settlement bracket. This form of mediation may be requested in order overcome a logjam identified during the mediation; or it may be agreed in advance during pre-mediation discussions with the mediator that a more directive or structured approach from a mediator with specialist knowledge of the subject matter by way of an initial evaluation of an issue or overall likely outcome would help inform subsequent facilitated negotiations within the mediation.

Our view at Trust Mediation is that dispute resolution lawyers now need not only knowledge of the options available, but also the ability to be flexible as circumstances change during negotiations. Our experience to date is that, irrespective when in the litigation cycle the mediation takes place, the resolution rate remains constant at around 80% with many of the remaining unresolved cases being resolved later as a result of progress made during the mediation. This means that earlier mediation, for example, at the end of or during the pre-action protocol period, is increasingly the gold standard to aim for, providing early payment of damages and resolution for the claimant and of course payment of costs for the lawyers.

A new six-hour model for mediation has been introduced for cases involving LIPs. In these cases, the mediator's fee is met by NHSR irrespective of outcome. Claimant's solicitors who withdraw from a claim may wish to signpost this Scheme to clients who wish to continue their cases themselves. These cases can lend themselves to evaluative mediation which has already proved to have been used successfully.

Neutral Evaluation

Neutral evaluation (NE) (often used with the unnecessary qualification "Early") is where a specialist independent neutral is asked to provide a stand-alone non-binding opinion on an issue or case as a whole. NE can benefit parties where there is deadlock over an issue or issues; where there is a large disparity in positions or simply where they agree it would be of assistance in their negotiations to have a non-binding steer as to the likely outcome or bracket. Illustrating the flexible nature of the tools available for dispute resolution, NE can readily be combined with (for example) a two-hour facilitative mediation or, by agreement between the parties can, and has in some cases already been treated as binding, effectively becoming an adjudication. NE can be carried out as a "paper only" exercise or involve some element of oral submission as the parties wish. Evaluators can be sole or double up, for example, where both medical and legal input is felt to be of assistance.

The new NHS Resolution contract followed two pilot studies and a public procurement tender. Even though the contract was awarded for four years from 1st August the form of the anticipated NHSR scheme is we understand still under development. In the meantime, we at Trust Mediation continue to provide NE in NHS and other cases on a bespoke basis.

Client Care

The increasing role of dispute resolution over court-based litigation should also be reflected in client care documentation. Instead of almost exclusively majoring on what happens in court such documentation should ideally now give prominence to dispute resolution and the various tools available. This avoids the claimant being caught by surprise when instead of his day in court he is advised to attend a resolution meeting whether that be a JSM or one of the many dispute resolution tools now

available which involve an independent neutral instead of a judge.

Try, Try and try again!

Understanding the different dispute resolution options is a new vital skill to dispute resolution lawyers in every field. Moreover, recent court judgments have emphasised that dispute resolution is a continuing obligation. Just because negotiations, a mediation or JSM have failed does not mean that a trial is inevitable. Case management judges are emphasising that parties should try and try again to resolve claims themselves and will be penalised if they do not.[6] The lesson is that, whilst resolution is not mandatory, positive participation at resolving claims certainly is!

To assist dispute resolution lawyers Trust Mediation has developed the concept of each firm appointing an ADR champion.[7] This together with online seminars and a brand new e-learning module[8] are all available for those interested in developing their skills in this fast changing environment, one in which experience over the last eight years of the NHSR Scheme strongly suggests meets the shopping list of clinical negligence claimants far better than the binary adversarial function of the decaying and antiquated court system which now, more than ever before, really should be a last resort.

6 *For example:* Heyes v Holt [2024] *EWHC 779 (CH) at para 5;* Francis v Pearson, Francis v Burston *[2024] EWHC 605 (KB) par 87-92;* Pentagon Food Group Ltd and others v B Cadman Ltd *[2024] EWHC 2513 (Comm),*

7 **https://www.trustmediation.org.uk/adr-champion**

8 **https://www.trustmediation.org.uk/e-learning-module/**

A six year campaign for justice after repeated medical data breaches and a cover up...

