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Lawyers Service Newsletter

Contents

Editorial

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During this period of social distancing and lockdown many of us have been both amazed and delighted to discover that software such as Microsoft Teams and Zoom really are easy to use and can change the way we work. Whilst this virtual technology cannot replace real, human interaction, AvMA does look forward to welcoming you to its "***Not the annual conference***" presentations which take place on Thursday 25th June between 10 am – 1.00 pm. Please see conference section at the end of this Newsletter for more details.

COVID 19 has placed unprecedented demands on healthcare, but what impact will it have on clinical negligence litigation? Some might ask: is it right for healthcare providers to be at risk of litigation for care provided in these extraordinarily difficult times?

There are no straightforward answers to these questions. However, this edition of the Newsletter contains some fantastic contributions from barristers who will help inform our thinking and the discussion. ***"The Possible impact of COVID-19 on clinical negligence litigation"*** is an article written by **Dominic Ruck Keene** of 1 Crown Office Row. Dominic highlights the difficulties practitioners may encounter in a range of possible claims, whether it is patients having acquired Covid-19 whilst in hospital or where the effect of redeploying resources to meet the needs of Covid-19 patients has had an adverse effect on patients requiring care for non Covid-19 conditions, such as cancer. Dominic discusses the practical management of those claims and quantum issues.

What standard of care is to be expected from medical staff who have been redeployed or who have returned to practise via the emergency registration route? This question is explored in more detail by **Nicholas Brown and Christopher Johnson**, both of Doughty Street chambers, in their article ***"All Hands on Deck – the private law implications of emergency staffing measures during the coronavirus epidemic"***

Emily Read and Elizabeth Boulden both practising barristers at 12 Kings Bench Walk ask: ***"Can anything be drawn from recent Supreme Court decisions considering the scope of duty and the application of the fair, just and reasonable principle that is pertinent to the Covid-19 pandemic?"*** and look at the public and legal policy considerations that may be relevant.

In ***"Stretched hospital resources in the covid world"*** **Christopher Hough** of Serjeants' Inn (a regular contributor to our Newsletter) offers some suggestions on how claimant lawyers might manage arguments that system failures occurred because resources were inadequate.

Covid-19 has had a serious effect on business. ***"Cashflow and Covid-19: Interim payments on account of costs"*** written by **James Marwick** barrister at St John's Chambers, Bristol looks at how to maximise your chances of securing an interim costs order.

Sarabjit Singh QC of 1 Crown Office Row, examines whether ***"Unlicensed but safe, drugs can be recommended on the grounds of its lower costs"*** with specific reference to the case of *Bayer Plc v NHS Darlington Clinical Commissioning Group [2020] EWCA Civ 449*. Sarabjit points out that the Court of Appeal's decision to uphold Whipple J, and her finding that the GMC guidance on prescribing licensed medicines was not exhaustive, could have implications in the race to find drugs that may treat or cure Covid-19.

2020 has seen some important legal decisions. **Anne Kavanagh**, Senior Associate Solicitor with Irwin Mitchell (London) and AvMA Panel member has been at the forefront of at least two of those decisions. Anne and **Claire Watson**, barrister at Serjeants' Inn Chambers and junior counsel in Anne's case of *Whittington Hospital NHS Trust v XX [2020] UKSC 14*, look at the Supreme Court's decision in XX and offer practice points for future claims in their article ***"Surrogacy costs after XX"***.

Cassandra Williams, barrister at Ropewalk Chambers, Nottingham, looks at the implications of another of Anne's cases, *Schembri v Marshall EWCA Civ 358*, in her extremely helpful article: ***"Medical Causation – Where are we now: pitfalls and hurdles"***. **Paul Sankey**, partner at Enable Law has a particular interest in training medical experts, he explores ***"The test of breach of duty in pure diagnosis cases"*** and argues that despite the court's recent decision in *Brady v Southend University Hospital NHS Trust [2020] EWHC 158 (QB)*, the test to be applied in pure diagnosis cases should be one of "reasonable care and skill", not Bolam and Bolitho.

"Patient confidentiality – to breach or not to breach" by **Tim Newman**, barrister at No 5 Chambers, looks at the interesting case of *ABC v (1) St George's Healthcare Foundation Trust (2) South West London & St George's Mental Health Trust (3) Sussex Partnership NHS Foundation Trust [2020] EWHC 455 (QB)*. **Robert Kellar QC** of 1 Crown Office Row, asks: ***"Vicarious liability: where are we now?"*** Although *Barclays Bank v Various Claimants [2020] UKSC 13* is not a clinical negligence case, lawyers who are considering suing private healthcare providers need to look to this Supreme Court decision and ask whether the treating clinician was in business on their own account or employed by the private hospital. They should also consider whether the private hospital owes a non-delegable duty of care.

We are pleased to include **Tara O'Halloran's** ***"Case note on Douse v Western Sussex Hospital NHS Foundation Trust"*** *[2019] EWHC 2294 (QB)*. In this case, the court had to consider whether the delay in delivery was due to an exceptionally difficult presentation with baby's head deeply impacted in the mother's pelvis or the registrar's failure to respond adequately to this complicated situation. Tara is practising at Old Square Chambers.

In Part 2 of ***"Lessons learned from the Bristol heart Scandal and Kennedy Inquiry"*** **Laurence Vick** looks at the findings from the Kennedy report and discusses amongst other things, the problems that arise when governments fail to implement and follow up the recommendations made by inquiries. He asks us to consider the uncomfortable question: How far have we really come since the 1990's?

One of the aims of the Lawyer Service Newsletter is to encourage practitioners to share experiences and offer tips on problems often experienced in private practice. **Stephanie Prior** is a Head of Medical Negligence at Osbornes Law, her article ***"Dealing with Clinical negligence claims when English is not your client's first language"*** does just that. Likewise, **William Chapman** barrister at 7 Bedford Row, makes his case for using a median life expectancy when calculating schedules of loss in young claimant's in ***"Why we should use the median rather than the mean for life expectancy"***. Sticking with a mathematical approach, **Thomas Herbert** at Ropewalk Chambers article "***Thou shalt not sit with statisticians"*** looks at the recent case of *R (Chidlow) v HM Senior Coroner Blackpool & Fylde [2019] Inquest LR 93,* where the Divisional Court examined the role of statistics in coronial findings on causation, he also considers *R (Smith) v HM Assistant Coroner for North West Wales [2020] EWHC 781 (Admin)*.

Finally, the last two articles will hopefully offer some hope and guidance on the perennial question of costs recovery. ***"Amending your costs budget"*** by **Alison Brooks** Partner at Barratts Solicitors shares her experience of the type of factors a court might consider to be "significant developments" entitling the claimant to revise the budget. ***"Claiming enhanced hourly rates on assessment of costs"*** by **Andrew Hogan**, barrister at Kings Chambers considers the various arguments that might be used to assess the hourly rate claimed in a bill of costs.

Before I sign off, I would like to draw attention to the fact that the PIC Magazine Awards have been postponed this year owing to Covid-19 but this also means the deadline for entries has been extended to 31 December 2020. The winners will be announced at the AvMA Conference - Mid Conference Dinner on the evening of 29 April 2921

Many thanks to all our contributors and best wishes,

The Possible Impact of COVID-19 on Clinical Negligence Litigation

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It is too early to know yet the full scale and implications of the Covid-19 pandemic for clinical negligence practitioners. However, since the first Covid-19 cases were confirmed in the UK on 29 January 2020, what has become clearer are some of the broad legal and practical issues that are likely to arise over the coming months and years.

The most obvious is of course in claims directly involving infection with Covid-19 and subsequent injury or death. However, that apparently straightforward category in reality engages a number of difficult and controversial legal issues and includes a wide spectrum of potential claimants and defendants. These claims should be further divided into cases where it is alleged that infection was avoidable or preventable, and those where treatment of that infection is itself criticised.

With regards to 'avoidable infection' cases, there is a further distinction to be made between an allegation that there has been a breach of Article 2 ECHR or an allegation of a breach of duty in tort. It is now relatively settled law that 'ordinary clinical negligence' does not in itself engage the state's obligations under Article 2 ECHR: *R(Parkinson) v Kent Senior Coroner* [2018] 4 WLR 106 at [66-89]. However, it appears increasingly likely that Article 2 ECHR will be cited in a variety of contexts.

Public authorities (which include NHS England, NHS Trusts, and care home providers giving publicly funded care) have an overarching systemic requirement to provide competent staff and have systems of work that will protect the lives of patients. States are required to *"make regulations compelling hospitals, whether public or private, to adopt appropriate measures for the protection of their patients' lives": Cavelli v Italy* [2002] (Application 32967/96) at [49]./ This includes preventing dysfunction in hospital services that could endanger the life of more than one patient: *Aydogdu v Turkey* [2016] ECHR 719 at [53-56], and *Lopes de Sousa Fernandes v Portugal* [2018] 66 EHRR 28 at [181-184]. Further, the state has an 'operational duty' that requires the state to take reasonable preventative operational measures to protect the life of a particular individual where the state knew or ought to have known of a real and immediate risk to their life: *Rabone v Pennine Care NHS Trust* [2012] 2 AC 72 at [12]. The operational duty applies exceptionally to certain categories of individual, typically those who are vulnerable and over whom the state has assumed responsibility and control.

The 'systemic duty' could be relevant if, for example, there was evidence of clinicians brought back to work under the Coronavirus Act 2020 provisions for the registration of recently retired medical professionals being insufficiently trained or checked as to their currency. It could also be relevant if, as seems the case, there were patients discharged from hospital in March/April 2020 earlier than would otherwise be the case in order to free up hospital capacity. If a blanket policy of discharge (in particular to care homes) was proved to lead an increased risk of Covid-19 infection and a patient discharged subsequently died from Covid-19, that could potentially engage Article 2. Alternatively, if such a premature discharge itself led to a fatal outcome for a non Covid-19 related reason, then Article 2 could still be engaged.

The 'operational duty' could be engaged if it is argued, as increasingly being claimed, that public authorities failed to take reasonable precautionary measures, in particular in respect of PPE provision, in order to mitigate a known risk of pandemic infection: see by analogy to natural disasters *Ozel v Turkey* [2016] (Application 14350/05) and *Budayeva v Russia* [2014] 59 EHRR 2. This is potentially more relevant to personal injury claims brought by or on behalf of NHS and care home employees arguing there has been a breach of Article 2 in failing to provide them with PPE. However, the operational duty could be relevant to patients or residents in care homes, for example if they could prove that they contracted Covid-19 due to a lack of PPE leading to cross contamination and avoidable infection from another patient or resident. There is a real and immediate risk to those patients from Covid-19, and they are vulnerable and dependant on the state to provide their care and protection from that risk.

In negligent infection cases involving either Article 2 or common law negligence, similar questions are likely to arise as to what are reasonable, practical and proportionate measures that should be taken by the state generally, or by a particular Defendant to prevent Covid-19 infection (in particular given the apparent ease with which asymptomatic individuals can infect others). The short timescale within which to bring Article 2 claims also may sit badly with the ongoing process of seeking to evaluate the relevant risks and the effectiveness of preventive and mitigation measures that the state could or has taken – questions that risk being parked until the near inevitable public inquiry concludes at some future point.

There could be significant difficulties in establishing whether or not someone has contracted Covid-19 as a result of any failure in care, rather than from 'societal infection.' Arguably, too little is yet known about how Covid-19 infection works to know whether the courts when considering causation would apply a balance of probability, or material contribution, or doubling of risk, or statistical approach. There could be calls to equate Covid-19 to asbestos with essentially an 'exposure' and material contribution to risk being equated to contribution to injury. However, that is likely to be strongly resisted on the basis of the 'floodgates' principle.

Even in respect of 'negligent treatment' cases, there are a number of issues that are likely to arise. One is the lack of knowledge of Covid-19 making it harder for an expert to assess, and a court to judge, what treatment would meet the Bolam test – there is a live debate as to the utility of ventilators for example. Another is what is the relevant duty of care: for example, if due to Covid-19 pressures on staffing a clinician is operating outside their normal expertise and makes a mistake. In *Wilsher v Essex AHA* [1987] 1 Q.B. 730 the Court of Appeal for the first time gave detailed consideration to the standard of care required of a junior doctor. (This issue did not arise in the subsequent appeal to the House of Lords). The majority of the court held that a hospital doctor should be judged by the standard of skill and care appropriate to the post which he or she was fulfilling, for example the post of junior houseman in a specialised unit. That involves leaving out of account the particular experience of the doctor or their length of service. Whether doctors are performing their normal role or "acting up", they are judged by reference to the post which they are fulfilling at the material time. The health authority or health trust is liable if the doctor whom it puts into a particular position does not possess (and therefore does not exercise) the requisite degree of skill for the task in hand; see the analysis of *Wilsher in FB v Rana* [2017] EWCA Civ 334 at [59]. Finally, if it is asserted that the cause of negligent treatment is a lack of resources, then a court will have to consider to what extent that should be taken into account: see for example *Hardaker v Newcastle Health Authority* (2001 WL 825226, unreported judgment of 15 June 2001.

The second broad category of claims will be those where Covid-19 has had an indirect clinical effect. The most numerous of these are likely to be claims where there has been delay in diagnosis or treatment due to patients being unable to access primary or secondary care services within the appropriate timelines. This may involve difficult questions of contributory negligence: for example, if a patient argues that the overall message from the Government was to stay home and save lives and that there was insufficient clarity given that primary and secondary care services were still accessible for 'normal business', and therefore did not seek appropriate medical advice sufficiently early.

More generally, it will be very challenging for experts to address questions as to what timelines, for example in cancer treatment, would have in fact been appropriate during the duration of the Covid-19 crisis. Different NHS trusts may have different capacity and varied approaches to the cancellation or postponement of non Covid-19 treatment. Questions of responsibility for any delay in treatment will be relevant, for example, it is the result of an individual Trust applying its own judgment, or is the Trust following advice or guidance from NHS England. This could lead to the further question of whether a Trust is obliged to follow generic direction from NHS England without taking the local Covid-19 situation into account if that has taken place. It is worth noting that while NICE has produced 'Covid-19 Rapid Guidelines', clinicians do face a significant challenge in implementing these guidelines, for example, in respect of systemic cancer treatment "*balancing the risk of cancer not being treated optimally with the risk of the patient being immunosuppressed and becoming seriously ill from COVID-19*." Where there is still such uncertainty over the relative risk from Covid-19 both of infection and then of serious illness (let alone death), it is clearly difficult to perform that balancing exercise and for a court to assess whether it has been done to a reasonable standard. That lack of knowledge of the risk from Covid-19 also raises issues of consent – for example, what information should clinicians give about the risk of hospital infection with Covid-19 to a patient weighing up conservative versus surgical treatment.

The third broad area where Covid-19 will have an effect is on the practical management of claims. In the short term there are of course delays from e.g. restricted

access to the courts, and difficulty of accessing experts, taking instructions and arranging examinations. There is also the side effect from the whole scale adjournment of complex inquests preventing claims being considered in light of that important preliminary fact-finding route.

More generally, there may be effects on the quantum of claims. In terms of general damages, it could be argued that any award for the Loss of Amenity element of PSLA that concerns a period while daily life is so restricted because of 'lockdown' should reflect the general lack of amenity during the current period. More significantly, as the economic damage from Covid-19 becomes ever more apparent and with the prospect of unemployment on a scale not seen in decades and suppressed wages Smith and Manchester awards will have to take into consideration any increased risk of unemployment generally resulting from Covid-19, rather than as a result of the effects of any negligence. The same applies when considering future loss of earnings: estimates of residual and 'but for' earnings may well have to be re-adjusted the different economic realities for future employment.

In conclusion, Covid-19 has the potential to both create a significant new number of clinical negligence cases, involving potentially highly contentious legal and quasi political issues, and also to make predicting the outcome and in some cases the quantum of cases not directly clinically related to Covid-19 much more difficult.

All Hands on Deck – The Private Law Implications of Emergency Staffing Measures During the Coronavirus Epidemic

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The government, the NHS and regulators including the General Medical Council ("GMC") and the Nursing and Midwifery Council ("NMC") have taken extraordinary steps to bolster staffing levels in response to the ongoing coronavirus epidemic. The steps taken fall into two categories: (1) emergency registration (the so-called "Dad's Army" of retired doctors and nurses); and (2) emergency re-allocation. This short article considers the measures taken and their potential private-law implications.

Emergency registration

Doctors

Pursuant to s18A of the Medical Act 1983, if the Secretary of State advises the GMC that an emergency has occurred, is occurring or is about to occur, the GMC gains the power to temporarily register doctors in relation to that emergency. The GMC must consider those doctors to be "fit, proper and suitably experienced"[2] but the conditions of registration are at the discretion of the GMC[3] .

The GMC has now given temporary registration to 11,856 doctors who: (1) left the register or gave up their licence to practise in the last three years; (2) don't have any outstanding complaints, sanctions or conditions on their practice; (3) have a UK address; and (4) did not opt out when contacted[4].

These doctors are exempt from the usual revalidation process[5] , including the requirement to undertake "enough appropriate CPD to remain up to date and fit to practise..." [6]

There is currently no provision for the emergency registration of medical students. Rather, medical students will be able to work as medical student volunteers, as they would in any event [7].

Nurses

S2 and Schedule 1 of the Coronavirus Act 2020 amend the Nursing and Midwifery Order 2001[8] so that the NMC has the power to temporarily register nurses in those circumstances where the GMC has the power to temporarily register doctors under the 1981 Act (see above).

The NMC has registered 7,510 nurses on its Covid-19 temporary register[9] . As with the GMC, the NMC has contacted nurses who: (1) left the register or gave up their licence to practise in the last three years; (2) don't have any outstanding complaints, sanctions or conditions on their practice; (3) have a UK address. Unlike the GMC, the NMC is requesting nurses to opt-in, not to opt-out[10] .

2 *s18a(1)*
3 *s18a(3)*
4 *https://www.gmc-uk.org/news/news-archive/coronavirus-information-and-advice/temporary-registration*
5 *https://www.gmc-uk.org/registration-and-licensing/temporary-registration/information-for-doctors-granted-temporary-registration/the-registration-process*
6 *https://www.gmc-uk.org/-/media/documents/cpd-guidance-for-all-doctors-0316_pdf-56438625.pdf*
7 *https://www.medschools.ac.uk/media/2622/statement-of-expectation-medical-student-volunteers-in-the-nhs.pdf*
8 *S.I. 2002/253*
9 *https://www.nmc.org.uk/news/press-releases/nmc-covid-19-emergency-register-goes-live/*
10 *https://www.nmc.org.uk/globalassets/sitedocuments/registration/covid-19-temporary-emergency-registration-policy.pdf*

The NMC acknowledges the possibility of extending these criteria as the epidemic evolves, stating:

> *This is an unprecedented and evolving situation and we have already identified other groups of people who we consider might meet the requirements for temporary registration depending on the overall evolution of this pandemic and the severity of the resulting workforce shortages over the coming weeks. Such groups include final year nursing students, former registrants who left the register more than three years ago, and overseas qualified nursing and midwifery professionals already working or studying in the UK in other healthcare roles.* [11]

As with doctors, nurses on the Covid-19 temporary register will be exempt from revalidation[12] .

Emergency re-allocation

It is anticipated that we will see emergency re-allocation of doctors and nurses from their normal fields of practice to deal directly with Coronavirus patients (this has already been acknowledged by the GMC)[13].

One envisages – although I have been unable to find any definitive answer – that many of those doctors and nurses given temporary registration will be deployed to the "front line", and that, for many, this will be unfamiliar territory.

The GMC has already suspended the usual rotation of foundation year doctors and has indicated that it envisages that their redeployment in response to the Coronavirus [14].

The private law implications of these emergency measures

In an action for clinical negligence, a doctor or nurse will be judged by the standard of skill and care appropriate to the post which he or she was fulfilling.

This principle arises from the judgment of the Court of Appeal in Wilsher v Essex AHA[15] . The most recent restatement of the principle is in the judgment of Jackson LJ in FB v Princess Alexandra Hospital NHS Trust[16] . After considering the case law, Jackson LJ turns to the facts at [67], stating:

> *The conduct of Dr Rushd in the present case must be judged by the standard of a reasonably competent SHO in an accident and emergency department. The fact that Dr Rushd was aged 25 and "relatively inexperienced" (witness statement paragraph 5) does not diminish the required standard of skill and care. On the other hand, the fact that she had spent six months in a paediatric department does not elevate the required standard. Other SHOs in A&E departments will have different backgrounds and experience, but they are all judged by the same standard.*

In the context of the staffing measures taken in response to the coronavirus epidemic, the ramifications of this principle are as follows:

1. Doctors and nurses who have returned to practice following retirement will be held to the same standard as all other doctors and nurses.
2. Doctors and nurses working outside of their normal fields of practice will be held to the same standard as doctors and who are experienced in those posts.