BARRY ELSBY
JUSTICE4PATIENTS

...culminates in Justice4patients successfully taking the Falkland Islands Government and Medical Department to the Supreme Court.

The Falkland Islands is a British Overseas Territory just off the bottom of South America. Our laws are largely based on UK legislation with most lawyers here being UK trained.

All our doctors and nurses have to be General Medical Council (GMC) /Nursing and Midwifery Council (NMC) or equivalent registered and most have wide experience of working in the UK.

In 2018 two members of our group, both retired doctors and one an elected Member of the Falkland Islands Assembly (MLA), asked for confirmation of who had looked at their daughter's computerised medical records. Their daughter had taken her own life in 2017 whilst an inpatient at the Falkland Islands only hospital. She was being treated for serious mental health problems.

They were met by a total refusal from the medical department. The medical department's Caldicott Guardian was and remains a GMC registered doctor. A Caldicott Guardian is a senior person in a health or care organisation, responsible for safeguarding the confidentiality of health and care information of individuals.

It is important to say at this point that there is no Data Protection or Freedom of Information legislation in the Islands but professionals in the medical department were bound by the GMC/NMC Duty of Candour. It is a professional duty and something they seemed to ignore. Unlike England, there is no statutory duty of candour in the Falklands.

The parents continued to ask the hospital and then the Government's Legal department for an audit trail but were refused. They had had power of attorney (POA) and were their daughte's executors.

What is an Audit trail and who can request one?

An audit trail is a comprehensive record that shows who accessed a medical record, when it was accessed and what actions were performed on them.

In the Caldicott report published in March 2013 the number one recommendation was that patients be able to access audit trails[1]

The then Secretary of State for Health, Jeremy Hunt, accepted all the recommendations. Since then, the NHS will produce an audit trail for any patient upon request. This is "good practice" and not part of any UK legislation.

The Island's Caldicott Guardian, the Director of Health, the Hospital Manager, clinical Governance officer and Attorney General were all made aware of the NHS policy. Indeed, apart from the AG, all were trained and worked in the NHS and were well aware of this "best practice" policy.

So what happened?

Parents continued to demand this information from the hospital and the legal department

In January 2019 the Chief Executive of the Falkland Islands Civil Service finally instructed the Attorney General to see who had looked at their daughter's medical records.

This showed that 23 of approximately 64 employees in the hospital had read her notes after she died. The inappropriate access continued for as long as a full fifteen months after she died.

The medical department refused to give an audit trail or divulge the names of the employees involved. They said that 19 employees' viewings were "appropriate" but refused to explain how they arrived at that decision.

1 The Information Governance Review

No Guidance

In February 2019 the Falkland Islands UK trained Attorney General, wrote a very long letter to the parents stating that he had *"searched the world regarding access to Audit Trails and could find no law or guidance that would allow you to have an audit trail."*

In April 2019, the hospital manager again refused an Audit trail on advice from the AG.

By May 2019 the parents had filed complaints with the Government seeking answers, an apology and a promise of improvements – all refused. They were supported by a local legal firm, Waverley Law, who were outstanding, hugely supportive and with a strong moral compass. Some work was pro bono and much at very reduced rates.

The case is raised in the Assembly

In July 2019 the father, an MLA, spoke in the Legislative Assembly about what he believed was a data breach in the hospital that might affect hundreds of patients. This caused widespread concern in the community, and the Attorney General was interviewed on the radio. He was dismissive of the breach, referring to it as *"simply a bit of nosiness"* and, when challenged, declined to involve the police despite agreeing it was likely to be an illegal act.

The family reported matters to the Royal Falkland Islands police. They were outstanding, kept the family informed and were very supportive.

Conflict of Interest

The police built a strong case for prosecution under the Crimes Ordinance, Misuse of a Computer[2] against one perpetrator but they were concerned that the Attorney General, as DPP, would not agree to charge her.

The family sought a meeting with the then Governor, who has ultimate responsibility for "Good Governance" on the Islands, expressing their concerns about a conflict of interest on the part of the AG due to his previous public statements. His Excellency sought input from the Supreme Court Judge. The prosecution proceeded.

Covid delayed Court Case

The case against one individual came to court in March 2021 but she was found not guilty as she was an untrained, non professional when employed and in the eight years in the medical department she had been able to avoid almost all compulsory training The department could not provide evidence that she had been properly trained in the use of the computerised medical records system before being given high level access or her use audited afterwards. The department could not produce evidence of providing any training in confidentiality and she had not signed the required confidentiality form confirming training.

Post Trial

A few weeks after the trial the parents again requested an audit trail for their daughter and the rest of the family.

They were provided with this but with no explanation as to any change in AG advice or Departmental policy. This showed that all family members had been targeted.

They asked for a meeting with the medical department so that they could understand these inappropriate accesses but this was refused, being told they had *"left it too long"*!

Again no apology or support was offered and the dept. refused to search for other victims saying to do so would: cause reputational harm to the department.

Next Breach

Now Audit trails were available the family asked for one every few months, so distrustful were they of the department.

In October 2022 a routine application identified another medical department employee who had illegally accessed their grandson's (their dead daughter's child) records.

The difference with this case is that the new Director immediately organised a search and found another 289 victims and called in the police within a matter of days.

This employee was charged with Misuse of a Computer, found guilty in court in May 2023 and given a six month custodial sentence, suspended for two years as she had a new born baby. Again, no apology or support was offered for victims.

Formation of Justice4patients and Supreme Court Action

The original family now had support from other victims and the group was formed. The aim was to campaign for justice and answers. The four key demands were:

2 fiord-2014-13_2025-02-03.pdf

1. A full, detailed public apology

2. A CQC inspection of the medical dept – the last inspection had been fifteen years previous

3. Public inquiry into what we believe amounted to a cover up by Government.

4. Compensation for all those affected

In July 2023 there was an Appeal to the Governor in her role of ensuring "Good Governance", to set up a public inquiry. She refused.

The group started targeting MLAs in private and when they held public meetings.

In October 2023, the group paid for UK based Counsel's opinion to advise on any breach of the Constitution and/or ECHR law.

On December 1st 2023 we issued a Letter of Claim to the Falkland Islands Government (FIG) in respect of a Breach of section 9 of the Falkland Islands constitution[3]. We were promised a "substantive response" within three months, but it has never arrived.

Instead, they offered a few hours of mediation but only online – the group refused.

In mid 2024 the MLAs agreed that a hospital inspection was necessary but only parts of the dept would be inspected initially. Four inspectors were recruited from the UK.

In September 2024, the group's Legal Aid application was approved by the Falklands Court for their action against the Falkland Islands Government in the Supreme Court.

In January 2025 an hospital inspection report shows much good practice but many areas needing improvement.

Also in January 2025, Particulars of Claim were issued to FIG for action in the Supreme Court.[4] Private Eye carried this in their magazine.

Response

Soon after receiving the Particulars of Claim, the Government indicated a desire to settle.

The group then spent months with our lawyer from Waverley Law meeting with the Director of Health and Head of Legal Services arguing over the wording of a public apology.[5]

They also agreed to an independent external "review" of how Government Officers had acted, with the report to be made public in full. We spent many meetings with our lawyer and FIG arguing the TORs and choosing the experts who would come from the UK. FIG refused a public inquiry and refused to agree that evidence be taken on oath.

Apology

The agreed apology was read out in the Falkland Islands Parliament in August 2025 and carried in full in all media outlets.[6]

"Hillsborough Law"

The UK Government recently published the draft law to enshrine a "Duty of Candour" for civil servants in the UK, something our group have also been pushing for here.[7]

Supreme Court Ruling – October 2025

A Consent Order was agreed, with the Government accepting they had breached our constitutional rights and noting the apology and the external review. It is due to be read out in the Supreme Court by the Chief Justice on November 18th.

The Falkland Islands Government paid compensation to the individuals in our group and the legal costs we incurred over the six years.

Lessons learned

As with many campaigning groups, there were times when we wanted to give up and move on or questioned ourselves over the validity of the campaign. We knew there was a great injustice here and if a group whose members included doctors, pilots, MLAs, Hospital employees, teachers etc could not get justice, then what chance others without this background or the ability to engage lawyers?