The benefit and risk of these measures

The benefit of emergency registration and emergency re-allocation is obvious: an increase of (already) c. 20,000 doctors and nurses to treat patients with Coronavirus.

But these measures also entail risks. One imagines that the risk to patients of negligent treatment is increased and, as a corollary, the risk to clinicians of a successful claim is increased. This is a personal risk to clinicians – it is trite that employed professionals are themselves tortfeasors and can be sued accordingly[17] .

The approach of the Courts in Wilsher and FB, discussed above, will provide some reassurance to patients, that despite the extraordinary measures that are (or will be) in place, they can expect the same standard of care and will be compensated if that standard is missed.

The Government has sought to reassure clinicians through the inclusion of indemnity provisions in the Coronavirus Act. The guidance to the Coronavirus Bill (as it was) states that the Bill will:

11 *Ibid.*
12 *Ibid.*
13 *https://www.gmc-uk.org/news/news-archive/coronavirus-information-and-advice/our-guidance-for-doctors*
14 *https://cached.offlinehbpl.hbpl.co.uk/NewsAttachments/PGH/Rotation_announcement_letter.pdf*
15 *[1987] 1 QB 730*
16 *[2017] EWCA Civ 334*
17 *See, for example, Fairline Shipping Corp. v Adamson [1975] QB 180.*

provide indemnity for clinical negligence liabilities arising from NHS activities carried out for the purposes of dealing with, or because of, the coronavirus outbreak, where there is no existing indemnity arrangement in place. This will ensure that those providing healthcare service activity across the UK are legally protected for the work they are required to undertake as part of the COVID-19 response. This is in line with and will complement existing arrangements.[18]

At the present time, no scheme/draft scheme has been produced by the Secretary of State. If the purpose of the indemnity provisions is to reassure clinicians then this is an oddity, and s11 may not achieve what the government set out to do. In these days when there is so much outsourcing in the NHS, it is in everyone's interests that anyone working for or as an outsourced independent contractor and any returning GP has the appropriate indemnity cover. The Secretary of State should produce a scheme and make clear his intentions as soon as possible.

Christopher Johnson and **Nick Brown** are members of the Clinical Negligence and Personal Injury Team at Doughty Street Chambers[19] . All members of the Team are continuing to practise from home during this difficult time.

18 *https://www.gov.uk/government/publications/coronavirus-bill-what-it-will-do/what-the-coronavirus-bill-will-do*

19 *https://www.doughtystreet.co.uk/clinical-negligence-personal-injury-product-liability*

Can Anything Be Drawn From Recent Supreme Court Decisions Considering The Scope Of Duty And The Application Of The Fair, Just And Reasonable Principle That Is Pertinent To The Covid-19 Pandemic?

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Darnley v Croydon Health Services NHS Trust [2018] UKSC 50 and *ABC v St George's NHS Healthcare Trust and Ors* [2020] EWHC 455 (QB) appear to be pushing at the boundaries of previous understanding of the scope of the duty of care in clinical negligence claims. However, on a closer look, only one of these is a true addition to the categories of duty of care in clinical negligence. This article considers other recent cases where the Court's agility was tested on the issue of scope of duty, and explores the synthesis of what the Courts can and cannot do, with a glimpse at legal policy and where the crux might lie in situations involving Covid-19.

The principles for existence and scope of duty

The current principles for the existence and scope of a duty of care centre around 2 individual situations: either the duty and its particular scope have been contemplated in existing case law, or, alternatively, based upon previous case law, an incremental addition to the existing law is justified such that a novel category of duty of care can be created. Three recent cases have examined the existence and scope of the common law duty of care: *Robinson v Chief Constable of West Yorkshire Police* [2018] UKSC 4; *James-Bowen & others v Commissioner of Police of the Metropolis* [2018] UKSC 40 and *Poole Borough Council v GN & another* [2019] UKSC 25.

Taken together, these three cases, along with the case of Darnley, reiterate that there is no general principle which can provide a practical test for every situation to in order determine whether a duty of care exists and the scope of any such duty. The four cases, in particular *Robinson,* clarified the ratio of *Caparo Industries plc v Dickman* [1990] 2 AC 605, restating that the familiar tripartite formula of proximity, foreseeability, and whether imposition of a duty is fair just and reasonable was not a "test" to be applied to determine whether a duty of care exists. Rather, courts are to use existing authorities to apply already established principles to the facts of each case, and only in novel types of case where such principles did not provide an answer would the courts need to consider whether a new duty of care should be recognised, *"developing the law incrementally and by analogy with existing authority"* [ABC at paragraph 29]. In such novel cases, part of the exercise of judgment would be the consideration of what is fair, just and reasonable.

The clearest exposition of this analysis of *Caparo* is in *Robinson*. The facts, put simply, are that police officers were involved in a struggle while arresting a suspect, and, whilst the group moved in the struggle, they collided with the claimant thus causing her to fall and sustain injury. The key issue before the court was whether the defendant police force owed the claimant a duty of care, and the Supreme Court overturned the Court of Appeal's decision that no duty was owed. The Court of Appeal had held as a general principle that actions against the police would not pass the third limb of the *Caparo* "test". However, Lord Reed refuted that *Caparo* provided a "test" applicable to all negligence claims, and that a court would only impose a duty of care where it was considered fair, just and reasonable to do so on the facts. He held that in established categories of a recognised existence or non-existence of a duty of care, it was not necessary to reconsider whether the existence of the duty would be fair just and reasonable, unless the court was being invited to depart from established authority, because such

consideration had already been dealt with in establishing the existing principles.

Lord Reed made clear that the notions of justice and reasonableness were not reasons for discarding established principles and deciding cases on their broader merits, and discussions of the policy considerations were not routine and would be *"unnecessary when existing principles provide a clear basis for the decision"* [paragraph 69]. He disagreed with Lord Hughes' view that policy was the ultimate reason as to why there was no duty of care owed by police officers engaged in the investigation and prevention of crime to victims, suspects and witnesses; instead this was due to a long-established common law principle of there being no duty to protect persons against harm caused by third parties, in the absence of a recognised exception. In considering previous cases and precedent (in particular Lord Keith's dictum in *Hill v Chief Constable of West Yorkshire* [1989] AC 53, 59), the majority in the Supreme Court in *Robinson* held that the defendant's police officers owed the claimant a duty of care to avoid causing her physical harm (unless statute or common law provided otherwise, which did not arise on the facts). This finding was in accordance with the ordinary principles of tort law, and with the court having held that injury was reasonably foreseeable on the facts of the case.

In contrast to *Robinson*, the factual situation in *James-Bowen & others v Commissioner of Police of the Metropolis* [2018] UKSC 40 was said to be *"very clearly one in which it is sought to extend a duty of care to a new situation"* [paragraph 23 of *James-Bowen*]. The claims in *James-Bowen* were brought by police officers involved in the arrest and detention of a terrorism suspect. The suspect initiated his own compensation claim against the defendant police force, to which the claimant police officers were not a party, which was settled by the defendant with an admission of liability and apologising for the claimant officers' *"gratuitous violence"*. The claimant officers alleged that the defendant police force had assured them their interests would be safeguarded and that the suspect's claim would be vigorously defended. They thus argued that the defendant police force owed them a duty of care, as their employer or quasi-employer, to protect their economic and reputational interests, which included the handling of the litigation brought by the suspect. The majority in the Supreme Court held that no duty of care was owed, thereby allowing the defendant's appeal.

In paragraph 23 of his judgment, Lord Lloyd-Jones referred to dictum of Lord Bingham at paragraph 7 of *Customs and Excise Comrs v Barclays Bank plc* [2007] 1 AC 181 that the closer the facts of a novel case to those of a case involving an existing duty of care, the more ready a court will be to find that the principles in *Caparo* were satisfied. He added that the proposed duty would then have to be tested against legal policy considerations, and judgment exercised in relation to the individual case and the development of the law. Lord Lloyd-Jones had difficulty in finding a duty of care, when in *Calveley v Chief Constable of the Merseyside Police* [1989] AC 1228, no duty was owed by the chief constable to protect the economic and reputational interests of his officers in the prosecution of an investigation or disciplinary proceedings. Lord Lloyd-Jones went on to test the proposed duty of care against policy considerations and its potential impact on the coherence of the law; in particular discussing the potential for a duty of care to give rise to conflicting interests, the underlying policy considerations for such competing interests, legal policy, and the practical conduct of legal proceedings. In *Robinson* it was notable that, whilst the defendant was in a position analogous to an employer, she also held public office and needed to be free to act in accordance with her public duty; it was held that such stark differences between the interests of employer and employee would strongly suggest that the existence of the duty of care proposed would not be fair, just or reasonable.

Like *James-Bowen*, the case of *Poole Borough Council v GN & another* [2019] UKSC 25 was decided post-Robinson, and was based in part upon this re-clarification of Caparo. *GN* was a claim by children, one of whom was a child "in need" pursuant to section 17 of the Children Act 1989, for physical and psychological damage as a result of the defendant local housing authority placing them in a property near neighbours who gave significant harassment and abuse (and were known by the defendant to persistently engage in anti-social behaviour). The claim was initially struck out – the judge found that the defendant did not owe the duty contended for by the claimants. When it finally got to the Supreme Court, the claimants' appeal was dismissed, with a finding that no duty of care was owed. Of key relevance is the discussion of the case of *X (Minors) v Bedfordshire County Council* [1995] 2 AC 633 in light of the decision in *Robinson* (which was not decided when GN was before the Court of Appeal). *X (Minors)* held that in relation to alleged negligence by a social worker and psychiatrist dealing with allegations of abuse in a family, there was no duty of care owed by council employing the social worker, the social worker or the psychiatrist; whilst the "first two limbs" of *Caparo* were conceded, Lord Brown-Wilkinson considered that there were a number of public policy reasons for denying liability. In the hearing of GN in the Court of Appeal,

Irwin LJ had placed emphasis on the policy concern in *X (Minors)* that liability in negligence would complicate decision making in a difficult and sensitive field and potentially lead to defensive decision-making. Whilst considering difficulties in this approach, particularly with regard to the intervening case law (where such policy reasons had been doubted in cases since *X (Minors)*), the Supreme Court notably held at paragraph 75 of GN that "*rather than justifying decisions that public authorities owe no duty of care by relying on public policy*", if a duty did arise in accordance with the common law, it could be sufficiently excluded or restricted by being inconsistent with the scheme of statute under which the public authority was operating. It was therefore again made clear that public policy considerations could not exclude categories of duty of care which had already been held to exist.

Contrasting cases: existing and new categories of duty of care in *Darnley v Croydon Health Services NHS Trust [2018] UKSC 50 and ABC v St George's NHS Healthcare Trust and Ors [2020] EWHC 455 (QB)*

Two recent cases highlight the contrasting situations identified by the clarification of the *Caparo* dictum in *Robinson*, namely the application of existing principles in *Darnley*, and the development of new law in *ABC*.

In *Darnley*, the duty of care contended for was held to fall into an existing category, rendering analysis of the principles of fairness, justice and reasonableness unnecessary. The case concerned a claimant who attended A&E following a head injury. He was informed by the receptionist in A&E that he would have a 4-5 hour wait; however, the receptionist failed to inform him of the standard practice that he would be subject to triage in 30 minutes/as soon as possible. The claimant returned home, suffered a deterioration, and sustained permanent brain damage. He argued that, had he remained in hospital, he would have been treated earlier and would have made a full recovery. He contended, *inter alia*, that there was a breach of duty by the reception staff regarding the information provided about how long it would take to be seen by a clinician. In the Court of Appeal, Jackson LJ held that there was not an actionable misstatement, that the receptionist had not assumed responsibility to the claimant for potential catastrophic consequences resulting from him walking out of the hospital, and that it would not be fair, just or reasonable to impose a duty on the receptionist or the trust to not provide inaccurate information about waiting times, which would add a new layer of responsibility to clerical staff and a new head of liability for NHS health trusts. Jackson LJ also considered that the scope of the duty would not extend to liability for the consequences of the claimant walking out of A&E without telling staff.

The Supreme Court held that this fell squarely within an existing category of duty of care, with Lord Lloyd-Jones considering that the starting point was to look at established categories where a duty of care has been recognised, in accordance with *Robinson and Michael v Chief Constable of South Wales Police (Refuge intervening)* [2015] AC 1732. A category was already held to exist, as in *Barnett v Chelsea and Kensington Hospital Management Committee* [1969] 1 QB 428, with the defendant owing the claimant a duty to take reasonable care not to act in such a way as to foreseeably cause a patient to sustain physical injury, the scope of which extended to a duty to take reasonable care not to provide misleading information which may foreseeably cause physical injury [paragraph 16]. As per *Robinson*, Lord Lloyd-Jones held that the *Caparo* principle did not require a re-evaluation of the 3 criteria in every case applying an established category of duty, noting that such exercise has already taken place, and that this would normally only be necessary in novel categories. He further determined that the distinction between medical and non-medical staff was not relevant to the existence or scope of the duty of care, only to whether there was a breach of that duty. In relation to the policy concerns voiced by the Court of Appeal, the Supreme Court held that such undesirable consequences of the duty were "considerably over-stated" [paragraph 22], with a finding that the usual requirements of proving negligence and causation were sufficient control factors.

In contrast, the case of *ABC v St George's NHS Healthcare Trust and Ors* [2020] EWHC 455 (QB) did involve the creation of a new category of duty of care in a clinical negligence setting. In this case, the claimant's father's multidisciplinary team, as part of his court-ordered restricted hospital order, suspected he had the hereditary condition Huntingdon's disease, to which he subsequently tested positive. The claimant's father refused to allow his medical team to reveal the diagnosis to his daughters, despite the claimant being pregnant at the time; however, the diagnosis was accidentally revealed to the claimant following the birth of her child. The claimant alleged that, in failing to inform her of this hereditary risk in time for her to terminate her pregnancy, there was a breach of the duty of care owed to her by the defendant healthcare trusts, who were variously responsible for her father's healthcare and psychiatric treatment as well as for the family therapy which the claimant attended.

The claimant argued there was a broad duty owed to her because the defendants knew of information relevant to her welfare and knew that such information would impact on her. She also contended that, by undergoing family therapy, she was a patient of the second defendant, from which a duty of care arose, or alternatively that the defendants had assumed responsibility for her welfare and wellbeing. Alternatively, it was suggested that there should instead be an incremental extension of established principles as per *Caparo* and *Robinson*, with there being a duty on the defendants to conduct a balancing exercise of the claimant's interest in being informed of the genetic risk versus her father's interest in the confidentiality of his diagnosis being preserved (but being limited to serious genetic conditions and first-degree relatives). The defendants, jointly represented, argued that no duty was owed as the claimant was a third party, that even if she was a patient for the purposes of family therapy this case fell outside that duty, that there was no assumption of responsibility, and that this was a novel case for which no duty had ever previously been recognised by the courts and it would not be fair just and reasonable to impose a duty in this case. Whilst Mrs Justice Yip DBE found that the claimant was a patient of the second defendant in her participation in family therapy, she held that the claim did not fall within the scope of this duty, noting that the case could not properly be characterised as one of badly performed family therapy. The judge also held that the claimant's allegation that there was an assumption of responsibility for deciding whether she should be told of her father's diagnosis did not fall into an established category of cases where a duty of care exists. Turning to whether the a new duty of care should be recognised, Mrs Justice Yip noted that, whilst the defendants' counsel conceded that the authorities did not preclude the court finding that a doctor could owe a duty to a third party, the defendants argued that to find such a duty would be a giant rather than an incremental step. However, she held that the defendants' objections related to a duty much wider in scope than the claimant contended for, and that she only had to decide whether, on the facts of the case, a relevant duty was owed to the claimant. She concluded that, in reference to previous cases, duties owed by doctors or health authorities to third parties are "*only capable of arising where there is a close proximal relationship between the claimant and defendant*" [paragraph 170]. The judge held that there was a close proximal relationship between the claimant and second defendant, and that the risk of harm to the claimant from non-disclosure of the genetic risk was foreseen by the second defendant. Regarding the policy concerns raised by the defendant, Mrs Justice Yip determined that the imposition of a duty of care would not have such a negative impact on the duty of confidence, noting that the duty of confidence between doctors and patients was already established not to be absolute, and therefore the new legal duty only reinforced the balancing exercise already present in the professional guidance.

How the principles apply to the Covid-19 crisis

The effect of the Covid-19 crisis, which started to cause distress to the NHS in early March and continues to ravage the economy, healthcare workers, PPE providers and the population at large, throws to the fore the much heightened concern that judges must have to protect the viability of the NHS at a time when demand upon is it of an unprecedented nature, medical staff are sacrificing themselves and being asked to work in areas in which they are unfamiliar, wear PPE that is restrictive and change their usual practices in unchartered ways. The Government has not legislated as to the effect this may have, nor have any clear shifts in public policy properly crystallised, such that it will be difficult to say that a shift in public policy might justify any departure from established principles of negligence.

However, is this pandemic and the resulting state of emergency sufficient reason to permit or compel judges to ask themselves questions of legal policy: What is the best policy for the law to adopt?

Looking specifically at the issues of the existence and scope of duty of care, the authorities make it clear that it is not permissible to remove or limit a category of duty purely as a result of policy considerations. Further, there has been much criticism of "judicial activism" in late 2019, and considering the best policy for the law to adopt would face accusations of just that.

One may hypothesise that the issues that Covid-19 raises seem most relevant to the questions of the standard of care and breach of duty; it is unlikely that the courts will simply abrogate areas of the duty of care. In the Court of Appeal hearing of *Darnley*, Jackson LJ drew attention to the difficult conditions in which staff in A&E departments work, and at paragraphs 75-76 of *Robinson*, the Supreme Court highlighted the need for police officers to make difficult decisions in pressured circumstances, and that sometimes there may be circumstances in which a risk to the safety of members of the public is justified.

Having said that, the court is not excluded from deciding that public policy considerations of previous rank are no longer of application and that a change in legal policy is

coherent with evolving public policy. Examples include *X (Minors)* and more recently *XX v Whittington NHS Trust [2020] UKSC 14,* a case changing the law on the recoverability of the costs of surrogacy and allowing the reasonable costs of procuring foreign commercial surrogacy. Having set out what she described as "*dramatic*" developments in the law's ideas of what constitutes a family and developments in the law and social attitude towards surrogacy, Baroness Hale encapsulated the effect of legal policy on her own wisdom at paragraph 45: "*In Briody, I expressed the view that this* [surrogacy arrangements using donor eggs] *was not truly restorative of what the claimant had lost. It was seeking to make up for what she had lost by giving her something different (para 25) [...] In my view it was probably wrong then and is certainly wrong now.*"

The dissenting judgment of Lord Carnwath in *XX* (with Lord Reed PSC agreeing) cites *Rees v Darlington Memorial Hospital NHS Trust* [2003] UKHL 52, an "*unwanted birth*" case arising from allegedly negligent sterilisation, in which Lord Bingham of Cornhill set out with approval in his leading judgment the infamous passage from Lord Denning MR in *Dutton v Bognor Regis Urban District Council* [1972] 1 QB 373. In relation to legal policy, Lord Denning had stated that:

> *"In previous times, when faced with a new problem, the judges have not openly asked themselves the question: what is the best policy for the law to adopt? But the question has always been there in the background. It has been concealed behind such questions as: Was the defendant under any duty to the plaintiff? Was the relationship between them sufficiently proximate? Was the injury direct or indirect? Was it foreseeable, or not? Was it too remote? And so forth.*
>
> *"Nowadays we direct ourselves to considerations of policy. In Rondel v Worsley [1969] 1 AC 191 , we thought that if advocates were liable to be sued for negligence they would be hampered in carrying out their duties. In Dorset Yacht Co Ltd v Home Office [1970] AC 1004 , we thought that the Home Office ought to pay for damage done by escaping Borstal boys, if the staff was negligent, but we confined it to damage done in the *316 immediate vicinity. In SCM (United Kingdom) Ltd v W J Whittall & Son Ltd [1971] 1 QB 337 , some of us thought that economic loss ought not to be put on one pair of shoulders, but spread among all the sufferers. In Launchbury v Morgans [1971] 2 QB 245 , we thought that as the owner of the family car was insured she should bear the loss. In short, we look at the relationship of the parties: and then say, as matter of policy, on whom the loss should fall."*

In *Rees*, regarding the potential for substantial damages to be awarded to the disabled mother of a healthy (albeit unwanted) child against the background of stretched NHS resources, Lord Bingham went on to say that this "*would rightly offend the community's sense of how public resources should be allocated*" and that "*Kirby J was surely right to suggest in Cattanach v Melchior [2003] HCA 38, para 178, that: "Concern to protect the viability of the National Health Service at a time of multiple demands upon it might indeed help to explain the invocation in the House of Lords in McFarlane of the notion of 'distributive justice'*." Could this be a relevant consideration in law when the NHS has suddenly been faced the greatest health threat in living memory? It will inevitably be present, what remains to be seen is how it will manifest itself in questions of negligence.

In *Rees*, Lord Bingham also made it clear that departing from previously established principle would be highly undesirable, stating "*that it would be wholly contrary to the practice of the House to disturb its unanimous decision in McFarlane given as recently as four years ago, even if a differently constituted committee were to conclude that a different solution should have been adopted. It would reflect no credit on the administration of the law if a line of English authority were to be disapproved in 1999 and reinstated in 2003 with no reason for the change beyond a change in the balance of judicial opinion*." To date, there have undoubtedly been unqualifiable and unquantifiable shifts in social attitudes towards the NHS and medical professions as a whole, but it is difficult to identify a definitive shift in public policy.

In light of this and the other recent authorities considered herein, the dissenting judgment in *XX* makes interesting reading, setting out some of the many obstacles to legal policy in adapting to change in a way which accords with ordinary notions of what is fit and proper, yet maintains consistency and does not disrupt the essential harmony of the law. This has echoes of the Caparo principle, where heavy reliance is placed upon established principles and pre-existing judicial analysis rather than policy considerations, and it is the approach that Lord Reed endorsed in *Robinson*. But that dissent in *XX* is possibly illustrative of the difficulty judges may face if asked to consider cases in light of Covid-19 as a matter of policy. A far more attractive approach might be a more forensic factual analysis and well-rounded legal analysis regarding breach of duty and standard of care, and to avoid asking the question as to the proper policy for the law to adopt in a situation where to date there has been no explicit public policy change that is obviously relevant to questions of negligence in clinical negligence cases.

Stretched Hospital Resources In The Covid World

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SERJEANTS' INN

This piece is written in glorious sunshine, but during the height of the Covid lockdown. Who knows where we will be by the time it is published and read? Some children may be back at school, we may be allowed to use public transport, courts may begin to reopen and clinical negligence claims against the NHS may be something to be discussed in polite company.

As the number of deaths rises towards 40,000, it may seem somewhat parochial or insensitive to ask what the impact of Covid might be on clinical negligence. There seem to be a number of aspects:

i. Untrained or rusty doctors returning to the NHS to help. The MDU have requested that doctors lacking appropriate qualifications or experience should be immune from suit if (or perhaps when) they make mistakes. Quite rightly, this kite seems not to have taken flight.

ii. But, possibly alarmed by the twin threats of Hospital/public transport acquired Covid and being treated by an out of date and retired orthopod, tens of thousands of people are not attending Hospital when they should be. Estimates are that 18,000 cancer patients will die through want of treatment. Patients with time sensitive conditions (a stroke, for example) will suffer avoidable harm through delay in presenting. Self-evidently, there will be no claim if the patient does not seek help.

This article looks at a third aspect – whether Trusts might use Covid to argue that their resources were stretched by Covid needs, and that systems broke down, without culpability. This argument occasionally appears in Defences and, perhaps more frequently, in expert reports – but the "30-minute Caesarean" and the "3-4.5 hour stroke management" cannot be avoided by waffling on about overstretched A&E departments.

The NHSR is a cunning fox and will probably sniff that judges might be persuaded to allow some slack in judging systemic failings. With that in mind, it is worth remembering some old Court of Appeal cases to encourage the courts not to go along with this.

In Bull v Devon Area Health Authority 198 22BMLR 79 the Court of Appeal had to consider a delay in delivering a second twin. A "resources defence" was argued. There were problems in finding a Registrar. The Court held:

Slade LJ

In the face of this evidence, any unnecessary waste of time in attempting to secure the attendance of one or other of the registrar and the consultant could have been critical, particularly as it appears that neither of them was present at the hospital, and would inevitably take a little time to get there ... It is possible to imagine hypothetical contingencies which would have accounted for a failure, without any avoidable fault in the hospital's system or any negligence in its working, to secure for Mrs. Bull attendance by any obstetrician qualified to deliver the second twin between 7.35 p.m. and 8.25 p.m. In my judgment, however, all the most likely explanations for this failure point strongly either (i) to inefficiency in the system for summoning the assistance of the registrar or consultant, in operation at the hospital in 1970, or (ii) to negligence by some individual or individuals in the working of that system. This is, in my judgment, accordingly a case where the res ipsa loquitur principle had to be applied, whatever hardship this may cause the authority at this late date. The onus fell on the authority to explain satisfactorily the hospital's failure to secure the attendance of either Dr. Golding or Mr. Jefferiss before about 8.25 p.m. and to call Dr. Golding's back-up, Mr. Jefferiss, by about 7.45 p.m. It did not discharge this onus. A breach of duty has in my judgment therefore been established and the judge was right so to decide.

Dillon LJ:

It was enough the defendants had a system under which a registrar or consultant would be in the delivery room within 10 or 15 minutes of being summoned, or, in the case of a multiple delivery, within 20 minutes of the birth of the first baby. But, as I have indicated, it was

very chancy whether the defendant's system would achieve this. The risks of failing to provide attendance for the patient's foreseeable requirements was so great that the system could only rank as an acceptable system if it was operated with supreme efficiency.

Of such efficiency there is, in my judgment, no sign in the present case .... . Plainly the system had broken down. Precisely why it had broken down or what went wrong we cannot know. But all the most likely explanations involve fault on the part of people for whom the defendants are responsible, ... the plaintiff has succeeded in proving, by the ordinary civil standards of proof, that the failure to provide for Mrs. Bull the prompt attendance she needed was attributable to the negligence of the defendants in implementing an unreliable and essentially unsatisfactory system for calling the registrar.

It is argued for the defendants that delays and difficulties of communication are implicit in any system where the same staff are required to service different departments in different buildings on a split site, or in separate hospitals ... However these arguments, which really come down to saying that the defendants should be entitled to the benefit of any delays that are inherent in their system, can only be valid if the phrase "as soon as reasonably practicable" is to be construed without regard to the urgency of the patient's requirements; in my judgment, as already indicated, it is not.

Mustill LJ

.... proper care of the mother and the second twin would demand either the presence or the immediate availability, at all times after the birth of the first twin, of someone with skill, experience and authority sufficient to bring about the delivery of the second twin, if symptoms of crisis showed that it was unsafe to wait for the delivery to take place naturally.

When one looks at the system which actually existed, it is plain that it fell short of this standard. Unless the consultant or registrar, and the anaesthetist, happened to be in the building when the first twin was delivered, there would inevitably be an interval whilst (a) the house officer and midwife completed their immediate duties regarding the first twin, (b) the switchboard located the registrar, and (c) he made his way to the hospital from wherever he happened to be, and scrubbed-up and found out what had been happening, in preparation for the delivery of the second twin. If stage (b) failed, then there would be a further interval whilst the switchboard found the consultant, and whilst the consultant came in and prepared himself. Since the house officer and midwife could tackle a natural delivery of the second twin, but could not intervene in the event of an emergency, it was implicit in the system that the mother and foetus would inevitably be left for a substantial period without the care which safety required.

This decision was followed in **Richards v Swansea NHS Trust** 2007 EWHC 407 and explained as follows:

The defendant (in Bull) contended that it had an adequate system for the provision of appropriate care and that the fact it could not now say why no registrar was present did not mean that it was at fault. The trial judge decided that the onus was on the defendant to show that the situation arose without fault on its part and that it had failed to do so. His decision was upheld by the Court of Appeal. Slade LJ applied the res ipsa loquitur principle, as the trial judge had done. The delays were so substantial as to place on the defendant the burden of justifying them. Dillon and Mustill LJJ did not apply the res ipsa loquitur principle. Dillon LJ held that the system had broken down and the second plaintiff did not have to adduce positive evidence to disprove every theoretical explanation, however unlikely, that could explain what had happened in a way which absolved the defendant of fault. The second plaintiff had succeeded in proving by the ordinary civil standard that the failure to provide the mother with prompt attendance was attributable to the negligence of the defendant. Mustill LJ said that in the absence of a proved explanation for the inordinate delay or one which proved itself because it was obvious, the judge had no choice but to decide as he did.

The systemic duty was defined in **Robertson v Nottingham Health Authority [1997] 8 Med LR 1** , 13 Brooke LJ said:

"Although it is customary to say that a health authority is vicariously liable for breach of duty if its responsible servants or agents fail to set up a safe system of operation in relation to what are essentially management as opposed to clinical matters, this formulation may tend to cloud the fact that in any event it has a non-delegable duty to establish a proper system of care just as much as it has a duty to engage competent staff and a duty to provide proper and safe equipment and safe premises (compare Wilsher v Essex Area Health Authority [1987] QB 747 per Sir Nicolas Browne-Wilkinson, at p 778 a-d , and Glidewell LJ, agreeing on this point, at p 775 b-c . A health authority owes its patient a duty to provide her

with a reasonable regime of care at its hospital (**Gold v Essex County Council [1942] 2 KB 293** per Lord Greene, MR, at pp 302 and 304; and per Goddard LJ, at p 309; **Roe v Minister of Health [1954] 2 QB 66** per Denning LJ, at p 72, applying what he said in **Cassidy v Ministry of Health [1951] 2 KB 343** , 359–365, and per Morris LJ, at pp 88–89).

Putting these cases together, I believe that there remains a duty to maintain safe systems for all patients, including non-Covid.

Cashflow And Covid-19: Interim Payments On Account Of Costs

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This article examines the circumstances in which payments for an order on account of costs can be made in ongoing proceedings.

But please don't look away now if you had hoped to read about interim payments after judgment or settlement which is its own separate minefield (though whilst we are here it is worth a reminder that the Court of Appeal has now emphatically confirmed that there is jurisdiction to order interim payments on account of costs upon acceptance of a Part 36 offer contrary to various earlier High Court authorities: see *Global Assets Advisory Services Ltd Grandlane Developments Ltd [2019] EWCA Civ 1764).*

Whilst I know I now inwardly groan at every email I receive which starts with "*I hope you are well in these difficult/strange/unprecedented times*", it is probably more important than ever to be live to the management of costs and cashflow in ongoing proceedings with no immediate end in sight to the COVID-19 Pandemic.

The Courts have now recognised the jurisdiction to make awards on account of costs in reasonably high value cases where liability has been determined or is admitted but the proceedings continue in relation to quantum. The ability to obtain prospective orders in relation to costs is an increasingly important tool for a litigator in light of the present pandemic.

The first key case is *X v Hull & East Yorkshire NHS Trust* (25th February 2019, unreported but widely available online or please let me know if you would like a copy) which was a catastrophic birth injury claim before HHJ Robinson on appeal in the Sheffield County Court in respect of an application for an interim payment on account of costs.

It is worth noting immediately that permission to appeal the decision was refused by the Court of Appeal. Irwin LJ in brief reasons refusing permission agreed that there was jurisdiction to make prospective orders on account of costs and emphasized the importance of interim costs payments for the cash flow of solicitors.

In *X* there had been an agreed liability settlement for 90% of the value of the claim, approved in the High Court in 2012, and which had resulted in an order for an interim payment on account of liability costs of £100,000 in accordance with the costs order in favour of the claimant on approval. Some years down the line in 2017, with quantum investigations still ongoing, the claimant sought further payments on account of damages and costs. Whilst the damages payment was approved by the District Judge on consideration of the application, a further payment on account of costs sought in the sum of £150,000 was refused on the basis that the answer was for the claimant to seek a detailed assessment of its liability costs order from 2012 with no enthusiasm for an argument that payment of prospective quantum costs could be awarded.

The appeal was heard by HHJ Robinson who with characteristic robustness held that the Court had jurisdiction to make prospective costs orders under the wide discretion conferred by CPR 44.2(1) & 44.2(2) and went onto exercise his discretion to make the order sought for payment of £150,000. In doing so he placed strong emphasis on the need to ensure adequate cash flow for claimant solicitors especially in protracted litigation], recognising that otherwise there would be a real disincentive to take on such cases. More specifically he bore in mind the absence of any Part 36 offers from the defendant in a context where the claimant was likely to recover costs incurred to date well in excess of the sums sought as an interim payment and any lump sum award of damages was likely to exceed £3 million.

X was a somewhat paradigm case for an interim payment on account of costs: high value and protracted litigation with no Part 36 offers on the table.

Not every case will be that clear cut and important practical guidance on applications was given by Master Cook in the subsequent decision of *RXK v Hampshire Hospitals NHS Foundation Trust [2019] EWHC 2751 [2019] All ER (D) 142.*

In that decision the Master recognised that there had been an uplift in applications for interim payments following X and that High Court guidance was required on the jurisdictional basis and presentation of such applications. *RXK* was a further birth injury case where judgment had been entered for damages to be assessed, however, the application before Master Cook was for an interim payment for quantum costs where the only previous order related to liability costs.

Master Cook cited CPR 44.2 and agreed with HHJ Robinson's observations that it conferred a wide discretion including a jurisdiction to make prospective/ anticipatory costs orders (unsurprisingly given the refusal of permission to appeal by the Court of Appeal). He added that there was no exceptionality threshold and that applications were to be considered in accordance with the factors listed at CPR 44.2(4) and (5). The appropriate application was for a costs order to a specific date and an interim payment on account of those costs.

Master Cook identified the following checklist of relevant considerations to be evidenced in support of any application: -

i. The type of funding agreement and details of any payments made under that agreement.

ii. Whether any Part 36 or other admissible offer has been made, and if so, full details of the offer.

iii. Details of any payments on account of damages made to date.

iv. A realistic valuation of the likely damages to be awarded at trial.

v. A realistic estimate of the quantum costs incurred to the date of the application.

vi. Any other factor relevant to the final incidence of costs, such as the possibility of an issue-based costs order, arguments over rates or relevant conduct

vii. The likely date of trial or trial window.

The application before the Master was adjourned off on the basis that it was no more than a *cri de cooer* for more money with none of the issues in the checklist adequately addressed (hence no doubt why general guidance was given).

So the practical implication of RXK is that the Court has the ability and willingness to approve applications but the relevant information must typically be set out in a witness statement or there is risk the application is simply refused.

Before the lockdown, I had found that a soundly evidenced application at the CCMC stage in liability admitted proceedings would be well received by District Judges even in county court cases which could not be said to be high value in any context let alone relative to the birth injury cases in the key authorities. Thus in cases pleaded in the region of £150,000 to £200,000 (and perhaps which will ultimately be worth less), there was a willingness to award a reasonable percentage of incurred costs (as will be clearly set out in the budget at the CCMC) where there had been no Part 36 offers and there are no issues outside of the normal litigation risks to the claimant solicitor's ultimate recovery of incurred liability and quantum costs.

As HHJ Robinson recognised, in a worst case if a claimant failed to beat a later part 36 offer such that there was ultimately a refund due to a defendant on costs then such an amount could be set off against the damages payable.

Obviously, some cases will not be suitable for applications. Where there are significant causation issues or fundamental dishonesty is alleged, discretion is unlikely to be exercised in favour of a claimant. The Court may also be unwilling to make such orders if any delay before a quantum determination is not protracted or where the claim is of modest value, but as I have said from experience I have found the Court not to be overly cautious in making orders applying an approach comparative to that applied to interim payments on account of damages.

One would expect the COVID-19 pandemic to mean that most Judges will not be slow to order interim payments on account of costs recognising the delays, disruption and complications caused in recent weeks.

There are no restrictions placed on the timing of applications or the ordering of successive prospective costs orders. CCMC stage has the attraction of ready costs information to hand and is sufficiently early in proceedings that the likelihood of competitive Part 36 offers and/or an imminent trial is lower.

But there is no obstacle to applications being made at a later stage and particularly if quantum investigations have been disrupted by the non-availability of medico-legal experts, as I have said, there ought to be an increased judicial appetite to entertain applications given the endemic delays presently to the litigation process.

In summary, clinical negligence and personal injury practitioners ought to be live to this important jurisdiction which enables cashflow to be maintained particularly in higher value and protracted litigation.

Unlicensed But Safe And Effective Drug Can Be Recommended On The Grounds Of Its Lower Cost

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In the interesting case of *Bayer Plc v NHS Darlington Clinical Commissioning Group* [2020] EWCA Civ 449 in the Court of Appeal, two pharmaceutical companies, Bayer Plc ("Bayer") and Novartis Pharmaceuticals UK Ltd ("Novartis"), appealed against the dismissal by Whipple J of their judicial review challenge to a policy adopted by a number of Clinical Commissioning Groups ("CCGs") in North Cumbria and the North East, under which the CCGs in effect recommended to NHS Trusts that the preferred treatment option for an eye disease generally referred to as wet age-related macular degeneration ("WAMD") was a drug that happened not to be marketed by either Bayer or Novartis.

WAMD is generally treated by the injection into the eye of so-called "anti-VEGF agents", which inhibit the over-production of the protein which causes WAMD. There are three anti-VEGF agents that are equally effective and safe in treating WAMD. Two of them, Lucentis and Eylea, were marketed in Europe by Novartis and Bayer respectively and had been licensed specifically for ophthalmic use. The third, Avastin, produced by a different pharmaceutical company, was licensed for the treatment of certain cancers but had never been licensed for ophthalmic use. Moreover, unlike Lucentis and Eylea, a dose of Avastin had to be divided into smaller doses in a process known as 'compounding' before it was suitable for ophthalmic use.

Nevertheless, the CCGs adopted a policy in which Avastin rather than Lucentis or Eylea would be offered to patients with WAMD as the preferred treatment option. This was solely on cost grounds, as it was enormously more expensive to use Lucentis or Eylea as compared to Avastin. Per injection, Lucentis cost about £550 and Eylea cost about £800, whereas Avastin cost only about £28.

Because the pharmaceutical company that produced Avastin did not hold a marketing authorisation for ophthalmic use, Bayer and Novartis judicially reviewed the legality of the CCGs' policy. They claimed that the implementation of the CCGs' policy would lead to breaches by NHS Trusts of the EU and domestic legislation regulating the marketing and manufacture of medicines. It was accordingly necessary for the Court of Appeal, like Whipple J before them, to consider EU legislation and caselaw in some detail.

In giving the main judgment in the Court of Appeal, Underhill LJ noted that the CJEU caselaw *did* permit Member States to adopt measures which were aimed at saving costs, in order to ensure the financial stability of their domestic healthcare system.

Further, although Article 6 of the Medicines Directive (Directive 2001/83/EC) stated in terms that no medicinal product could be placed on the market of a Member State unless a marketing authorisation had been issued, there had already been CJEU caselaw that considered whether the use of unlicensed Avastin fell foul of that provision. That was because health providers in other countries in Europe were just as anxious as the CCGs to take advantage of the lower cost of Avastin as a treatment for WAMD.

The key decision of the CJEU was *Novartis Pharma GmbH v Apozyt GmbH*, C-535/11, ECLI:EU:C:2013:226 ("*Apozyt*"). The principal effect of the decision in Apozyt was that the supply of Avastin by a compounder to a clinician did not constitute a 'placing on the market' within the meaning of Article 6 of the Medicines Directive, and so did not require a marketing authorisation, but only if the compounding process did not result in a modification of the medicinal product and was carried out solely on the basis of individual prescriptions.

The appellants, Bayer and Novartis, argued that Avastin in its compounded form should be treated as modified, because of the risk of contamination or other changes to its substance as a consequence of poor quality control during compounding. Underhill LJ had no hesitation in rejecting this argument, because on analysis of the decision in *Apozyt*, what mattered was whether there was a change to the physical, chemical or biological

properties of Avastin that was necessarily inherent in the fact of compounding, and there was no evidence that the compounding process involved any such change.

The appellants also claimed that the systematic use of Avastin undermined or evaded the legislative scheme because it eroded the primacy given by the Medicines Directive to the promotion of patient safety. They emphasised the importance of maintaining control over the distribution chain and avoiding the risk of contamination and other quality failures during the compounding process. Again, Underhill LJ had no hesitation in rejecting this argument. As he put it, following the CJEU's decision in *Apozyt*, *"that boat has sailed"* [183]. The unspoken premise of the appellants' complaint was that the requirements of the Medicines Directive, particularly Article 6, were intended to apply to the compounding of Avastin, but the CJEU had held just the opposite in *Apozyt*. There was accordingly no question of the preparation and supply of Avastin in its compounded form undermining or evading the legislative scheme.

The Court of Appeal's decision in this case is worth reading in full because there are many other interesting aspects of the decision, including a discussion of whether guidance issued by the GMC prohibited clinicians from taking account of cost when considering whether to prescribe an unlicensed medicine. The default position in the GMC's guidance was that doctors should 'usually' prescribe licensed medicines in accordance with the terms of their licence, which would have precluded the prescription of Avastin for the treatment of WAMD because Avastin was not licensed for ophthalmic use. Certain exceptions to that default position were spelt out in the guidance but none of them referred to cost as a possible justification for prescribing an unlicensed medicine.

Whipple J held that the guidance was not exhaustive and that there could be other exceptions to the usual position not expressly referred to in the guidance, and moreover she decided that the present case was far outside the category of 'usual' cases envisaged by the guidance in any event, given the extensive material that showed that unlicensed Avastin was of equivalent clinical effectiveness and safety for the treatment of WAMD as the licenced alternatives. Accordingly, she decided that the GMC's guidance did not prohibit the prescription of Avastin for the treatment of WAMD on the grounds of cost, and the Court of Appeal upheld her reasoning.