We were heartened by a lawyer from the Government's legal department quietly saying to us that we were in the right and must continue the campaign.

We took inspiration from the excellent *Mr Bates v the Post Office* series and also from AvMA who were very

3 183245COVS

4 *Falklands Government to face Supreme Court claim over medical confidentiality breaches.* Falklands Radio

5 164-25P.pdf

6 164-25P.pdf

7 Hillsborough Law to ensure truth never concealed by state again - GOV.UK

supportive when we were losing heart towards the end and welcomed their clear advice.

We were always clear that we were fighting for justice for the many hundreds of patients affected, not just our core group. We will be publishing details on how people can claim compensation if they feel they have been affected by the breaches, hoping the Government will not force others to go to court. Our group will continue, ensuring that lessons learned from the review, when completed, are implemented.

Celebrating Pro Bono Week 2025

PRO BONO WEEK 2025

TOBY BROWN
PRO BONO WEEK UK

Each November, Pro Bono Week shines a spotlight on the power of free legal advice to change lives through lawyers volunteering their time to help those who might otherwise be unable to access justice.

Pro Bono Week 2025 took place across the UK from 3rd to 7th November. This year's overall theme – *Pro Bono in Action* – encouraged us to highlight not just individual acts of generosity but the impact of pro bono work across our society.

But it's clear that the commitment to access to justice doesn't stop when the week ends. Across the year, so much vital, often unsung pro bono work continues to make a real difference for people who would otherwise go without legal help or support.

Pro bono in numbers during 2024:

• 84 law firms undertook a record 637,000 hours of pro bono work across the UK in 2024. (Source: UK Collaborative Plan for Pro Bono)

• Barristers contributed 45,747 days of pro bono work in 2024. (Source: Bar Council of England and Wales)

• The 2025 Pro Bono Recognition List saw a record rise of over 1,000 lawyers recognised for volunteering 25 hours or more of free legal support to those in need. (Supported by the Lady Chief Justice, Law Society, the Bar Council and the Attorney General's Pro Bono Committee)

Events took place across the UK during Pro Bono Week 2025, highlights include:

• The week began with a launch at Simmons & Simmons, London, featuring the Attorney General Lord Hermer KC, new chair of LawWorks Lord Goldsmith KC and other senior legal figures.

• The new Scottish Pro Bono Roundtable met, bringing together the pro bono community in Scotland. Projects such as JustRight Scotland's partnership with Norton Rose Fulbright LLP highlighted how joint efforts expand access to justice for marginalised groups.

• LawWorks and the Law Society hosted a roundtable on coordinating pro bono advice in response to national or major incidents, strengthening resilience and rapid access to legal help.

• Young lawyers met to discuss how pro bono helps clients and can support careers, with the Solicitor General Ellie Reeves MP providing the keynote address.

• Individuals and firms were celebrated for their pro bono, including as part of the Greater Manchester Pro Bono Awards.

• The Great Legal Bake took place nationally during Pro Bono Week, involving hundreds of teams and raising thousands of pounds for access to justice.

• Numerous social media and website posts under ***#ProBonoWeek*** and ***#WeDoProBono*** amplified stories, firm pledges, and volunteer recognition.

With Pro Bono Week completed for the year, we turn back to the practicalities of how lawyers volunteer their time. We're really proud to see how lawyers undertake pro bono with organisations like AvMA, making pro bono a reality every week.

For example, AvMA's Helpline, made up of a small team of experienced medical and legal volunteers, provides information and signposting to other sources of support to clients in relation to medical negligence claims. Whether advising on the prospects of a legal claim, explaining how to navigate NHS complaints procedures, or simply offering a listening ear, these professionals help bring clarity and confidence to those who feel lost in a complex system.

Beyond the helpline, AvMA relies on pro bono volunteer barristers to represent clients at medical inquests. Pro bono representation at inquests can be transformative. These hearings often expose systemic failures and drive improvements in patient safety. When counsel step forward to assist bereaved families at no cost, they help

ensure that truth is uncovered, lessons are learned, and future harm is prevented. Not only are families provided with representation, but counsel gains valuable advocacy experience and hones their client care skills.