The Court of Appeal's decision is of particular interest in the current climate, where efforts are ongoing to find drugs that may treat or even cure Covid-19. Cases may arise where relatively cheap drugs developed for wholly different purposes are shown on an experimental basis to have some effect against the virus, but their unlicensed use against the virus may conflict with the financial interests of pharmaceutical companies developing their own drugs to treat the virus which they may seek to supply to desperate public health authorities at relatively great cost. The decisions of Whipple J and the Court of Appeal indicate that the courts will not kowtow to the commercial needs of 'Big Pharma' and will uphold the right of public health authorities to make prescription decisions aimed at protecting the public purse, wherever legally permissible to do so.

Surrogacy Costs after XX

Whittington Hospital NHS Trust v XX [2020] UKSC 14 (01 April 2020)

CLAIRE WATSON, SERJEANTS' INN CHAMBERS
ANNE KAVANAGH, IRWIN MITCHELL

On 1 April 2020, the Supreme Court rejected the Appeal by the Whittington Hospital and upheld the December 2018 judgment of the Court of Appeal, allowing full US commercial surrogacy costs including the costs of using donor eggs, in this clinical negligence case.

Background Summary

In December 2008 XX underwent a routine cervical smear test at her GP surgery. In January 2009, this smear test was wrongly reported as normal. In 2011 XX began to experience gynaecological symptoms and she was referred to the hospital for investigation. Her symptoms were dismissed as psychological. In 2012, a repeat smear test was also wrongly reported, as were cervical biopsies taken in 2012 and 2013 during a colposcopy and subsequent LLETZ procedure. In May 2013 XX's LLETZ biopsy was reviewed and it was discovered that she had advanced cervical cancer.

A Serious Incident Report within the Trust, which included external review of all pathology samples, concluded that all of the samples from December 2008 onwards had been inaccurately and incorrectly reported. From 2008 to 2013 there had been progression from a benign wholly treatable pre-cancerous condition to a highly invasive cancer.

By the time of her diagnosis with stage 2B cervical cancer in June 2013, the disease was too far advanced for fertility sparing surgery. She was encouraged by her treating clinicians to undergo egg harvesting, completing 1 cycle in July 2013 which was followed by a course of chemo-radiotherapy. In addition to rendering her infertile, the treatment caused irreversible damage to her bladder, bowels and vagina.

Proceedings

Liability was admitted in February 2016 and thereafter the matter proceeded to the assessment of damages with a Trial on quantum only listed on 13 June 2017.

Throughout, XX maintained that she had always intended to have a family of 4 children. The agreed medical evidence was that the claimant and her partner would have to use the services of surrogate, as they wished to have children with a genetic connection to one or both of them. The fertility experts were also agreed that it was likely that 2 live births would result from the 12 eggs harvested and she would need to rely on donor eggs to complete her family. However, XX had no close female relatives who could act as a surrogate for her and she would have to find a surrogate either in the UK or abroad.

High Court

At trial Sir Robert Nelson found XX to be a very credible witness and accepted her evidence as to her desire to have 4 children with her partner and (crucially) that she would pursue this through a surrogacy arrangement in California, if she had the funds to do so, or in the UK if California was not open to her.

The trial judge held that it is not illegal or contrary to public policy to enter into a surrogacy arrangement in the UK provided the requirements of the Surrogacy

Arrangements Act 1985 ("SAA") are met and, where the prospects of success of a live birth are reasonable if not good, he could find no reason why a claim for the cost of surrogacy in the UK should not succeed. However, he felt bound by the authority in *Briody v St Helen's & Knowsley Area Health Authority* [2002] QB 856 in terms of the claim for the costs of US Surrogacy and the use of donor eggs.

He therefore allowed the costs of surrogacy for two children using XX's own eggs in the UK under the 'altruistic' system and awarded a total of £74,000, i.e. £37,000 for the total costs of each of the surrogacy arrangements.

In respect of XX's claim for pain and suffering, he awarded £160,000. The total award made, to include sums in respect of future treatment costs for her radiation injuries, was £580,618.52.

Permission to appeal to the Court of Appeal in relation to the costs of commercial surrogacy in the US and the use of donor eggs was granted. The Trust cross-appealed against the award of UK surrogacy costs and, in the alternative, in respect of the level of the award of General Damages, and permission was granted by the Court of Appeal on 27 February 2018.

Court of Appeal

The Appeal was heard by McCombe LJ, King LJ and Davies LJ on 7 and 8 November 2018 and the unanimous judgment of the Court was handed down on 18 December 2018.

The judgment restated and reaffirmed established principles in the assessment of damages, within the relevant statutory framework and common law. The principles for the assessment of damages had not changed (ref. *Livingstone v Rawyards Coal Co* (1880) 5 App Cas 25) and the Court treated the issue of surrogacy costs claimed as another head of loss to be considered in the same way as any other.

The Court held that the legal framework around surrogacy (including amendments to the SAA) had moved on significantly since the *Briody* judgment was handed down in 2001. Those statutory changes reflected the significant changes in our society which have taken place over the intervening 17 years, from the introduction of civil partnerships and same sex marriage, giving rise to the increasing resort to surrogacy, to changes in social attitudes towards surrogacy and, perhaps central to all of that, the widening definition of what constitutes a family.

Considering the issue of whether allowing the cost of commercial surrogacy abroad would be contrary to 'public policy' the Court followed the principles set out by the Supreme Court in the case of **Patel v Mirza [2017] AC 467,** in which the law of illegality as a bar to a civil claim was carefully examined and comprehensively re-stated. McCombe LJ stated "*this new case, of the highest authority, does put Ms X's claim in a different light from that which shone upon this court in Briody*." [68]

The Court of Appeal's judgment confirmed the statutory position within the SAA that as an Intended Parent, nothing XX proposed to do, either in the UK or the US, was unlawful. S.2 (1) SAA (the ban on commercial surrogacy payments) relates solely to acts undertaken in the UK – but not to any acts undertaken by those within the intimate surrogacy relationship i.e. the Surrogate and Intended Parent(s). Applying the trio of considerations in *Patel*, the Court of Appeal held that XX's proposal to enter into a commercial Californian surrogacy arrangement was not unlawful or contrary to public policy and a bar on recovery of the costs claimed, so as to prevent full recovery of damages, would be overkill.

Having reviewed the developments in the law in the Family Division in parental order applications and the changes in social attitudes towards surrogacy, and having considered the proper application of the restitutionary principle of an award of damages in Livingstone, the Court also held that maintaining the distinction between "own egg" surrogacy and "donor egg" surrogacy - which was the subject of obiter dicta by Hale LJ (as she then was) in the Briody case - would be entirely artificial.

The Appeal was allowed in full and XX received damages of £632,945 for the cost of having 4 children through Californian surrogacy arrangements. It was conceded on behalf of XX that if she succeeded on her appeal there should be a reduction in her general damages award and the cross-appeal was allowed in part, reducing the amount awarded in respect of PSLA by £10,000, from £160,000 to £150,000.

The Order made confirmed the total damages award at £1,129,563.52 plus costs, which included an additional amount of £75,000 pursuant to Part 36.17.

The Court of Appeal refused the Respondent Trust's application for permission to appeal to the Supreme Court, however permission was granted by Lady Hale on 26 June 2019, following direct petition. The appeal to the Supreme Court was heard on 16 and 17 December 2019. Significantly, this was the last case heard by Lady Hale before her retirement.

Supreme Court

By the time permission was granted to the Appellant, the Law Commissions (Law Commission of England and Wales and the Scottish Law Commission) had published a Consultation Paper '*Building families through surrogacy: a new law*' (2019) (LCCP 244, SLCDP 167). This Consultation Paper highlighted the problems with UK surrogacy in practice and concluded that the law on surrogacy was "*overdue for re-examination in light of the societal and medical changes that have occurred*" over the last 30 years.

By a majority of 3 to 2 the Court dismissed the Appeal and upheld the decision of the Court of Appeal, albeit with different reasoning; the dissenting judgment relating to what was considered to be the most contentious issue, namely, the recoverability of commercial surrogacy costs.

The Judgment summarises the 3 issues before the Court, as follows:

i. Are damages to fund surrogacy arrangements using the claimant's own eggs recoverable?

ii. If so, are damages to fund surrogacy arrangements using donor eggs recoverable?

iii. In either event, are damages to fund the cost of commercial surrogacy arrangements in a country where this is not unlawful recoverable?

All of the justices were agreed in respect of the first two questions and held that damages are recoverable to fund surrogacy using the claimant's own eggs and using donor eggs.

On the third issue – described by Lady Hale as 'the 'most difficult' [49] - the majority (Lady Hale, Lord Kerr and Lord Wilson) answered this question in the affirmative and held that it was no longer contrary to public policy to award damages for the costs of foreign commercial surrogacy.

In a short dissenting judgment, Lord Carnwath and Lord Reed maintained that the Court of Appeal in Briody was correct and it would not be consistent with legal coherence to allow damages to be awarded for commercial surrogacy.

Q1: Own egg surrogacy in the UK

XX's primary submission at Trial, in the Court of Appeal and in the Supreme Court was that her case ultimately concerned the assessment of reasonable damages to compensate her for being wrongly deprived of the ability to bear her own children.

The Supreme Court accepted that submission. However, in contrast to the Court of Appeal, all members of the Court (including Lords Carnwath and Reed) were of the view that the defence of illegality and the principles set out in *Patel v Mirza* [2016] UKSC 42, [2017] AC 467 did not assist in such an assessment, as nothing which Ms X proposed to do involved a criminal offence either in the UK or abroad [40].

The Court therefore restated the 'restitutionary' principle, as established by the case of *Livingstone v Rawyards Coal Co* (1880) 5 App Cas 25, in that a claimant should '*as nearly as possible*' be put back into the position she would have been in but for the tort - subject only to considerations of public policy and reasonableness.

Having reviewed the developments in the law, society and fertility treatments Lady Hale then went on to agree with McCombe LJ and Sir Robert Nelson, that it was difficult to see why in principle damages could not be recovered for surrogacy arrangements lawfully entered into in the UK. She referred to the tentative view she had expressed in *Briody* in 2001 that this would be a "step too far" but noted that , even then, she did not consider there to be a point of general principle or public policy to preclude the recovery of the costs of an own-egg surrogacy arrangement made on a lawful basis in the UK [44]. Even 20 years ago, Lady Hale recognised the force in the contrary argument that "it should be capable of attracting an award" with the right evidence of the reasonableness of the procedure and prospects of success. In this case, the chances of a successful live birth using Ms X's own eggs were far greater than the '*vanishingly small*' chances in *Briody* and the Supreme Court therefore concluded that it was difficult to identify any principled basis on which to deny the claim.

Q2 – Donor egg surrogacy

Lady Hale's view in *Briody* was that an award of damages for donor-egg UK surrogacy was not truly restorative of the claimant's loss, in that it would be replacing something she had lost by giving her something different. Lady Hale, reflecting that whether or not this view was technically obiter, candidly accepted that that view '*was probably wrong then and is certainly wrong now*' [45].

The Court accepted the imperfect but apposite analogy put forward on XX's behalf of an amputee receiving a prosthetic limb which was not her own genetic material but replaced what was lost "as nearly as possible." In recalling the argument in *Briody*, that there were said to be four things a woman could hope for from having a child,

Lady Hale noted that using a donor egg and her partner's sperm, whilst not perpetuating Ms X's own genes, would still allow her to bring up a child as her own, which for many women is '*far and away the most important benefit of having children*' [46-47].

In relation to the expanding definition of a 'family' in the intervening 19 years since the *Briody* decision, Lady Hale quoted approvingly from the judgment of King LJ in the Court of Appeal, who stated that in those 'blended' families, '*psychologically and emotionally the baby who is born is just as much "their" child as if one of them had carried and given birth to him or her*.'

As with surrogacy using a claimant's own eggs, subject only to considerations of reasonableness, the Court held that damages can be claimed for the reasonable costs of UK surrogacy using donor eggs [48].

Q3: Commercial surrogacy abroad

Lady Hale acknowledged that in the UK surrogacy agreements are not enforceable and noted that it is well-established that the UK courts will not enforce a foreign contract that would be contrary to the public policy of this jurisdiction. However, the question on this appeal was not whether a commercial surrogacy agreement entered into abroad should be enforceable but whether the UK court should 'facilitate the payment of fees under such contracts by making an award of damages to reflect them.' [49]

In this case Counsel for XX had put before the Court a table which set out the comparative costs of UK and California surrogacy arrangements. Lady Hale took the opportunity to carefully look at these itemised costs and in so doing she noted that many of the items in the Californian arrangement would also be claimable if the surrogacy took place in the UK, including the costs of the fertility treatment, egg donation and, significantly, a payment to the surrogate mother [50]. The only items which would be unlawful in the UK but not in California (and even then not unlawful for XX or the surrogate personally) would be the fees paid to the US lawyers and surrogacy agency. The question Lady Hale posed was whether this was enough to taint all of the items in the bill. She concluded that it was not.

In a succinct analysis of the true ambit of the prohibitions in the SAA, Lady Hale noted that, '*It has never been the object of the legislation to criminalise the surrogate or commissioning parents*.' The only deterrent for those looking to surrogacy abroad is the risk of the courts refusing to retrospectively authorise such payments in a parental order application; however, it was acknowledged that this is really no deterrent at all as '*there is no evidence that that has ever been done*' and the courts' paramount consideration will always be the child's welfare [51].

In considering the true ambit of the law on surrogacy in the UK, the approach of the Government and the courts to familial relationships created by surrogacy was also highly relevant. Although the Law Commissions' Consultation Paper does not herald a change to the law which would allow commercial surrogacy agencies to operate in this jurisdiction, Lady Hale noted that the courts '*have bent over backwards to recognise the relationships created by surrogacy, including foreign commercial surrogacy*'; the government openly supports surrogacy as a means of building families; the use of assisted reproduction is now widespread and socially acceptable; and the Law Commissions have provisionally proposed a new pathway for surrogacy which would enable the child to be recognised as the child of the commissioning parents from birth "*thus bringing the law closer to the Californian model...*" [52].

For all of these reasons, Lady Hale considered that it was '*no longer contrary to public policy to award damages for the costs of a foreign commercial surrogacy*' [53]. The Trust's appeal was accordingly dismissed.

The dissenting judgment

Lord Carnwath gave the dissenting judgment in answer to Q3 above, with which Lord Reed agreed. The minority placed reliance on the case of *McFarlane v Tayside Health Board* [2000] 2 AC 59, a so-called 'wrongful birth' case, and were clearly concerned by the principle of consistency and coherence in the law.

Lord Carnwath and Lord Reed took the view that public policy is reflected in the criminal law of this jurisdiction. Although it was agreed that there had indeed been 'striking' developments in society's approach to surrogacy and the arrangement proposed would not be unlawful in California, as there had been no change to the criminal law affecting commercial surrogacy here, it would be contrary to the principle of coherence or consistency in the law '*for the civil courts to award damages on the basis of conduct which, if undertaken in this country, would offend its criminal law*' [66].

Commercial Surrogacy as a head of loss

The majority decision comes with important limiting factors [53]:

i. The claimant's **proposed programme of treatments** must be reasonable. This involves a consideration of whether the proposed number of children is reasonable;

ii. It must be reasonable for the claimant **to seek foreign commercial surrogacy** rather than UK surrogacy. If the proposed foreign system is not well-established, not regulated and/or does not have appropriate safeguards, it is unlikely to be reasonable;

iii. The **costs involved** in the proposed arrangement must be reasonable.

Throughout the case the Trust had not disputed XX's desired number of children nor had they challenged the costs associated with surrogacy, whether in the UK or abroad. Lady Hale was keen to stress however that '*it should certainly not be taken for granted that a court would always sanction the sorts of sums of money which have been claimed here.*' [53]

Practice Points in future claims

In light of Lady Hale's comments, in any future claims defendants will no doubt wish to challenge the claimant's factual evidence, seek their own expert evidence, and make robust submissions in opposition to such claims. Claimant lawyers will therefore need to make sure that each and every step in the proposed arrangement is reasonable and fully supported by robust factual and expert evidence, whether the proposed arrangement is in the UK or abroad.

There will need to be clear evidence to support the number of children in respect of whom surrogacy costs are claimed and thought will need to be given to whether there are any limiting factors on the size of a claimant's family arising from the negligently caused injuries. For example, if the claimant has sustained a significant psychiatric injury, will the defendant argue that this will affect her ability to care for a child and, if so, has this been appropriately addressed in the claimant's factual and expert evidence.

In addition, expert evidence will be required to establish reasonable prospects of successfully achieving live births as a result of the particular arrangement, whether from the claimant's own eggs or donor eggs. What constitutes reasonable prospects of success has yet to be determined but if less than 50%, the expert evidence will need to provide some statistical context for the argument that the claimant's chances of success are reasonable.

As in any clinical negligence case, both sides will no doubt be able to put forward reasonable arguments for and against recovery of the sums claimed. Each case will turn on its own facts and the parties will often need to be prepared to compromise. In any claim that goes to trial, it should be remembered that the courts will be scrutinising the claim for surrogacy costs just as carefully as any other head of loss – potentially even more so given the significant sums that may be involved and Lady Hale's warning that '*it should certainly not be taken for granted that a court would always sanction the sorts of sums of money which have been claimed here.*' [53].

NHS Resolution and Insurers will no doubt herald this judgment as 'opening the floodgates' to claims in respect of infertility due to negligence. However, given that reasonableness of all steps will have to be proven in every case, as per the limiting factors above, this is unlikely.

Nevertheless the judgment is welcome clarification for those cases involving infertility arising as a result of negligence and not just confined to clinical negligence.

Medical Causation – Where Are We Now: Pitfalls And Hurdles

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In the context of clinical negligence cases, causation can be just as tricky to establish as breach, perhaps even more so. The difficulties arise in part because many of these cases involve Claimants who were injured or ill before seeking the treatment or advice that they ultimately complain of and, they remain ill or injured after receiving the same (or not, as the case may be).

In addition, when addressing the issue of causation, the court is often required to pose the hypothetical question of what would have happened if there had not been a breach of duty by the Defendant. This usually gives rise to a number of imponderables and possibilities, which can make resolving that question a far from straightforward exercise.

In most cases, the central issue for the court to determine when approaching the question of causation is whether, on the balance of probabilities, there is a causal connection between the Defendant's breach of duty and the damage of which the Claimant complains. In the vast majority of cases, this issue is resolved by applying the "but for" test, namely, whether, on the balance of probabilities, the injury would have occurred but for the Defendant's negligence.

The case of *Hotson v East Berkshire Health Authority*[2] highlights how important it is not to lose sight of this core test.

The Claimant, Stephen John *Hotson* sustained a serious leg injury when he fell from a tree. As a result of the Defendant's negligence, there was a five-day delay before the Claimant's leg injury was correctly diagnosed and treated. The Claimant subsequently developed avascular necrosis and was left with a permanent deformity of the left hip. Breach of duty was admitted. On the issue of causation of the avascular necrosis, the trial Judge found that even if the Claimant had been correctly diagnosed and treated, there was a 75% risk that the Claimant's injury would have followed the same course. He then went on however to award the Claimant damages based on the loss of a 25% chance of recovering from the injury.

The decision was upheld by the Court of Appeal, but subsequently reversed by the House of Lords. Their Lordships found that trial Judge's findings of fact unmistakably amounted to a finding that the Claimant's injury and not the delay, was the sole cause of the avascular necrosis and its consequences. What the trial Judge had done was consider the quantification of damage (where considerations of loss chance may arise) without first considering whether causation had been established on the balance of probabilities. Lord Ackner in particular observed, "*to my mind, the first issue which the Judge had to determine was an issue of causation – did the breach of duty cause the damage alleged. If it did not, as the Judge so held, then no question of quantifying damage arises.*" [3]

The but for test can however cause problems for Claimants in cases where there are multiple causes for their injury or condition, which is often the case in clinical negligence claims. If there are multiple cumulative causative factors, only one of which being the negligent cause, it may be impossible for the court to apply the but for test to determine a causal link between the Defendant's breach of duty and the damage suffered by the Claimant. In such cases, it is appropriate for a modified test to be applied and instead, the court should be asked to consider whether the contribution of the negligent cause was material.

The application of this modified test is exemplified in the case of *Bailey v Ministry of Defence and Another*[4] . In that case, the Defendant appealed against the decision of Foskett J, who found the Defendant liable in damages for a serious brain injury suffered by the Claimant. The Claimant was a patient on the renal ward of the Defendant's hospital for operative removal of a gallstone. It was accepted that the Defendant failed to provide the Claimant with adequate post-operative management, which resulted in the Claimant undergoing further procedures that

2 *[1987] A.C. 750*

3 *Ibid p.792 [G]*
4 *[2009] 1 W.L.R. 1052*

would not otherwise have been necessary. The Claimant however, developed pancreatitis independent of the Defendant's poor management. These factors caused the Claimant's condition to deteriorate and she became extremely weak.