Find out more about taking part in pro bono work for AvMA at **avma.org.uk/get-involved**

To catch up on all the action from this year, and to be the first to hear news, opportunities and free resources for Pro Bono Week 2026, follow us at @ProBonoWeek on **LinkedIn**, **Bluesky** or on Twitter/X at **@ProBonoWeekUK**.

To every lawyer who has contributed pro bono work over the last year – thank you. As Pro Bono Week reminds us, let's put pro bono into action.

AvMA Specialist Clinical Negligence Panel: Reaccreditation Update

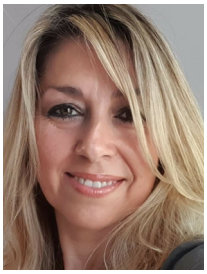
JAYNE NICOL
ACTION AGAINST MEDICAL ACCIDENTS

We have been exploring ways to streamline the Panel application process whilst ensuring that the quality and rigour of the process is maintained. Following a successful trial earlier this year, we now have Trustee approval to reduce the number of case reports submitted as part of the reaccreditation process from four case reports to two reports. AvMA reserves the right to request additional case reports on a case-by-case basis as required. Panel members are referred to the updated Panel Reaccreditation Booklet and Panel Obligations on the AvMA website for further details. This includes an update on supervision requirements.

The new Panel application process remains unchanged at present.

For any queries or for further information please contact Jayne Nicol, Panel Accreditation Manager jayne@avma.org.uk

Our helpline is as busy as ever!



GILLIAN SAVAGE
ACTION AGAINST MEDICAL ACCIDENTS

But did you know sadly for every one call we receive, we lose one due to capacity restrictions. This is how you can help us reach more people....

Do you have members of your team who would be interested in volunteering for our helpline or perhaps it would be something you would like to do?

We currently have over 100 regular volunteers with legal or medical backgrounds who have found the experience to be extremely helpful when dealing with clients back at their place of work.

It's a fantastic opportunity for firms to work more closely with AvMA and support our core service.

Calls can be challenging and varied, providing the volunteer with an opportunity to put their existing skills to good use or enhance the training needs for those less experienced.

We offer a training programme tailored to meet their needs, including complaints procedures.

Helpline sessions are staffed remotely from the volunteer's home or office, using a virtual call centre. Sessions are on a rota system with a 1½ or two-hour session either weekly, fortnightly or every four weeks.

We like to shout from the roof tops when our volunteers receive positive feedback by sharing Kudos on LinkedIn, great recognition for the volunteer, publicity for their firm and AvMA.

If you have members of your team who would like to volunteer, please look at the link below where they'll find more information and an application form:

avma.org.uk/get-involved/helpline-volunteer

Or if you would prefer to have a chat before applying, please do drop me an email **support@avma.org.uk**

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

- I absolutely love volunteering for the helpline. The staff were so supportive during the training and I am reassured that they will be there if I had any issues. It is great speaking to a range of people from the public.
- I value the opportunity to share my legal experience in order to help people who have suffered medical accidents - often the helpline is the first place they turn to, so it is very rewarding to be able to be a voice of compassion and support
- It helps my continued development, skills relating to thinking on my feet and quickly and accurately

Thank you for your support!

"It Can Happen to Anyone" - AvMA's Christmas Campaign

ANNA DEVINE
ACTION AGAINST MEDICAL ACCIDENTS

avma
action *against* medical accidents

Every story of avoidable medical harm represents a life changed — or a life lost. This Christmas, AvMA's It Can Happen to Anyone campaign shares the voices of people and families affected, shining a light on the human impact of unsafe care and the urgent need for change.

Over recent months, I've spent many hours speaking with people affected by avoidable harm, sometimes those who live with the consequences themselves, and sometimes bereaved families still searching for answers. These conversations have been humbling and profoundly moving. Many people told me it was the first time they had been able to share their story fully. I shared a little of my own experience too, of harm and of loss, and each conversation reminded me why AvMA's work matters so deeply.