The Claimant sustained brain damage when she aspirated her vomit, which caused her to suffer cardiac arrest. It was the Claimant's case that her weak condition was materially contributed to by the lack of care provided by the Defendant, leading to her inability to prevent herself from aspirating, which in turn led to her cardiac arrest and consequent brain damage. The Defendant argued that the pancreatitis was the effective cause both of the vomiting and the aspiration or that at least, the evidence did not establish that but for the want of care, the Claimant would not have aspirated.

The Defendant's argument was not accepted by Foskett J, who found that there were two material contributory causes of the Claimant's weakness; the non-negligent pancreatitis and the negligent lack of care and since the overall weakness caused the aspiration, causation was established.

The Court of Appeal upheld this decision. In his lead judgment, Waller LJ gave the following helpful guidance as to the application of the modified test; *"if the evidence demonstrates on a balance of probabilities that the injury would have occurred as a result of the non-tortious cause or causes in any event, the Claimant will have failed to establish that the tortious cause contributed. Hotson's case* [discussed above] *exemplifies such a situation... In a case where medical science cannot establish the probability that but for an act of negligence the injury would not have happened but can establish that the contribution of the negligent cause was more than negligible, the but for test is modified and the Claimant will succeed. The instant case involved cumulative causes acting so as to create a weakness and thus the Judge in my view applied the right test, and was entitled to reach the conclusion he did."* [5]

In order to succeed in an argument that a Defendant's breach materially contributed to the damage suffered by the Claimant:

a. the negligence must contribute to the damage itself (and not merely an increased risk of damage, save for in exceptional cases); [6]

b. the contribution must be material (more than negligible);[7] and

c. there must be no alternative complete cause of the injury. [8]

The modified test was necessary to address the inevitable evidential difficulties that are faced by Claimants in clinical negligence cases, where the difficulty of attributing causes to a particular condition is the product of scientific uncertainty.

When considering the potential problem of a lacuna in evidence about the etiology of a particular condition, it is perhaps helpful for Claimants to remind themselves of the presumption enunciated *per curium* by the Privy Council in *Williams v Bermuda Hospitals Board*[9] namely, that *"if it is a known fact that a particular type of act (or omission) is likely to have a particular effect, proof that the Defendant was responsible for such an act (or omission) and that the Claimant had what is the usual effect will be powerful evidence from which to infer causation, without necessarily requiring a detailed scientific explanation for the link."*

Indeed this appears to be the approach taken by the Court of Appeal in recent case of *Mario Schembri v Ian Marshall*[10]. In his decision at first instance, Stewart J found that he was unable to identify a specific train of events or mechanism, which would have prevented the deceased's death but for the negligence of the Defendant GP in failing to refer her to hospital when she attended his surgery complaining of symptoms of breathlessness. Stewart J was nonetheless of the view on the evidence that the deceased's chances of survival would have been significantly increased had she been in hospital overnight and found that on the balance of probabilities it was more likely that she would have survived had she been referred.

In his judgment, Stewart J referred to the case of *Drake v Harbour*[11] in which Toulson LJ stated *"where a claimant proves both that a defendant was negligent and that loss ensued which was of a kind likely to have resulted from such negligence, this will ordinarily be enough to enable a court to infer that it was probably so caused, even if*

5 *Ibid p.1069 [46] – [47]*

6 *See Fairchild v Glenhaven Funeral Services Ltd t/a GH Dovener & Son [2002] UKHL 22*

7 *See Bonnington Castings Ltd v Wardlaw [1956] A.C. 613, 621*

8 *In Wilsher v Essex Area Health Authority [1988] A.C. 1074 the Claimant was unable to show that the Defendant's negligent administration of excess oxygen during his birth was a more likely cause of his retrolental fibroplasia than the various other known possible causes*

9 *[2016] A.C. 888, 907 [48]*

10 *[2020] EWCA Civ. 358*

11 *[2008] EWCA Civ [25] [28]*

the claimant is unable to prove positively the precise mechanism."

The Court of Appeal in affirming the first instance decision, observed *inter alia* that Stewart J, in concluding on his analysis of the evidence that he was unable to find a specific mechanism that would in all probability have prevented the deceased's death, was entitled to take a "pragmatic" and "common sense" view of the evidence as a whole, which led him to find that causation had been established.

It can be seen that the developments in the common law discussed herein, have had a significant impact on clinical negligence cases. These developments have been necessary to ensure that Claimants, where justice demands it, are able to overcome the inevitable pitfalls and hurdles that arise in complex litigation, such as in clinical negligence cases where there are live causation issues.

The Test Of Breach Of Duty In Pure Diagnosis Cases

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Asked what the test of breach of duty is, many clinical negligence lawyers will refer to *Bolam v Friern Hospital Management Committee*[2] and the familiar words of McNair J.

Under the Bolam test, care is negligent if it falls below the standard expected of responsible medical practitioners of a particular discipline. Conversely it is not negligent if it accords with a practice accepted as proper by a responsible body of practitioners even if there is a body of opinion taking a contrary view. Looking at a number of legal websites you could be forgiven for thinking that the matter stops there. In fact, the Bolam test does not apply to all types of breach of duty. It clearly no longer applies in consent cases where the test is that set out in *Montgomery v Lanarkshire Health Board*[3] and, as Simon Fox QC points out, there are other areas where different tests probably apply[4] . What about diagnosis?

This article will consider some weaknesses of the Bolam test both in general but in particular in its application to diagnosis. It will then review the reported cases on diagnosis.

Bolam, Bolitho and their weaknesses

The Bolam test is open to criticism in relation to treatment – which arguably is the sole context in which it belongs – but makes little sense in relation to diagnosis.

There are in fact 2 tests in Bolam: one of reasonable skill and care and the other of a responsible body of doctors. It is the second test which has created a legal muddle. Whether care falls below a reasonable standard should be judged by whether a practice is reasonable and not by whether its practitioners are. (Reasonable people make still unreasonable decisions at times.) The test blurs the distinction between what is normally done and what should be done.

The Bolitho[5] gloss on Bolam was a welcome step in the right direction. A judge is not required to accept the views of a truthful expert as to the existence of a responsible body of opinion if unpersuaded of its logic. So, the mere presence of a responsible body supporting a practice should not rule out a finding of breach of duty if that practice was irrational. But Bolitho did not go far enough in several respects.

First, 'logic' as a test of conduct is unhelpful in this context. There are likely to be medical, scientific and other uncertainties involved in any decision controversial enough to end up with opposing parties taking different stances in litigation. Recognising that this is not just a simple matter of logic, reasonableness is a more appropriate concept [6].

Secondly, the Bolitho exception was expected to be only rarely invoked. Lord Browne Wilkinson (with whom the rest of the House of Lords agreed) said it would only be in a 'rare' case, 'very seldom' that a judge would hold the views held by competent experts to be not reasonable. This is hardly an invitation to look critically at expert evidence. It risks reinforcing a failure by the courts properly to assess medical decision-making, delegating the judicial function to the medical profession.

The Bolam test in diagnosis cases

Thirdly, the judgment refers to weighing risks against benefits as the context to consider whether a decision is logical. This is fine so far as it goes. I would comment in passing that it is unclear that the House of Lords actually

2 *[1957] 1 WLR 582*

3 *UKSC The duty is '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 is 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 *Simon Fox, 'Bolam is dead. Long live Bolam!' JPI Law 2019, 4, 213-217*

5 *Bolitho v City and Hackney Health Authority [1996] 4 All ER 771*

6 *Rob Heywood, 'The Logic of Bolitho' PN 2006, 22(4), 225-235*

carried out that exercise in Bolitho. Had they done so it is difficult to see how they could they have concluded that the intrusion of intubation outweighed the risk of death of a 2 year old. (Doctors always seem troubled when I try to explain the facts in Bolitho). But weighing risks and benefits simply does not happen in one context in which Lord Browne Wilkinson said the Bolam test applies - diagnosis as opposed to treatment.

Weighing of risks and benefits is an issue when it comes to treatment. There may be a variety of ways of treating a condition and even different ways of performing the same treatment. The outcome with and without treatment may be uncertain. There may be divergences of reasonably-held views. Charting the best course for a patient involves the exercise of judgement. The law rightly recognises that there may be no right or wrong and that more than one option may be reasonable. However, the same does not apply when it comes to diagnosis. A diagnosis is either right or wrong. If wrong, it is may be reasonable. The evidence for the nature of a condition may be unclear or ambiguous. Scans are read in shades of grey. A pattern may be more or less difficult to discern. The shape of a cell under the microscope may suggest different possibilities. A wrong call can still be reasonable. But there is no weighing of risks and benefits.

In fact the responsible body test makes no sense at all in this context. There is no scope for divergent practices. A diagnosis is either the product of the exercise of reasonable care and skill or it is not. A test of 'reasonable care and skill' would make much more sense that the Bolam test, with or without its Bolitho gloss.

The reported cases

Rather surprisingly there have been few reported pure diagnosis cases. Unfortunately, the reported cases reinforce the application of an illogical Bolam/Bolitho test. They get to the right result. But they do so via a contrived route.

Penney v East Kent HA[7]

Penney v East Kent HA involved a pre-diagnostic decision. Screeners examined cervical smears not to diagnose but to identify abnormalities. Abnormal smears were referred to specialists to interpret.

Unfortunately, they overlooked abnormalities in 4 smears and wrongly categorised them as normal. Correct categorisation would have led to early diagnosis of pre-cancer and minor surgery only. In fact 4 women each developed adenocarcinoma of the cervix. The experts agreed that the slides had been misinterpreted but disagreed as to whether the mistake was reasonable.

The trial judge thought the Bolam test 'ill-fitting' in these circumstances and not applicable. This was not a case where there could be different schools of thoughts or divergences of practice. The judge weighed the views of the experts, rejected those of the defendant's expert and found for the claimants.

However, in case he was wrong to reject the Bolam test, he reached the same result by applying the test through the gloss of Bolitho. For a practice to be responsible or reasonable, it must be capable of logical analysis. This meant the court could look at the merits of the body of medical opinion represented by the defendant's expert. He rejected it: there was no logical basis on the facts of this case to accept a misinterpretation of the smears as reasonable.

On appeal, Lord Woolf gave the majority Court of Appeal judgment. This was an opportunity to reject the Bolam test in pure diagnosis cases. Sadly, he did not take it. He upheld the trial judge's decision but on the basis that the Bolam/Bolitho test applied to the question of whether a screener exercising reasonable care could treat the slide as negative.

This was the right result. But instead of a simple test of 'reasonable care and skill' Lord Woolf took the circuitous route, applied the Bolam test and then used Bolitho to reject one side's expert evidence.

Muller v Kings College Hospital NHS Foundation Trust [8]

The next case – which was a pure diagnosis (rather than pre-diagnosis case) - was *Muller v Kings College Hospital NHS Foundation Trust*. Diagnosis of the claimant's acral lentiginous melanoma, an uncommon type of malignant melanoma, was delayed when a pathologist misinterpreted tissue taken from a biopsy as a benign ulcer.

The experts in fact agreed that the sample was inconsistent with a benign ulcer. The defendant's expert nevertheless thought a pathologist exercising reasonable care and skill could miss them.

7 *[2000] PNLR 323*

8 *[2017] EWHC 218*

Kerr J would have preferred to discard the Bolam test in these circumstances. As he said, *'In a case involving advice, treatment or both, opposed expert opinions may in a sense both be "right", in that each represents a respectable body of professional opinion. The same is not true of a pure diagnosis case...where there is no weighing of risks and benefits, only misreporting which may or may not be negligent. The experts expressing opposing views on that issue cannot be both be right'.* Exactly.

However, he considered himself constrained by the Court of Appeal decision in Penney to apply the Bolam test for all its lack of logic. But since this was a case where the experts on both sides could not both be right, it was appropriate to consider the Bolitho qualification of Bolam. In Penney there had been 'a liberal invocation of Lord Browne-Wilkinson's Bolitho exception'. This was 'no doubt because this was...not a case in which there was any "weighing of risks and benefits"'.

He found that the defendant's expert was applying too lax a standard and his view did not stand up to logical scrutiny.

In both these cases, the courts had found themselves faced with the problem of Bolam and got round it with the help of Bolitho. In the context of pure diagnosis cases, formulating the question in Bolam terms - 'whether the practice accorded with a respectable body of opinion' – was in reality indistinguishable from an alternative test – one of 'reasonable skill and care'. There is something of a legal fiction going on here – the circuitous route through Bolam and Bolitho is a way to reach the same result that the simpler test would yield.

Brady v Southend University Hospital NHS Trust [9]

The most recent diagnosis case is Brady v Southend University Hospital NHS Trust although one where the claimant failed to establish a breach of duty. It does, however, reinforce the approach taken in Penney and Muller.

The medicine here was quite complex. Unlike Penney and Muller it did not involve pathology. The claimant had developed an actinomyces infection 2013 and claimed damages on the grounds that diagnosis was delayed at Southend University Hospital. This led to a psoas abscess, the need for surgical drainage, abdominal scarring and continuing symptoms.

After surgery for acute appendicitis she developed acute epigastric pain and underwent a CT scan on 5th August 2013. The report indicated a mass in the right upper quadrant 'most likely' due to omental infarction (an unusual vascular condition where the blood supply to the largest fold of the peritoneum is disrupted). Her clinicians accepted that diagnosis. Her pain continued and she was treated with antibiotics.

She had a further CT scan on 20th September 2013. The report indicated an abdominal mass, but the radiologist was unsure of the diagnosis, discussed it with the surgeon and recommended a biopsy. Her surgeon took a specialist second opinion which concluded the diagnosis was probably an omental infarction. She continued to take antibiotics and her condition improved. She was discharged.

By November 2013 she was reviewed, suffering abdominal pain. She was thought to have an abdominal mass. She was referred for a gastroscopy which she did not attend and for a further CT scan a month later.

On 14th February 2014 she was admitted through the Emergency Department and underwent a CT scan which was reported as showing a psoas abscess. Microbiology suggested an actinomyces infection. She had to undergo surgical drainage followed by a number of surgical procedures under general anaesthetic.

Her claim was that the CT scans of August and September 2013 showed an actinomyces infection but had been negligently reported, the first as showing an omental infarction and the second as being unclear. She also alleged breach of duty in failing to carry out a biopsy which, on her case, would have led to diagnosis of actinomycosis and successful treatment with antibiotics.

The defence was that she probably had both an omental infarction and an actinomyces infection but that missing the latter condition and treating her only for the former was reasonable if wrong. There were therefore allegations of breach of duty both in relation to diagnosis and (unlike Penney and Muller) treatment.

Considering the test of breach of duty in relation to diagnosis, the trial judge followed the approach in Penney and Muller: '*there can be no question but that the Bolam test with the Bolitho qualification, applies*'.

The judge found that the August 2013 scan had been misreported and showed infection rather than omental infarction. However, he accepted the defendant's evidence that a large number of radiologists would have made the same mistake. The report was reasonable, if wrong. The September 2013 scan also showed an

9 *[2020] EWHC 158 (QB)*

infection. Although the radiologist had not reached a diagnosis or identified differential diagnoses, she had recommended appropriate investigations. Her report, whilst sub-optimal, did not amount to a breach of duty.

In Penney and Muller, therefore, the application of the Bolam test, when qualified by Bolitho had established a breach of duty. In Brady, the claim failed but the same test had been applied and the judge accepted that the Bolam/Bolitho test unquestionably applied.

Conclusion

So we are left with the clear conclusion that the Bolam test applies to diagnosis even though it makes little sense in that context. To get round it, the courts have 'liberally' used the Bolitho gloss to reject the defendants' experts' opinions on the grounds of illogicality. In these cases there is no 'weighing of risks and benefits', which means that they are prepared to invoke Bolitho more liberally that the House of Lords probably had in mind with its 'rare' exception.

G K Chesterton wrote with affection of the rolling English road, 'A merry road, a mazy road, and such as we did tread/The night we went to Birmingham by way of Beachy Head'. The convoluted Bolitho route in pure diagnosis cases is an example of the rolling English road. It gets to its destination but only via a rambling route. A simpler, more logical and coherent test would be that of 'reasonable care and skill'. In Chesterton's eyes this might be a detested Roman road. But it would be a shorter route to the destination.

Patient Confidentiality - To Breach Or Not To Breach

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ABC v (1) St George's Healthcare NHS Foundation Trust (2) South West London and St George's Mental Health NHS Trust (3) Sussex Partnership NHS Foundation Trust [2020] EWHC 455 (QB)

Confidentiality is crucial to the relationship of trust and confidence between patients and their doctors. Huntington's disease is a hereditary condition. Children of a sufferer have a 50% chance of developing the condition usually as an adult. It leads to severe physical and cognitive impairment. It is life shortening and in its later stages full-time care is required. If a father is suspected of suffering this condition, should his daughter be told even if her father has not consented? *ABC v St George's Healthcare NHS Trust*[2] looked at patient confidentiality in just such a situation.

The facts

In 2007 the Claimant's father (XX) killed his wife, the Claimant's mother. He was convicted of manslaughter on the grounds of diminished responsibility and made the subject of Hospital and Restriction Orders under the Mental Health Act 1983. He was detained in the Shaftsbury Clinic at the Springfield Hospital which was run by the Second Defendant[3]. While there he was seen by a social worker employed by the Third Defendant. In late June 2009 XX was suspected of having developed Huntington's disease and referred to the First Defendant's St. George's Hospital. He was under the care of Dr Olumoroti, a consultant forensic psychiatrist. XX refused to undergo genetic testing. He did not want the Claimant or her sister to know because they would be distressed and such knowledge could impact on their decision about whether to have children or not. Neither daughter had started a family.

His patient confidentiality was respected by the First and Second Defendants. Huntington's disease was confirmed in November 2009. The Claimant took part in family therapy sessions arranged through the Second Defendant since she was supportive of her father as he approached possible release into the community. The Claimant became pregnant. She gave birth to a daughter in April 2010. On 23.8.10 Dr Olumoroti accidentally informed the Claimant about her father's diagnosis of Huntington's Disease. She subsequently underwent testing, and in January 2013 was herself diagnosed as suffering from Huntington's Disease.

The Claimant alleged that the Defendants were negligent in not informing her of XX's condition and had breached her rights under Article 8 of the European Convention on Human Rights.[4] Her case was that had she been informed, she would have been tested. If the test was positive, she would have terminated her pregnancy. She sought damages for the continuation of her pregnancy, psychiatric damage and consequential losses. The parties agreed that were the Court to find an actionable breach of duty on the part of the Defendants (or any of them) and that, but for that breach, the Claimant would have terminated her pregnancy, she should recover damages of £345,000.

The GMC had issued relevant guidelines in relation to patient confidentiality in 2004 and 2009.[5] Specific guidance had also been given by the relevant professional bodies[6] in the fields of genetics and psychiatry.

The evidence in respect of liability was heard by Yip J in November 2019 and judgment was handed down in February 2020. Prior to that, in May 2015, the Defendants

2 *[2020] EWHC the 445 (QB)*

3 *By the end of the trial, no specific allegations of negligence were made against the third defendant.*

4 *Yip J held that the Human Rights Claim added nothing to the claim in negligence. Nicol J and The Court of Appeal had been of the same view.*

5 *There are now 2017 Guidelines (updated in May 2018 to take account of GDPR).*

6 *"Consent and confidentiality in genomic medicine" now in its 3rd edition (July 2019). Joint Committee on Medical Genetics of the Royal College of Physicians, Royal College of Pathologists and British Society for Human Genetics. "Good Psychiatric Practice – Confidentiality and information sharing" (3rd edition, November 2017 CR209) Royal College of Psychiatrists*

successfully persuaded Nicol J to strike out the Claimant's case on the ground that there was no reasonably arguable duty of care to her.[7] This decision was reversed by the Court of Appeal in May 2017.[8]

The Decision

Yip J dismissed the Claimant's claim against all three Defendants. She found (para 138) that the Claimant was a patient of the Second Defendant's family therapy team. Even if better described as a "participant" in family therapy she found that position directly analogous to the situation of a patient undergoing therapeutic intervention. In Yip J's view "patient" or a "participant" in relation to family therapy was a matter of labelling which did not affect the substantive position as to the duty owed. The family therapy was provided by the hospital trust as part of the health service that it offered. Therefore, the duty owed by hospital trusts to patients to deliver their services competently applied to all those undertaking the family therapy. Yip J regarded that as applying established principles to a new factual situation[9] rather than recognising a novel duty. [10]

The Claimant would not naturally be described as a patient of the First Defendant's mental health unit where her father was accommodated. No patient record was created for her whereas entries relating to the family therapy were made in XX's medical records. However, in the context of family therapy, the Claimant's role was not simply that of XX's relative. Her participation was not solely for XX's benefit but was also designed to focus on her own needs and to offer a therapeutic benefit to her. The duty to patients to deliver that service competently and with professional skill and care applied to all those undertaking the family therapy. Participation in the therapy did not bring with it a right to receive confidential information about other participants such as XX. Similarly, the Claimant had been told that she could discuss matters in confidence without XX being told (para 141).

In fact, the Second Defendant's family therapy team took the view that the Claimant ought to have been informed about her father's diagnosis but did not do so. The responsibility in deciding whether to maintain confidentiality lay with Dr Olumoroti as the doctor responsible for XX's clinical care. Dr Olumoroti had received that information in his role as XX's doctor - not as part of the family therapy. The Claimant was not in a doctor-patient relationship with Dr Olumoroti but remained a third party to the relationship between each of the Defendants and XX (para 143).

Proximal relationship

Yip J considered whether a duty was owed to the Claimant and held that it would be inappropriate for her to attempt to define the limits of any duty of care owed by doctors to those who are not their patients. That was not the way in which the incremental development of the common law operated. The duty contended for by the Claimant was not a free-standing duty to disclose genetic information. Any duty could arise only where the outcome of a proper balancing exercise required XX's confidentiality to be overridden. Yip J considered examples such as the child abuse cases and those where vasectomies had failed (paras 167 – 169) and concluded that the courts had been willing to recognise that doctors or health authorities might owe a duty of care to persons other than their primary patient but that such a duty could only arise where there was a close proximal relationship between claimant and defendant.

The Judge found no close proximal relationship between the First Defendant and the Claimant. The position of the Second Defendant was different. The Claimant's participation in the family therapy was an important fact. The Second Defendant's clinicians had significant information about the Claimant - the circumstances of her father's offence, its effect on her, the family dynamics and the lack of support available to her. There was therefore a close proximal relationship between the Claimant and the Second Defendant.

A balancing exercise

The risk of harm to the Claimant if information about her genetic risk was withheld was foreseeable and had been foreseen by the Second Defendant. The Judge concluded that it was fair, just and reasonable to impose on the Second Defendant a duty to balance the Claimant's interest in being informed of her genetic risk against her father's interest in preserving confidentiality and the public interest in maintaining medical confidentiality generally. Any claimed duty would necessarily be tested by reference to the Bolam/Bolitho principles.

The Judge held that if defendants properly conducted a balancing exercise in accordance with professional guidance and reasonably concluded that disclosure should not be made, they will have discharged their duty even though others may have taken a different view.

7 *[2015] EWHC 1394 (QB)*
8 *[2017] EWCA Civ 336*
9 *Darnley v Croydon Health Services NHS Trust [2018] UKSC 50;*
10 *Caparo Industries plc v Dickman [1990] 2 AC 605*

Courts will recognise the pressures of day-to-day clinical practice and afford latitude to clinicians taking these difficult decisions.

Yip J carefully analysed the Claimant's evidence at trial and, while accepting the truthfulness of her evidence, she concluded that the Claimant's contention that she would have sought genetic testing and arranged a termination was reached with the benefit of hindsight and would not have been her decision at the time. Causation was not proved. [11]

The way ahead

The timeframe of the case meant that Yip J who heard the evidence on liability at the end of 2019 had to consider guidelines going back as far as 2004. The guidelines relevant to the facts in *ABC* are set out in paragraphs 41 – 44 of her judgment.

Disclosing confidential information without a patient's consent will be very unusual. Words such as "exceptional" and "rare" appear in more recent guidelines for various disciplines which emphasise the primacy of confidentiality. The 2017 publication from the GMC sets out 8 principles. Para 8f states: *"Ask for explicit consent to disclose identifiable information about patients for purposes other than their care or local clinical audit, unless the disclosure is required by law or can be justified in the public interest."* At paras 22 and 63 the benefit of confidential medical care to society as well as the individual is emphasised, but exceptions are recognised. Disclosure may be justified *"to protect individuals or society from risks of serious harm, such as from serious communicable diseases or serious crime"*; at para 64 *"..... Where a patient has refused consent, disclosing personal information may be justified in the public interest if failure to do so may expose others to a risk of death or serious harm. The benefits to an individual or to society of the disclosure must outweigh both the patient's and the public interest in keeping the information confidential;"* and at para 75, in a section headed "Disclosing genetic and other shared information", this is repeated and it continues *"if a patient refuses to consent to disclosure, you will need to balance your duty to make the care of your patients your first concern against your duty to help protect the other person from serious harm."*

The Joint Committee on Genomics in Medicine 2019 guidelines recognise at para 2(1) that health professionals can find it difficult to know how to preserve the confidentiality of one patient and at the same time alert a family member to the risk of a particular condition. It is suggested that alerting a relative to the risk of developing a condition because of a family history or for some other reason which the clinician does not need to specify may be a solution as long as the details of the patient's condition remain confidential. *"Providing information about a familial risk is not the same as disclosing personal medical information about a relative, even if a relative subsequently uses this to make inferences about others."*

It is difficult to see how in the ABC case the familial risk could have been disclosed to the daughter without her being able clearly to infer that the risk could only have come from her father. These 2019 guidelines refer to the Court of Appeal decision in ABC[12] : "*The Court of Appeal stated that the position of geneticists was different to that of other practitioners, since, by the nature of their work they 'frequently acquire definite reliable and critical facts of clinical significance about their patients' relatives', and are already required by their professional guidance to consider whether disclosure of such information should be made to family members."* [13] The guidelines do however go on to identify the need to follow the GMC guidance and balance the obviously competing interests of patient and family member. [14]

So far as the Royal College of Psychiatrists is concerned, the 3rd edition guidelines set out as a starting point at para 64: *"if the patient has the capacity to refuse disclosure to the family/carers and does refuse, you should respect this wish unless there are overriding reasons of public interest not to do so."* This is repeated at para 87 where reference is made to the GMC guidelines and the need to inform the patient unless to do so would increase the risk of harm or inhibit effective investigation of risk.

Once a patient has been diagnosed with a genetic illness or condition a doctor will explain the likelihood of close relatives being at risk. Encouraging a patient to discuss such risks with relatives will, in turn, alert them to those risks. Should a patient refuse either to disclose those risks or to permit a doctor to disclose them, the guidance variously available provides that a doctor may disclose this information if it could be justified in the public interest. The starting point is not to disclose. There is a balance to be struck between patient confidentiality and a breach of that confidentiality.

11 *Note that the Claimant decided not to inform her sister of the situation. The sister later tested negative.*

12 *Para 2.2.2 The liability trial had not yet taken place when the Guidelines were published*

13 *The mixture of reported and direct speech is unsatisfactory. See paras 40 – 45 of Irwin LJ's judgment for the context.*

14 *See para 4.3*

The tragic and unusual facts of the ABC case bring into sharp relief the competing interests but Yip J was clear that there had been adequate consideration of that balance and that the Defendants were not in breach of their duty to the Claimant. The First Defendants owed no duty to the Claimant because XX was their patient. A duty to third parties can only arise where there is a close proximal relationship between a claimant and a defendant. Here the Second Defendant had a close proximal relationship because of its work with the Claimant in family therapy. There was therefore a balance to be struck between breaching patient confidentiality and the interests of a third party in being informed of facts which breached that confidentiality. Yip J found that the issue had been considered by the healthcare professionals and that the decision not to breach XX's confidentiality had struck the appropriate balance such that no breach of duty had been made out.

The idea of disclosing medical information without the permission of a patient is not a new concept. Take, for example, the position of a GP who has to disclose in appropriate circumstances a patient's unfitness to drive a vehicle; or the obligation in respect of communicable diseases to report such matters to the appropriate authority. Clearly, that is in the public interest. Is it so when those potentially harmed are a set of close relatives? What, in general are the risks of such information somehow falling into the wrong hands and should that militate against any disclosure of genetic information? Would, for example, volunteers for genetic testing in the field of medical research be reluctant to put themselves forward if they faced the possibility that genetic information might be disclosed to close relatives against their consent?

For some, sympathy may naturally lie with the Claimant in ABC. These are issues which, in one form or another will no doubt be tested in the years ahead. It is likely that such cases will be relatively few and far between. They are fact sensitive and likely to arise only where there is close proximity between a doctor and third-party. Clinicians will need to take account of professional guidelines. Non-disclosure will be the starting point. A fine balance will need to be struck in some cases. Decisions will be judged according to Bolam principles with reasonable latitude being afforded to busy clinicians at work. The distinction between "patient" and "participant", as Yip J stated the Claimant might more properly be described, may or may not be the subject of debate but certainly proximity between doctor and third-party will be key.

Vicarious Liability In Clinical Negligence Claims, Where Are We Now?

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In the *Christian Brothers* case Lord Phillips of famously declared that "the law of vicarious liability is on the move". The recent decision of the Supreme Court in *Barclays Bank v. Various Claimants* [2020] UKSC 13 has brought that movement to a juddering halt. The question posed by the appeal was a simple one. Is it possible to be vicariously liable for the acts of a self-employed 'independent contractor'? The answer the Court gave in this case was 'no'. This may have significant implication for clinical negligence claims.

Factual Background

The group litigation concerned the vicarious liability of Barclays for sexual assaults in the 1970s and early 1980s. The alleged assaults were committed in the North East by a now deceased general practitioner: Dr Bates.

Dr Bates was a self-employed medical practitioner with a portfolio practice. His work included conducting medical assessments and examinations of prospective Barclays employees. Barclays required job applicants – many of them aged 16 or under – to pass pre-employment medical examinations as part of its recruitment procedures. Barclays arranged the appointments with Dr Bates and provided him with a pro forma report headed "Barclays Confidential Medical Report". Dr Bates was paid a fee for each report. If the report was satisfactory, the applicant's job offer would be confirmed, subject to satisfactory GCE examination results.

Dr Bates conducted the (unchaperoned) medical examinations in a consulting room at his home. It was alleged that Dr Bates sexually assaulted 126 claimants in the group action during their medical examinations. After Dr Bates died in 2009, the claimants sought damages from Barclays.

The Court of Appeal

At first instance, the judge held that Barclays was vicariously liable for any assaults that Dr Bates was proved to have perpetrated. The Court of Appeal agreed and dismissed Barclays' appeal.

In finding that the Bank was liable, the Court of Appeal focussed on the "five factors" described by Lord Phillips in the *Christian Brothers Case [2012] UKSC 56* at paragraph 35, and by Lord Reed in *Cox v. Ministry of Justice [2016] UKSC 10* paragraphs 20-23. These were:

i. the employer is more likely to have the means to compensate the victim and can be expected to have insured against that liability;

ii. the tort will have been committed as a result of activity being taken by the employee on behalf of the employer,

iii. the employee's activity is likely to be part of the business activity of the employer,

iv. the employer, by employing the employee to carry on the activity will have created the risk of the tort committed by the employee, and

v. the employee will, to a greater or lesser degree, have been under the control of the employer.

The Court of Appeal held that the application of these factors to a particular case was the answer to whether vicarious liability arose. It dismissed the Banks' reliance upon the "independent contractor defence". Lord Justice Irwin stated that:

... it seems clear to me that, adopting the approach of the Supreme Court, there will indeed be cases of independent contractors where vicarious liability will be established. Changes in the structures of employment, and of contracts for the provisions of services, are widespread. Operations intrinsic to a business enterprise are routinely performed by independent contractors, over long periods, accompanied by precise obligations and high levels of control. Such patterns are evident in widely different fields of enterprise, from construction, to manufacture, to the services sector.

On the facts, both the High Court and Court of Appeal agreed that Lord Phillips' five factors were readily applicable to the Bank's relationship with Dr Bates.

The Judgment of the Supreme Court

The Court's starting point, and its final destination, was the proposition that:

It is trite law that the employer of an independent contractor is, in general, not liable for the negligence or other torts committed by the contractor in the course of the execution of the work: see D & F Estates Ltd v Church Comrs [1989] AC 177 at 208,

The Court held that there was nothing in the *Christian Brothers* case, *Cox v. Ministry of Justice or Armes v. Nottinghamshire CC* to cast doubt on the classic distinction between employees (and those in relationships "akin to employment") and independent contractors. Vicarious liability did not arise in respect of the latter.

The central question remained whether the tortfeasor was "carrying on business in his own account" or whether he was in a relationship "akin to employment" with the Defendant. The key would usually lie in understanding the "details of the relationship".

Where it was clear that a tortfeasor was carrying on business in his own account it was not necessary to go on to consider the various tests (the "five factors") described in previous Supreme Court decisions. On the facts, it was clear that Dr Bates was in business in his own account. Therefore, the Bank was not liable.

The Court also considered whether vicarious liability might arise in respect of self-employed people working in the "gig" economy: eg. Uber drivers, Pimlico Plumbers. Such people may not be employees in the traditional sense but may be "workers" within the meaning of section 230 (3) of the Employment Rights Act 1996. The Court observed that asking whether a person was a "worker" may be helpful in distinguishing "true" independent contractors from those were in a relationship "akin to employment". However, the Court held that it would be going "too far down the road to tidiness" to align the law on vicarious liability precisely with the statutory concept of "worker". This statutory concept which had been developed for a quite different set of reasons.

Comment

The reception of the Supreme Court's decision is likely be mixed. Some will welcome the decision as one which restores sensible boundaries to the runaway principle of vicarious liability. Others will rue the decision as a retrograde step. The author, who declares his bias as junior counsel for the Claimants in *Barclays*, falls into the latter camp.

At the heart of the Supreme Court's decision was the long-established principle that a defendant is not liable for the torts of their independent contractors. But the Court did not explain why that should be so. Rather the justification for the independent contractor defence was treated as being self-evident. In the author's view, Lord Phillips' five "policy reasons" for imposing vicarious liability are plainly capable of applying to independent contractors. The High Court and Court of Appeal had no difficulty in finding that they applied to Dr Bates. If the policy reasons apply to independent contractors, it is not obvious why liability should not follow.

But does the Barclays' case at least restore an easily understood "bright line" rule? The Supreme Court's decision means that many cases will now turn upon the slippery distinction between persons "carrying on business in their own account" and those in a relationship "akin to employment". That distinction is easy to state but may well be difficult to apply. The Court stated that asking whether the tortfeasor was a "worker" may provide a clue. However, the boundary between workers and non-workers has given rise to protracted litigation in the employment law context. In *James v. Redcats (Brands) Limited [2007] ICR 1006*, Elias J observed that "the attempt to map the boundary separating workers from those in business dealing with a customer have proved elusive" [52]. The boundary drawn by the Supreme Court may prove to be just as indistinct.

Implications for Clinical Negligence Claims

The *Barclays* decision is likely to have significant implications for clinical negligence claims against practitioners working in private practice. The issue of vicarious liability often arises where there are concerns about the existence or extent of a private practitioners' professional indemnity cover. In such cases claimants will often look to the private hospitals or clinics as potential defendants with the ability to pay.

Where such organisations can show that the practitioner is an independent contractor who is in "business in their own account" they will have a complete defence to any claim based upon vicarious liability. However, determining whether a practitioner is truly in business in their own account is not always straightforward. For example, in

Hospital Medical Group v. Westwood [2012] EWCA Civ 1005, a general practitioner provided his services as a hair restoration surgeon to a company offering hair restoration services to the public. Under the terms of his contract with the company he was described as a self-employed independent contractor. The Court of Appeal held that he was still a "worker" for the purposes of the relevant employment legislation. He was described in the clinic's literature as "one of our surgeons". It was also relevant that he provided his services as a "central part of the company's undertaking". It remains arguable that private clinics and hospitals will continue to be liable for practitioners who provide their services in a similar way. The potential relevance of "worker" status also means that clinical negligence lawyers may find a working knowledge employment law helpful.

Even if vicarious liability does not arise on the facts, the *Barclays* case does not resolve the separate question of whether private hospitals and clinics may owe a non-delegable duty of care for private practitioners. It has been accepted that private healthcare institutions may owe a non-delegable duty in a number of cases dating back to Gold v. Essex County Council [1942] KB 293. It was assumed (obiter) by Lady Hale in Woodland v Essex County Council [2013] UKSC 66 that hospitals owed a non-delegable duty in respect of nursing staff employed by an agency. However, the Courts have not always held that such a duty arises. For example, no such duty arose in respect the negligent provision of diagnostic laboratory services to a Trust: see Farraj v. King's Healthcare NHS Trust [2010] 1 WLR 2139. Nor was such a duty been imposed where the defendant's involvement was limited to facilitating access to healthcare by third parties: see A (A child) v. MoD [2004] EWCA Civ 641 and Razumas v. MoJ. [2018] EWHC 215. Accordingly, whether a non-delegable duty arises is a highly fact sensitive question.

In the authors view the *Barclays* case therefore sets the scene for further litigation in respect of two main issues. First, whether self-employed private practitioners working for private hospitals or clinics are truly "in business in their own account" or whether they are in a relationship "akin to employment" for the purposes of vicarious liability? Second, whether and in what circumstances a non-delegable duty of care arises in respect of private practitioners? The narrowing scope of vicarious liability is likely to result in more claimants testing the boundary of the non-delegable duty principle. Watch this space for *"Barclays 2"* in the years to come.

Case Note On Douse V Western Sussex Hospital NHS Foundation Trust

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Case note

Hollie Douse (a child suing by her father and litigation friend Chris Douse) v Western Sussex Hospitals NHS Foundation Trust [2019] EWHC 2294 (QB). Ben Collins QC from Old Square Chambers represented the successful Claimant, instructed by Sue Bowler of Coffin Mew.

Background

The Claimant suffered a serious hypoxic ischaemic injury during the course of her birth by Caesarean section, which led to severe disability. The Defendant accepted that injury was caused by the operative procedure, which lasted approximately 16 minutes. The issue was whether or not the obstetric registrar was negligent in failing to deliver the Claimant within a shorter period of time, in particular within 5 minutes, which would have avoided injury.

The registrar had encountered difficulty because the baby's head was deeply impacted in the pelvis and deflexed in the ROP position. She was unable to deliver despite attempting a number of different techniques, including: using the midwife to apply pressure per vaginam, tilting the bed head down to allow some gravitational pull, an inverted T cut, and administration of terbutaline to relax the uterus and reduce contractions.

The on-call consultant was called and she arrived 14 minutes after the procedure began. She too encountered difficulty with a deeply impacted head, and gave evidence that it was necessary to 'scout around' for space behind the baby's head in order to obtain some sideways movement and allow flexion. She applied force to each side of the baby's head to create rotation and was able to deliver Hollie within 2 minutes (she said it usually took her about 10 seconds). The Claimant was born in poor condition and taken for resuscitation.

The issue

The issue for the court was whether the registrar had failed to respond adequately to a difficult but recognised situation, or whether the circumstances of the delivery were wholly exceptional.

The standard of care

The Claimant reminded the court that the standard of care did not depend upon the experience of a clinician, but rather on the nature of the task being performed. A hospital doctor should be judged by the standard of skill and care appropriate to the post which he or she was fulfilling, and where a doctor was "acting up", that standard should be derived from the role being undertaken: **FB v Princess Alexandra Hosptial NHS Trust [2017] EWCA Civ 334**. In other words, the registrar was fulfilling the role of an obstetrician competent to undertake Caesarean sections without supervision.

Expert evidence

The Claimant's expert asserted that no reasonably competent obstetrician would have failed to deliver by Caesarean section in the prevailing clinical circumstances. The degree of impaction was unlikely to have made delivery within 5 minutes impossible and the various measures adopted by the registrar were unlikely to have changed the situation so as to enable the consultant to deliver in only two minutes.

The Defendant's expert did not believe the registrar could reasonably have been expected to try other techniques, and that her approach was in accordance with a competent body of obstetric registrars. He likened the consultant's ability to deliver within two minutes to a sort of "jam jar" effect, i.e. that the measures adopted by the registrar had facilitated the consultant's ability to deliver.

Judgment

HHJ Wood QC found that the baby's head was more deeply impacted than anticipated, which created significant difficulties for the registrar and the consultant. But he did not find any material change in the clinical picture facing both doctors. He rejected the Defendant's submission that the various measures adopted by the registrar had made the delivery easier for the consultant. In his opinion, the consultant was able to deliver because of techniques that had not, but should have been used by the registrar. He did not consider it necessary to make a finding as to why the registrar had not adopted these techniques – i.e. whether due to lack of training or skill or other reason - it was sufficient to conclude that they should have been used, so as to enable delivery within 5 minutes. The Defendant was therefore liable.