The campaign is fronted by **Dr Agnelo Fernandes**, AvMA Trustee, who says:

"Avoidable medical harm can happen to anyone, at any age. As a doctor, I know how much trust people place in us when they come for care. When something goes wrong, we must face it openly. We must listen to patients and families and acknowledge when harm has occurred. Acknowledging harm is the first step toward healing, for everyone."

Tracey, who lives with chronic pain and cobalt poisoning after a hip replacement, speaks of turning pain into purpose and reminds clinicians that *"when patients say something isn't right, please listen."*

One story that really stood out to me was Maria's. At 88 years old, she lives with a spinal injury that has left her unable to walk and in constant pain, yet she remains bright, articulate, and determined to be heard. She continues to speak out so that others are never left in the dark about their care. Her strength and dignity embody everything this campaign is about.

Another voice belongs to Teo, aged 18, who reflects with optimism on the lessons of his delayed leukaemia diagnosis, urging decision-makers to *"listen to those who see the other 90 percent of someone's health."*

Then there are the voices of families who have lost loved ones. Corinne Cope, whose nine-year-old son Dylan died after multiple system failures, now campaigns to ensure humanity before process in NHS investigations. Dr Julie Alfrey shared the story of her son Johnny, just 22, whose repeated pleas for help were dismissed as anxiety until it was too late. Claire Wright spoke of her son Martyn's death after a delayed ambulance response, a tragedy that she says shows how fragile the system has become. And Sara Hunt honoured her father Brian, describing how AvMA guided her through the legal process with clarity and compassion.

These are just a few of the people and families whose voices form the heart of this campaign. Each story includes a heartfelt message to healthcare leaders calling for openness, honesty, and better support when harm occurs. These insights will directly inform AvMA's policy and advocacy work, helping shape recommendations for safer care across the UK.

The campaign also invites members of the public to share their own experiences through AvMA's website and to support our work by making a monthly or one-off donation. Every contribution helps us continue to provide free advice to people navigating the aftermath of medical harm and to push for reforms that prevent others from suffering.

As our campaign reminds us, it truly can happen to anyone. This Christmas, we invite our colleagues across the medico-legal community to stand with us for patient safety by supporting AvMA through donations, sponsorship, and activities such as our latest "**Bring and Buy Bonanza**" fundraiser. Together, we can help make healthcare safer for everyone.

Conference news

Forthcoming conferences and events from AvMA

For full programme and registration details, go to www.avma.org.uk/events or email conferences@avma.org.uk

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 Celebration

Evening of 28 November 2025, Grand Connaught Rooms, London

This event is now sold out.

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.

For sponsorship and exhibition opportunities please e-mail conferences@avma.org.uk.

36th Annual Clinical Negligence Conference (ACNC)

19-20 March 2026 (Welcome Event 18 March), Royal Armouries Museum, Leeds

Join us in Leeds on 19-20 March 2026 for the 36th 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. The programme this year will have a focus on neurology and neurosurgery, whilst also covering many other key medico-legal topics. Full programme details will be announced in mid-December.

The ACNC Welcome Event will take place on the evening of Wednesday 18th March at the Sky Lounge, Doubletree by Hilton Leeds and the Mid-Conference Dinner is on the evening of Thursday 19th March at the Royal Armouries Museum.

As well as providing you with a top quality, thought-provoking, learning and networking experience, the success of the conference helps AvMA to maintain its position as an essential force in promoting patient safety and justice.

Early bird booking opened at the end of October and will close on Monday 15th December 2025 at 5pm, so make sure you don't miss out!

For sponsorship and exhibition opportunities please e-mail conferences@avma.org.uk.

Look out for details on more AvMA events coming soon! For further information on our events:

www.avma.org.uk/events

e-mail conferences@avma.org.uk

AvMA Medico-Legal Webinars

For more information, please contact Kate Eastmond (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.

Our licensing prices

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

Single viewer licence - £49 + VAT

A personal licence allows one viewer access to a webinar title for 60 days. Click on the single viewer button to browse the webinar library to choose your title. You can purchase as many webinar titles as you want.