Comment

The discovery of an impacted foetal head, in the course of a Caesarean section procedure expected to be routine, is inevitably a heart-stopping moment for an obstetrician. It is hard not to feel some sympathy for a registrar doing her best in an extraordinarily pressurised situation. Obstetrics is a speciality that is particularly sensitive to time and if a consultant is not on site, there may be no opportunity for a registrar to obtain assistance. But for the purposes of practitioners, this case is a helpful reminder that the standard of care does not depend upon the experience of the doctor, but rather on the nature of the task being performed. The clinician performing that task may be expected to try all available techniques to achieve a positive outcome. And where one doctor is able to deal with a difficult clinical picture where another has failed over a significant and crucial period of time, a judge may well conclude that there is an evidential burden on the Defendant, if not a requirement for an explanation, to show a material change in circumstance facing each doctor.

Lessons Learned From The Bristol Heart Scandal And The 2001 Kennedy Inquiry – Part 2

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CONSULTANT SOLICITOR AND HONORARY MEMBER OF THE AVMA PANEL

Part 2 of a 2-part article

The Inquiry and the Duty of Candour

The Kennedy report found serious, systemic failures at a unit that had clothed itself in a 'club culture' of wilful blindness to safety concerns and poor practice, with staff closing ranks to protect their colleagues. On the eve of publication of the Kennedy report, which documented the lethal consequences of a toxic culture of denial within the collusive community operating at Bristol, the Chief Medical Officer at the time demanded that doctors should admit to patients when an error in their surgery had occurred.

The need for a duty of candour became obvious after Bristol: a duty on doctors and hospitals to report untoward incidents and to raise concerns. They should also, the report recommended, feel able if necessary to blow the whistle on failings and incompetence of colleagues or systemic issues within their hospitals, with proper legal safeguards to protect them from dismissal or victimisation if they have cause to take action.

My experience of acting for parents of these very sick children has shown that they have a heightened awareness and a desperate desire to place their children in the safest possible hands to give them the best chance of achieving a successful outcome. They want to know the truth before and after surgery. They want to know that the surgeon and medical team have the necessary resources and expertise in the procedure they are to carry out. As occurred at Bristol in the 90s, and as repeated across the country since, parents have little option but to place their trust in the surgeons and in the cardiologists who diagnose their children's conditions and refer them for their life-saving surgery.

Patients and families seek information and explanations if treatment has failed. This isn't 'hospital complaint' territory. It shouldn't be left for us as lawyers, after obtaining expensive expert reports, to have to explain to grieving parents what really happened to their child. In many cases, sadly, this was how they learned the truth.

I have misgivings as to whether patients and families in the context of high risk surgery where much depends on the experience of a unit or surgical team will benefit significantly from the duty of candour introduced for NHS healthcare providers in 2014. Children's heart surgery has unique features, in that it is carried out at a number of specialist units across the country. One unit may have a specific expertise or superior safety record in a particular procedure, less so in another. A classic example from Bristol in the 90s was the truncus arteriosus operation. Although on any level this is a highly complicated procedure, parents were not informed that the unit had a significantly higher mortality rate than comparable units in this same operation. It was revealed in a BBC Newsnight programme in October 1998 that, prior to a truncus arteriosus procedure Wisheart performed on a child in 1993, he had performed 11 of these operations in which nine children had suffered 'early' deaths. The patient in the 1993 operation sustained catastrophic brain damage. Clearly his chances of surviving without injury would have been significantly increased, and the NHS would not have had to pay substantial damages for those injuries and his future care needs, if he had been referred to another unit with a superior safety record. Would this explanation - to me, a full and meaningful explanation that I would want - be given to parents today with the duty of candour in place? I doubt it.

Those who sought explanations after their children died received limited explanations from the surgeons. In most cases, parents only came forward in response to the news reports around the time of the GMC hearings in 1998 and the Public Inquiry that began in 1999. Many of the operations had been carried out three or four years previously. Letters to parents from the Trust's new Chief Executive were written in sympathetic, compassionate tones but, as he was relying on medical and surgical staff still at the hospital for his information, they were of little benefit. The hospital sought to explain that the surgeons had encountered unexpected presentations of the

children's particular defects or abnormal anatomies that could not have been foreseen. I do not recall any letter accepting that the surgeons or cardiologists or other members of the team had been in any way to blame.

Parents were given no insight into the experience of the surgeons and their medical support team. Before surgery, the surgeons had given highly optimistic assessments of the likelihood of survival, often quoting 80 or 90% survival but with no warning of the risk of surviving with brain damage – a risk inherent in the best hands in these open-heart operations requiring cardio pulmonary bypass (CPB). Parents had been given optimistic success rates in the various procedures, which reflected national but not local experience. They were not given the choice of a second opinion or a referral to another centre with a superior safety record. None of the 25-30 sets of parents of children who had suffered permanent neurological injury over the 10-year time span covered by the Inquiry were, to my knowledge, offered any explanation, even though they had to return to Bristol for their children's continuing cardiology care. We referred to these unfortunate parents and children as the 'forgotten families. I pursued an unsuccessful judicial review of the GMC's decision to limit the charges to mortality rates, excluding consideration of the unit's non-fatal morbidity record, in a narrow category of operations.

All of the brain damage cases from Bristol in the 1990s were litigated and contested to the fullest extent in spite of the findings of the GMC and Public Inquiry. The financial cost to the NHS of these claims was enormous. The cost in damaged human lives was incalculable.

A generation later, how have developments in the law of consent and the introduction of the duty of candour affected the position?

In many ways, little has changed in children's heart surgery since the 1990s. Parents of a child with the extremely complex Hypoplastic Left Heart Syndrome, for example, may not know, but should be told, that a particular unit is pre-eminent as the leading centre for corrective surgery on this defect. Inevitably, units with a greater degree of expertise in these immensely difficult procedures achieve better outcomes in terms of lower mortality rates and a lower incidence of, and ability to cope with, post-operative complications. Units with this leading national expertise should of course be appropriately resourced by the NHS so that they can admit these children.

So, what can parents expect from the Duty of Candour if their child has undergone surgery at a unit that lacked expertise in this procedure? They may be given a frank explanation of why their child died, or why he or she suffered complications, but in the same way that they should have been informed of the facts before surgery, surely they should be informed that there may have been a quite different outcome if their child had been operated on at another centre with a superior safety record?

Data

"Comparative data" - performance of comparable units

Kennedy called for greater transparency in data recording so that no hospital could allow poor outcomes to go unscrutinised.

These features of the children's cardiac specialty raise a number of points. How can the outcomes and competence of a surgeon or unit be measured and how can a patient be advised of the risks if the surgeon doesn't know what other surgeons and units are achieving and how his outcomes compare with those of other units? How can a surgeon fulfil the requirement of a genuine consent process before surgery or of a meaningful duty of candour when explaining why surgery has failed without knowing how his or the unit's outcomes compare with similar units?

A recent article in the World Journal for Paediatric and Congenital Heart Surgery (reference below) in the context of how parents of children with a life-threatening congenital heart defect interpret and perceive risk. 8 in every 1000 babies are born with a cardiac anomaly. Pre-surgery discussions as to risk are difficult for clinician and parent. Many parents are too anxious (if not terrified) to take in Montgomery options. A number of the sets of 106 parents who participated in this UK study felt that the decision to operate or not should rest with the clinician, not the parents. Parents simply want to know that they are placing their child in the hands of a competent, experienced surgeon in a well-performing unit, giving their child the best chance of surviving with a successful repair. The availability of readily understandable data to enable these comparisons to be made and units to monitor their performance becomes a crucial element in both consent and candour.

Although the Public Inquiry concluded that, between 1990 and 1995, up to 35 children and babies had died as a result of poor care at Bristol, we calculated by extrapolation from the data that in fact as many as 170 might have survived

if they had been treated elsewhere. We never knew the numbers of how many children had survived surgery but suffered brain damage and other serious injury. The Trust denied that it held data to establish this. Even now, accurate, informative data can be difficult to locate and there is still no centralised collection of data on cardiac morbidity. So, a generation later, we have no measure of success or failure of a surgeon or unit other than 30-day mortality rates – if a child survives for a month he is regarded as a statistical success, even if he has suffered injury in the process. In reality, rates of mortality should provide an alert system only.

Families choosing a cardiac centre often struggle to interpret the data to make properly informed decisions about units and surgeons. The availability of readily understandable data is surely a facet of a meaningful duty of candour across the wider NHS. Reflecting this, Great Ormond Street hospital announced in 2016 that they were leading an ambitious National Institute for Health Research (NIHR) funded joint project to achieve a better understanding and categorisation of the non-fatal complications that can occur in children after heart surgery.

Despite cardiac surgery leading the way in the publication of data after Bristol, serious problems relating to reporting in this field have persisted. Operations at the children's cardiac unit at Leeds were controversially suspended in 2013 after NHS Medical Director Sir Bruce Keogh announced he wasn't satisfied with incomplete data disclosed by the unit in response to concerns that were reported to have been brought to his attention. The unit was soon reopened but it became difficult to establish whether and if so to what extent there really were problems at Leeds because the available data was so hard to interpret and allow comparisons to be made with the performance of other units.

In March 2016, following reports of long-standing problems at the adult cardiac unit at Queen Elizabeth Hospital, Birmingham, an editorial in the Guardian referred to the unit's 'disdain for the data' and the fact that, two decades on from the Bristol Scandal, the NHS 'continues to harbour some dangerously defensive instincts'.

More transparency is needed but the recommendation in the recently published Paterson report (see below) that every surgeon's expertise and experience should be published on a website may too simplistic. Paediatric cardiac surgery in particular is a 'team sport' involving a wide range of specialisms and this would not reveal the full picture.

Many of the Kennedy recommendations remain unresolved.

Whistleblowing

Sadly, whistleblowing in the NHS continues to be career suicide for medical staff. It is inexplicable that this is still the case given the cost to the NHS of ignoring warnings over dangerous practices that could have been addressed if the concerns of a whistleblowing doctor or nurse had been investigated. Every scandal that has emerged over the years since Bristol seems to have involved whistle-blowers who have been ignored or worse, suppressed , and intimidated.

Professor Sir Ian Kennedy carried out a detailed, robust review of disgraced breast surgeon Ian Paterson's NHS activities in 2013 and found that whistle-blowers had repeatedly been ignored. He said this was "a blight on the NHS and is one of the principal areas where lessons must be learned"

Twenty years after Kennedy's Bristol report NHS Trusts still go to astonishing lengths to suppress whistle-blowers, spending significant sums defending cases brought by employees who have blown the whistle. Whistle-blowers are still gagged as part of pay-off deals. Investigative journalist Tommy Greene made a number of FOI requests and revealed in a Telegraph report in January 2020 that NHS Trusts had spent £20m over a 4-year period battling whistle-blowers and contesting discrimination claims (see reference). So much for a learning culture we wanted to see in the NHS after Bristol

Reorganisation of children's heart units: Reconfiguration

Reconfiguration of our children's heart units, intended to concentrate expertise in a smaller network of national centres, was never completed as originally envisaged in the 2001 Kennedy report. The Government tried unsuccessfully to force through what became a long-delayed programme of national reorganisation and closure of units first proposed by Kennedy. The Safe and Sustainable Review, established in the wake of the Inquiry, brought about the suspension of operations at the John Radcliffe unit, Oxford in 2010, over which there had been worrying issues ever since the time of the Kennedy report. Even then, it was several years before action was taken.

Although there was a will to progress this in the early years, reconfiguration became a highly controversial

issue. Local populations and their MPs became involved in campaigns to resist closure; Leeds enlisted the support of the Archbishop of York. NHS medical director Professor Sir Bruce Keogh later described the delay in implementing this Kennedy recommendation as a 'stain on the soul of the specialty.' A generation on demographics has changed – the solution was ...

"Forgotten Inquiries"

When the report into the long-running scandal at Mid Staffs hospital was published in 2013 Dr Phil Hammond suggested in Private Eye that many of Sir Robert Francis QC's 290 recommendations could have been cut and pasted from Kennedy's 198 recommendations in the 2001 Bristol report. Dr Hammond made a similar 'cut and paste' observation in February this year regarding the recommendations in Bishop Graham James' Paterson report. The Paterson scandal which had its roots as far back as 2003 when colleagues first raised concerns involved a rogue surgeon carrying out unnecessary and inappropriate operations and inflicting life-changing harm on patients over a 14 year period before he was eventually stopped. The "culture of avoidance and denial" in a "dysfunctional" healthcare system where there was "wilful blindness" to his actions identified in the report sounded all too familiar. The Inquiry recommended that 11,000 former Paterson patients should be recalled for their surgery to be assessed.

Incredibly there were problems again in Bristol in the years 2012 to 2014. Following a series of deaths at the children's heart unit Professor Sir Ian Kennedy was called in again after families tweeted their concerns to NHS Medical Director Sir Bruce Keogh who appointed Eleanor Grey QC to carry out the New Bristol Review for NHS England with Kennedy as Consultant Adviser. The CQC had issued a Warning Notice in 2012 after Inspectors noted a lack of sufficiently experienced staff to meet the needs of children requiring high dependency care. We represented 10 families at inquests into deaths over the period covered by the Review. The report, published in June 2016 (which parents described as 'inexcusably weak'), found that much of the care was good but the treatment of 27 children raised particular concerns. Bristol's 30-day mortality was found to be the 6th lowest in the UK out of 13 units. The report included 32 recommendations including the need for a national review of paediatric intensive care units.

The call for a public inquiry so that scandals can be scrutinized and for lessons to be learned has become the inevitable and wholly understandable reaction of governments since Bristol and before that the 1969 inquiry into the abuse of patients at Ely Hospital , Cardiff. Many similar recommendations had been made even earlier than that in the Platt Report into the Welfare of Children in Hospital published in 1959. The problem is the failure of governments to follow up Inquiries and introduce a statutory mechanism making it mandatory to review and ensure implementation of recommendations of these hugely expensive investigations.

So, have the lessons of the Bristol Scandal of the 1990s been learned? Sadly, many of the issues investigated by the Kennedy Report still arise today. Some of the systemic, cultural failures at Bristol in the 90s have been repeated more than a generation later.

Much is rightly made of the need for a learning rather than a blame culture but with scandals including those that have emerged in Shrewsbury & Telford – described as the biggest in maternity services in the history of the NHS – and East Kent which involves reports of over 300 babies suffering brain damage as a result of oxygen deprivation during birth over a 4 year period - steps have to be taken to make doctors and managers accountable. This seems to be unavoidable. Sadly it is a case of the bad apples spoiling it for the overwhelming majority of doctors who are dedicated and conscientious but the medical profession seems collectively to have turned a blind eye and allowed these problems to grow from manageable failings into major scandals. The NHS simply can't afford these scandals. A dangerous state of affairs which exposes patients to a real risk of avoidable harm of which senior staff and management are aware but have failed to address exposes the NHS to negligence claims which it will find difficult to defend.

What is the solution? Listening to concerns raised by medical staff on the ground is crucial. Whistleblowing, like litigation, a blunt instrument to correct errant behaviour, drive up safety standards and achieve a measure of accountability, but why not impose a duty on managers to ensure that whistle-blowers in their organisations are encouraged and protected and their concerns properly investigated. What's the harm? I can't think of any whistle-blowers whose concerns over patient safety have not eventually been vindicated.

Dealing With Clinical Negligence Claims When English Is Not Your Client's First Language

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In this modern society the need to be understood is a necessity, especially for doctors or nurses meeting and caring for patients in hospital, or at the GP surgery. The recent reporting of the tragic situation for one of my clients (Mr Pintilie) reminded me of this once more.

When medical jargon is used, it can be very difficult for patients to grasp what a doctor or nurse is saying or explaining to them. If they are unwell and in a state of panic or emotional upset because of their medical condition, it can be even more unsettling.

A doctor's time is limited and there is only so much that can be said, at an appointment or consultation, and it is important that the doctor or nurse is understood and the patient understands what is said to them, expected of them and they are able to ask questions where appropriate.

This situation is much worse if the patient's first language is not English. To be in an environment which is intimidating, unknown and not to be able to speak the native language of those treating you in hospital or at the doctor's surgery is probably a very scary situation.

I ended up in A & E when on holiday in Croatia 3 years ago and it was difficult. I could not understand the process, I did not know what was going to happen, how long it was going to take and I was very anxious despite previously working as a nurse and having over 21 years' experience working as a clinical negligence practitioner. The two and a half hours waiting at night-time in a hospital where only a few departments were open and a handful of staff were on duty was a very different experience from the NHS which is all systems go 24/7. The hospital was dark, creepy and the atmosphere was eerie.

I was not able to express myself and I was short of breath as one of my ribs was protruding and I was made to go into a room off of a small corridor where I was met by two nurses and administration staff. It was very difficult as I had to show my rib to the staff while the door to the waiting area full of patients was left open.

Eventually I was guided to x-ray and I was asked if I had been in a car accident. This made me panic a little. It was a minor situation, yet I was anxious and out of my comfort zone. I could not use google translate as I did not have a signal on my mobile phone and I had two my two children aged 10 and 12 with me and they were anxious and nervous walking around the strange desolate, dark hospital.

The difficulties of being understood by medical staff

If you are unable to express how unwell you feel; explain your previous medical difficulties or understand what the medical and nursing staff are telling you things become very difficult very quickly. GP's often use google translate.

In my case of Gabriela Pintilie (deceased), Gabriela was a Romanian woman who was 36 years of age and pregnant with her first child. At the time of her admission to hospital she was married and had a 15-year-old son and she had lived in the UK for 4 years. Up until she took maternity leave, she was working full time for a clothing manufacturer, packing clothes. Her command of the English language was good, and she spoke English very well. Her husband on the other hand, although working full time as a lorry driver was not able to speak English.

This was very difficult as when Gabriela was in hospital she had to translate what the medical and nursing staff were saying to her at the time, to her husband so that decisions that she needed to make in respect of delivery of her daughter could be made with her husband. While Gabriela was well, she was able to take on the responsibility of the translation of her medical care to her husband, despite the stressful situation that they found themselves in. She had opted for an elective C-section, but the plan of her care was changed during labour to vaginal delivery. It is unclear if she was happy with this. When her labour did not progress, she was then told that a C-section would be carried out, but this was significantly delayed.

However, once Gabriela was taken to theatre (out of hours) it soon became evident that the language barrier would create further difficulties for this family.

Gabriela remained awake during her C-section having opted for an epidural. The C-section had been significantly delayed and did not take place until 42 hours after her waters had broken. Further it took place after the elective C-section list had been completed and at 9.26pm when there were less staff in the hospital.

Post C-section Gabriela's husband left the theatre as he was unable to stay as he felt unwell. He left the theatre and sat outside. He was isolated from his wife and the medical and nursing staff. He then saw commotion in the theatre. He did not know what was going on which led to him becoming anxious and afraid. The treating doctors found it difficult to communicate with him when they needed consent from him to carry out emergency surgery on his wife, in an attempt to save her life. The doctors had to act quickly. They used google translate and it was very difficult for all parties concerned. Gabriela's husband was confused he was apparently given conflicting information about his wife's wellbeing and he was left outside theatre for several hours just holding his new-born daughter. He was afraid and uncertain as to what was happening.

Gabriela Pintilie suffered a major obstetric haemorrhage post-delivery of her daughter and she did not recover from this.

Eleven months after her death an inquest touching upon her death was held. Her husband attended the inquest each day and a court appointed interpreter also attended. This person had no knowledge of the case and arrived a short while before the hearing commenced. There was very little time for the interpreter to become au fait with the factual evidence and yet had to translate every single piece of evidence given in court. Fortunately, I was able to arrange for a Romanian colleague of mine who is a qualified solicitor in England and Wales to also attend the inquest with me so that she could spend time with the deceased's husband if he needed to leave the court room at any time. She was also familiar with the case and had met him several times prior to the inquest and was able to speak with him in depth about the case and how he was feeling during the process.

It is important that clients who do not speak English as their first language are able to express how they are feeling and interact with their legal team. They should be aware of what they are agreeing to and what they are signing.

More importantly, their expectations and goals must be recognised and met from the outset.

The senior coroner at Gabriela's inquest said that '*confusion was exacerbated by language barrier*.'

Following on from Gabriela's death the NHS Trust concerned made various recommendations one in particular that:

'Patients whose first language is not English should have at least one visit with professional interpreter'.

The senior coroner reminded the NHS Trust that it was not just the patient that they had to consider in this respect, but the spouse/partner of the patient.

Tom Moberly in his article in the BMJ in September 2018 has said that a research team at the London School of Hygiene and Tropical Medicine said that doctors use online translation tools. Sadie Bell, a research fellow in public health evaluation at the London School of Hygiene and Tropical Medicine, said at the Public Health Annual Conference on 11 September 2018:

"Healthcare workers discussed challenges during consultations with communication.... A large number of healthcare workers reported relying on using online communication tools- so, Google Translate – rather than going to more formal modes of communication, using telephone or face to face interpreters.... The perception around telephone and face to face interpreters was that they could be expensive and time consuming and that there are going to be issues with the messages getting lost in translation."

There are many challenges for lawyers too. Seeking instructions from a client whose first language is not English is time consuming. Often information can be lost in translation. Clients can view the issues with reference to the way hospitals are run in their native country. They may often view the law in their own country as being the way that their case is going to be conducted here in England. If so, it is essential to ensure that all client care letters, funding arrangements and accompanying letters are translated into their native language.