Multiple viewer licence - £150 + VAT

A group licence allows up to 30 multiple viewers from the same firm to have access to a singular webinar for 60 days. Once all colleagues are registered they will be able to watch the content at a time convenient to them.

Webinar subscription - £960 + VAT – Discount available until the 28th November 2025

A firm licence allows multiple viewers from the same firm to have access to the entire webinar library for 12 months, in addition to free access to any upcoming live webinars in that year.

To get an invoice, please contact Kate Eastmond (kate@avma.org.uk).

Our latest webinar titles include:

- The Preventable Deaths Tracker
- Delayed Primary Care Referrals for Suspected Cancer
- Dispute Resolution in Clinical Negligence Cases
- Consent: A Clinicians Perspective
- Perinatal issues in Paediatric Neurosurgery
- Costs Management – Best Practice & Sanctions for Unreasonable Conduct

And more....

Download our 2024 – 2022 Webinar List

AvMA Live Webinars in 2025 & 2026

Disparities in Black Maternal Care with Five X More – Tuesday 11th November 2025 @10.30-11.30am

We are delighted to be joined by Clo Abe & Tinuke Awe, Co-Founders of Five X More CIC for a live webinar on Tuesday 11th November 2025 @ 10:30am discussing Black Maternal Care.

Over the hour they will discuss:

- MBRRACE Reports
- Issues/Barriers for Black Women in Maternity
- The power of advocacy
- Key observations from The Black Maternity Experience Report
- Q & A

Speakers Bio:

Tinuke and Clotilde (Clo) are the co-founders of Five X More CIC, the UK's leading organisation dedicated to improving Black maternal health. Founded in 2019 after MBRRACE data revealed Black women were five times more likely to die during pregnancy and childbirth than

white women, Five X More has become a powerful force for systemic change.

In 2020, they launched a petition that gained more than 187,000 signatures and led to Black maternal health being debated in Parliament for the first time in history. Their work has since helped secure a landmark government commitment to set a target to end the disparity in maternal deaths for Black women.

More recently in 2025, they published the second Black Maternity Experiences Survey, the largest of its kind in the UK, capturing the voices of over 1100 Black women. The findings have been quoted in national reports and cited in Parliament, shaping policy recommendations at the highest level. Five X More also runs the secretariat for the All-Party Parliamentary Group on Black Maternal Health, ensuring Black women's voices are represented in decision-making spaces.

Their relentless advocacy has contributed to the UK Government committing, for the first time, to set a target to end the disparity in maternal outcomes for Black women. Alongside their policy influence, Five X More has created practical tools such as the Five X More App, offering resources to empower women to advocate for themselves during pregnancy.

For more information visit: **https://fivexmore.org/**

Book your spot today: **https://avma.org.uk/events/avma-live-webinar-blackmaternalcare/**

Save the dates:

• Ambulance Services & Paramedic Practice with Dr Vincent Clarke BSc (Hons), PGCE, MA, EdD, PFHEA, FCPara, – Thursday 22nd January 2026 @ 10:30am (**Bookings now open**)

• Maternal Medicine with Dr Karan Sampat MRCOG, MBBS, BSc – Wednesday 11th February 2026 @ 10:30am (Bookings will open in December 2025)

To view our calendar of webinars please visit:

https://www.avma.org.uk/events/

If there are topics you would like to be covered, or have any speaker suggestions please email Kate at:

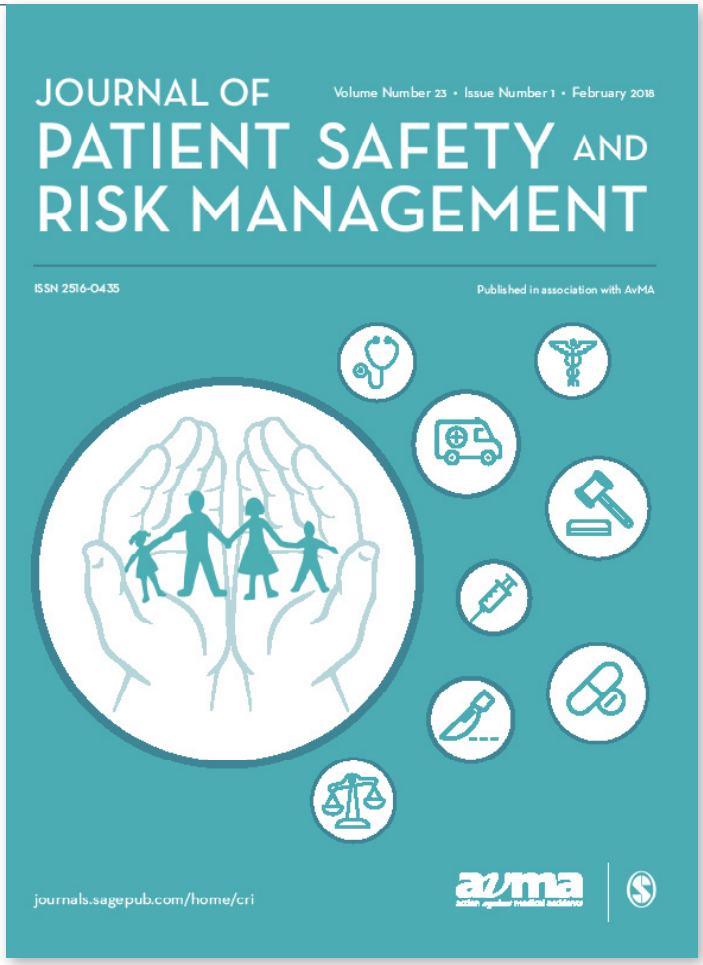
kate@avma.org.uk

Journal of Patient Safety and Risk Management

If you would like more information about the journal, or are interested in subscribing, please contact Sophie North, Publishing Editor on sophie.north@sagepub.co.uk

The Journal of Patient Safety and Risk Management, published in association with AvMA, is an international journal considering patient safety and risk at all levels of the healthcare system, starting with the patient and including practitioners, managers, organisations and policy makers. It publishes peer-reviewed research papers on topics including innovative ideas and interventions, strategies and policies for improving safety in healthcare, commentaries on patient safety issues and articles on current medico-legal issues and recently settled clinical negligence cases from around the world.

AvMA members can benefit from discount of over 50% when subscribing to the Journal, with an institutional print and online subscription at £227.10 (+ VAT), and a combined individual print and online subscription at £177.22 (+ VAT).



partners in costs
Your Costs Experts

Established in 1996, PIC are a nationwide leading firm of Costs Lawyers. We provide dedicated and bespoke solutions, specialising in Clinical Negligence, Catastrophic Injury and Personal Injury.

Our clients are at the centre of everything we do, we listen to our clients' requirements and understand the importance of tailoring our approach to suit.

Our highly skilled Legal Costs Specialists are committed to establishing and maintaining outstanding relationships with our clients and we are proud to be described as "truly experts in our field" and "brilliant".

We provide regular knowledge updates, weekly e-newsletter, free issues of our Partners In Costs magazine, podcasts and tailor-made costs training.

Contact Us

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PIC Legal Costs Specialists

Legal Costs Professionals

What we do

Our team work closely with you to get a real and accurate understanding of your needs and requirements. It is this collaborative and proactive approach that ensures we achieve the best outcome. Our extensive knowledge of costs law enables us to provide tailored advice and litigation.

Our appreciation of the significance and impact that turnaround time has to releasing cash flow, allows us to assist you drive down "lockup".

Introduce new innovative ways of recovering costs such as our Total Timeline + and providing fixed costs advice.

Our focus is to;

1. Help to deliver your financial objectives.
2. Work in collaboration in a fast-changing market.
3. Employ experienced costs experts to maximise recovery of fees.
4. Stand shoulder to shoulder with you, as we understand the pressures you face.
5. Provide clear risk assessments and advice.
6. Keep you fully informed throughout.
7. Proactively drive the recovery process to reduce case lifecycles.
8. Treat your money as we would our own.

We are your Partners in Costs.