At Osbornes Law we act for many clients whose first language is not English and our client care letters, funding arrangements and other letters and documents are prepared in various languages to ensure that our clients are fully informed from the outset.

We also have access to foreign speaking experts and case managers which assists in the larger cases where the client has suffered a catastrophic injury so that the

case manager and legal team can work with the client together and get to the hub of the salient issues quickly.

Important documents such as medical records, witness statements, medical reports and Schedules of Loss and Damage are translated into the client's language.

In Gabriela Pintilie's inquest, I made sure that her husband's statement was translated into Romanian and that the expert evidence commissioned by the coroner was translated as well as the NHS Trust's Root Cause Analysis report. This saved so much time during the inquest and assisted the interpreter and the senior coroner greatly.

Foreign Language Legal Support Teams

At Osbornes Law, we are fortunate enough to have practitioners in our personal injury and clinical negligence department who speak a multitude of languages including Polish, Romanian, Bulgarian, Hungarian, Slovakian, Czech and Spanish. Many of the clients I represent come from Eastern Europe and some have suffered significant life-changing injuries and require access to tertiary services which is a complete minefield for them to organise on their own without assistance.

Our team spend time with our new enquiries from the outset as well as existing clients, they assist in translating medical reports and preparing witness statements and that allows the cases to proceed with ease.

Our foreign speakers also attend court hearings; inquests, conferences with counsel and they can usually translate medical records from the client's country of origin. They work with case managers too, keeping the client fully briefed and always central in everyone's minds.

Our aim is to be truly client focussed and to ensure that our clients understand what is going on and more importantly what is required of them. Often information can get lost in translation and coupled with client anxiety and distress communication channels can become difficult. When clients are most vulnerable communication is the key to providing advice, assistance and structure in often life changing circumstances.

Why We Should Use The Median Rather Than The Mean For Life Expectancy

WILLIAM CHAPMAN
7BR

1. The Ogden Tables are based upon mean life expectancy for men and women. This is wrong. It should be based upon median life expectancy. It makes a significant difference for younger claimants. Using the mean tends to understate life expectancy by up to 3 years for men and 2 ½ years for women compared to the median for young claimants. Using the mean tends to overstate life expectancy by up to 8 months for claimants over the age of 80.

Table 1: Mean and Median life expectancy for men and women at different ages [2]

	Men, years			Women, years		
Age	**Mean**	**Median**	**Difference**	**Mean**	**Median**	**Difference**
0	89.88	92.93	3.05	92.48	95.05	2.57
10	78.98	81.79	2.81	81.63	84.04	2.41
20	67.74	70.60	2.86	70.51	72.99	2.48
30	56.70	59.46	2.76	59.48	61.95	2.47
40	45.91	48.41	2.50	48.63	50.98	2.35
50	35.46	37.47	2.01	38.01	40.07	2.06
60	25.52	26.84	1.32	27.87	29.36	1.49
70	16.67	17.05	0.38	18.53	19.21	0.68
80	9.27	8.78	-0.49	10.45	10.22	-0.23
90	4.24	3.56	-0.68	4.71	4.06	-0.65
100	1.86	1.43	-0.43	2.02	1.57	-0.45

2 *ONS data, principal projection for 2016, with age attained in 2020.*

2. It is a difference that, if justified, would make a significant difference for Schedules of Loss for young claimants. An additional 3 years for a multiplier in an obstetric case could be worth several hundred thousand pounds.

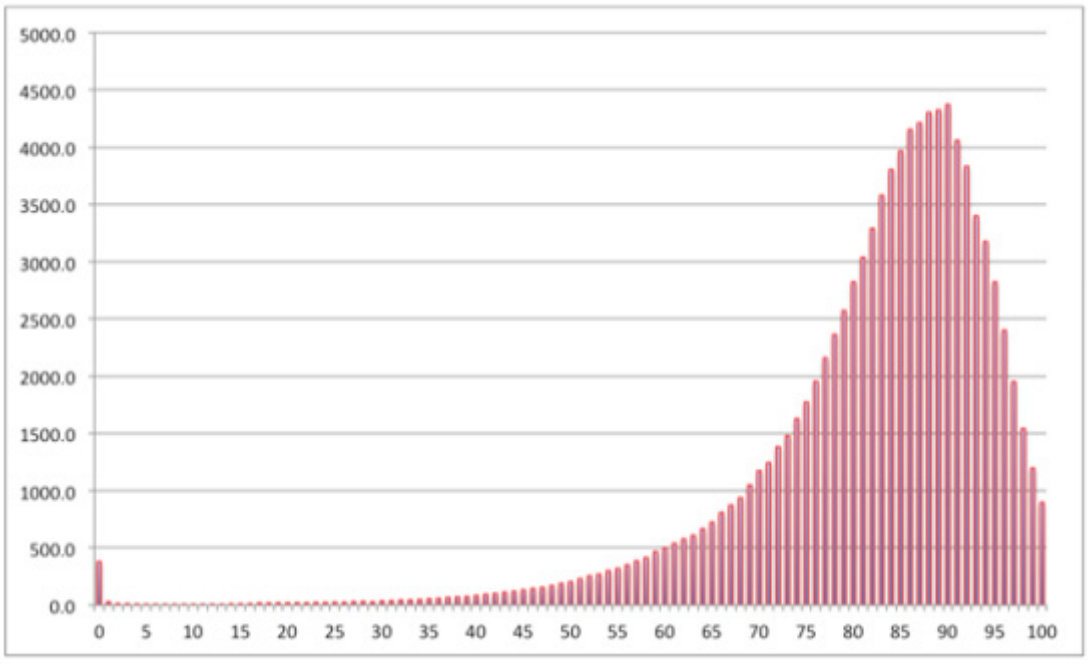
3. This article seeks to justify the use of the median. It suggests a suitable way of calculating the multipliers required in calculations for damages in personal injury claims.

Why is there a difference between the mean and median?

4. The mean sums every observation and divides by the number of observations. The median ranks every observation in order and selects the observation in the middle. Therefore, the median is unaffected by the magnitude of observations either side of the median. Since the mean is affected by every observation, it is affected by outliers. The median is not.

5. This makes a difference when the distribution of observations is skewed. Mortality is heavily left-skewed. This is because there is effectively an upper bound for age at death. Virtually no one lives beyond 110. On the other hand, people do die early because of accidents and other freak misfortunes. That brings the mean down to below the median.

Figure 1: Numbers of women expected to die at each age assuming mortality remains as it was in 2010-2012[2]. Mean=83; Median=86; Mode=90.



6. Using the data in Figure 1, a woman at birth will probably reach the age of 86 or higher. Half of all women will. Yet, the mean says that she is expected to live for only 83 years.

7. As a person gets older, the left-skewed tail ceases to be relevant. The person has survived the accidents and misfortunes of youth. It is now age itself that is pressing. What is left of the curve becomes less skewed. The mean and median tend to converge. Beyond the age of 70, in fact, the curve becomes slightly *positively* skewed; the mean begins to exceed the median. This explains the figures in Table 1.

2 *https://understandinguncertainty.org/why-life-expectancy-misleading-summary-survival*

Is the difference justified?

8. For any person under 70, using the mean tends to underestimate how long that person will probably live. The mean is skewed by outliers, by misfortunes that are unrelated to age.

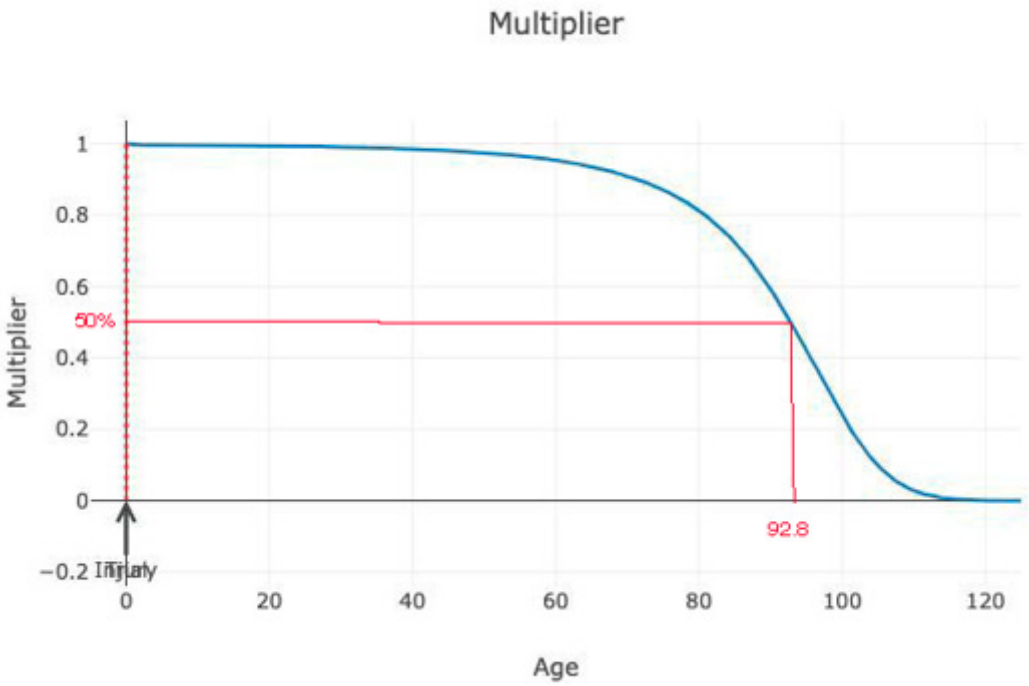
9. It is the same reason that the median is used to calculate 'average' income. Income is skewed the other way. It is *positively* skewed. No one earns less than a certain subsistence amount. That is a lower bound. But there is no upper bound. A few people earn vast sums. The mean is higher than the median. We choose median income because that is not skewed by the atypical earnings of a few.

10. In the same way, a person's expectation of life should not be skewed by the atypical experiences of a few.

Calculating the median life span

11. The median is the middle observation of all the observations ranked in order. This can be seen readily in a cumulative graph of survival statistics, Figure 2.

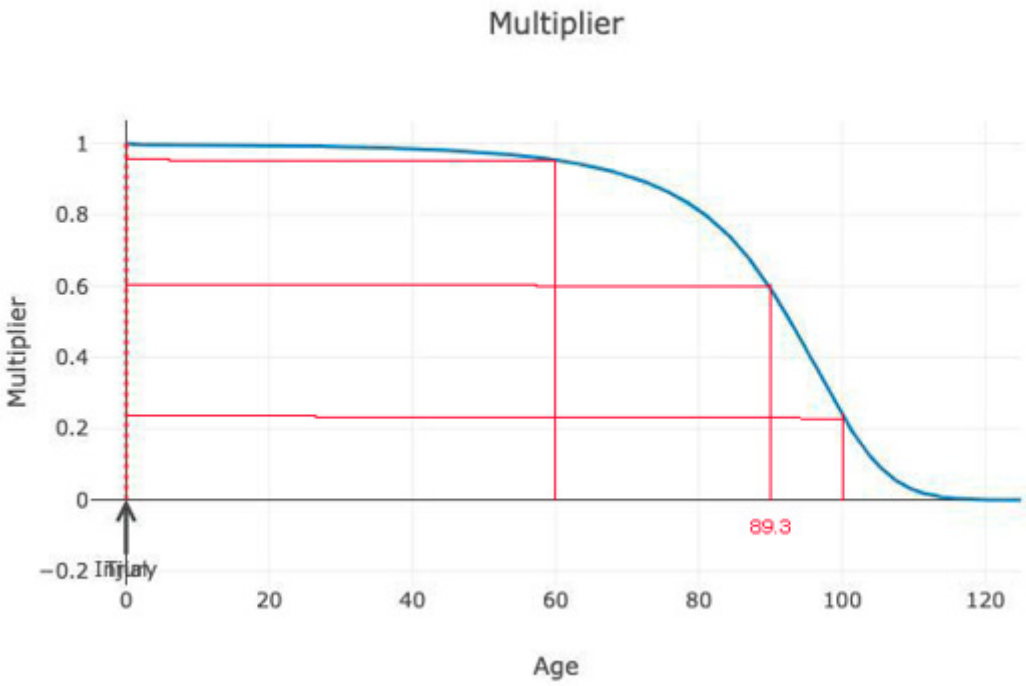
Figure 2: Probability that male born in 2019 will reach given age (ONS data 2016)



12. Half the males born in 2019 will live beyond 92.8 years. Half the males born in 2019 will die before 92.8 years.

13. How should we use the median to calculate the typical number of years a person is expected to live between two given ages in the future?

Figure 3: Median survival between the ages of 60 and 100 for male born in 2019 (ONS 2016 data)



14. A male born in 2019 has a) a 97.5% chance of reaching the age of 60, b) 22.5% chance of reaching the age of 100. The median male who lives to age 60 but dies before age 100 will live to 89.3 years. This is calculated by taking the median male in the cohort of males that live between 60 and 100: (97.5% + 22.5%) ÷2 = 60%. 60% of males will live until the age of 89.3. Therefore, the median survival in that period is 89.3 - 60 = 29.3 years.

Accounting for accelerated receipt

15. The calculations so far take no account of accelerated receipt.

16. In the first example, we need to discount for a term certain over 92.8 years, using the formula:

$$\frac{d^y - 1}{\ln d}$$

where d is the discount factor and y is the number of years.

17. Using the current discount rate of -0.25% the discount factor d = $\frac{1}{1-0.25\%} = 1.0025063$.

Note that the negative discount rate tends to inflate, rather than discount, future losses.

So the discount factor for a term certain over 92.8 years is $\frac{1.0025063^{92.8}-1}{\ln 1.0025063} = 104.46$. This compares to a multiplier of 100.10 using the conventional (mean) approach, Table 1 Ogden Tables.

18. In the second example, we need to discount for a term certain over 29.3 years and then apply a further discount for accelerated receipt to account for the period until age 60.

a. The term certain over 29.3 years = 30.40

b. Apply a further 'one-off' discount for accelerated receipt over 60 years using the formula

$$d^y = 1.00250627^{60} = 1.1621.$$

c. The overall discounted figure is 30.40 x 1.1621 = 35.33. This is close to the multiplier of 35.43 using the conventional (mean) approach.

Conclusion

19. The median gives the *typical* life expectancy. It is justified for the same reasons that defendant insurers use median income when calculating loss of earnings: it ignores outliers. Using median life expectancy will increase the multipliers for most claimants under the age of 70. There is a marginal difference above that age. The calculations are no more difficult to calculate than for the mean. It would, however, require a new set of Ogden Tables.

"Thou Shalt Not Sit With Statisticians"

THOMAS HERBERT
ROPEWALK CHAMBERS

ROPEWALK
CHAMBERS
Barristers regulated by the Bar Standards Board

Thou shalt not sit

With statisticians nor commit

A social science.

— W H Auden, *Under Which Lyre* (1948)

Introduction

We have all heard a lot about statistics recently – and had a lot of time to dwell on them. We have heard about the risks of making international comparisons; the comparative advantages of logarithmic versus linear scales; and the importance of good and representative data.

For lawyers, two questions arise. Can valid predictions about individual cases be made using statistics? Can statistics alone be used to prove causation?

This article aims to show that the answers to those questions are, respectively, 'yes' and 'no', with a particular focus on the coronial jurisdiction by reference to two recent cases: R *(Chidlow) v HM Senior Coroner for Blackpool and Fylde* [2019] Inquest LR 93 and R *(Smith) v HM Assistant Coroner for North West Wales* [2020] EWHC 781 (Admin).

Using statistics to make predictions

Not long after Auden wrote the lines above, Darrell Huff wrote *How to Lie with Statistics* (1954). Provocative as the title may be, it makes a serious point. The statistical process involves turning experience into (necessarily imperfect) data, then using that data to draw conclusions or make predictions. As Nate Silver put it in *The Signal and the Noise* (2012):

> *The numbers have no way of speaking for themselves. We speak for them. We imbue them with meaning.*

Statistics, then, are always to some extent constructed on the basis of judgements.

A further problem arises when statistics are used to make predictions – so-called 'predictive analytics'. In *The Art of Statistics* (2019), Professor Sir David Spiegalhalter discussed a predictive model called Predict 2.1, which looks at the expected benefit of various adjuvant therapies to suppress secondary tumour formation after breast cancer surgery:

> *Predict 2.1 is not perfect, and the figures [from the model] can only be used as ballpark guides for an individual: they are what we would expect to happen to women who match the features included in the algorithm, and additional factors should be taken into account for a specific woman.*

This difficulty – drawing valid conclusions about an individual using a statistical model – comes to the fore when statistics are deployed to prove causation in legal proceedings.

Statistics and the law

In *Wardlaw v Farrar* [2004] PIQR P19, Brooke LJ opined as follows at [35]:

> *While judges are of course entitled to place such weight on statistical evidence as is appropriate, they must not blind themselves to the effect of other evidence which might put a particular patient in a particular category, regardless of the general probabilities.*

This focus on individual characteristics accords with Professor Spiegalhalter's advice above.

Indeed, the problems with statistical evidence have been considered at the highest level of authority. In *Gregg v Scott* [2005] 2 AC 176, Lord Nicholls of Birkenhead explained them in this way at [28]:

> *Statistical evidence ... is not strictly a guide to what would have happened in one particular case. Statistics record retrospectively what happened to other patients in more or less comparable situations. They reveal trends of outcome. They are general in nature.*

> *The different way other patients responded in a similar position says nothing about how the claimant would have responded. Statistics do not show whether the claimant patient would have conformed to the trend or been an exception from it. They are an imperfect means of assessing outcomes even of groups of patients undergoing treatment, let alone a means of providing an accurate assessment of the position of one individual patient.*

And at [111] in the same case, Lord Hope of Craighead said this:

> *Statistics may act as a guide. In some cases, they may be the only guide that it is available. But they are no more than a guide to that which must be proved. This is because the claim is personal to the individual. It is the effect of the injury on his own prospects of survival that sounds in damages, not the effect which injuries of that type may have on the population generally.*

Both Lord Nicholls and Lord Hope dissented as to the result in *Gregg v Scott*, but their exposition of the status of statistics was consistent with the approach of Lord Phillips of Worth Matravers MR in the majority. Lord Phillips opined that that the statistical model in evidence *"was a very inadequate tool for assessing the effect of the delay in treatment on Mr Gregg's process and prognosis":* see [157] (and see generally [147]-[159]).

It is thus fair to say that the courts have generally been cautious in adopting statistical evidence to prove facts on the balance of probabilities: for an example in a different context, namely epidemiological evidence in industrial disease cases, see Sienkiewicz v Greif (UK) Ltd [2011] 2 AC 229.

Coroners, statistics and causation

Following R *(Tainton) v HM Senior Coroner for Preston and West Lancashire* [2016] 4 WLR 157, it is now well-established that in considering causation, it must be asked whether, on the balance of probabilities, the conduct in question more than minimally, negligibly or trivially contributed to the deceased's death.

It is also well-established, following R *(Secretary of State for Justice) v HM Deputy Coroner for the Eastern District of West Yorkshire* [2012] EWHC 1634 (Admin), that when determining what conclusions or findings to leave to the jury, the coroner must apply the so-called 'Galbraith Plus' test. First, the coroner must ask whether there is evidence upon which the jury properly directed could properly reach the particular finding (applying *R v Galbraith* (1981) 73 Cr App R 124). Secondly, the coroner must consider whether it would be safe for the jury to reach the conclusion or finding upon the evidence.

In R (*Chidlow*), the Divisional Court examined the role of statistics in coronial findings about causation in individual cases and set out a number of principles.

The deceased in that case fell ill and suffered a cardiac arrest during an admitted period of delay before an ambulance arrived. Expert evidence at the inquest was to the effect that, had paramedics arrived earlier, the deceased would, on the balance of probabilities, have survived. This opinion was based on statistical evidence from a number of studies. The coroner held, however, that it was not safe to leave the issue of causation to the jury because the deceased's cause of death was unascertained.

By judicial review proceedings, the deceased's brother sought to quash that decision. The issue was whether causation could be proved by statistical evidence as to the prospects that the deceased might have survived had he received expert treatment in good time.

At [38]-[52], Pepperall J (with whom Hickinbottom LJ agreed) reviewed the authorities before drawing a number of conclusions at [52]. Insofar as relevant:

> *In considering whether it is safe to leave … an issue to the jury, a coroner must have regard to all relevant evidence. In addition to evidence relating to the particular deceased and the circumstances of his or her death, that may include general statistical evidence drawn from population data such as the rate of survival in a particular group.*
>
> *Such general statistical evidence alone is, however, unlikely to be sufficient. For example, even where the rate is over 50%, a raw survival rate for the group into which (without the relevant event or omission) the deceased is said to fall is unlikely to be sufficient because, without evidence supporting the proposition derived from the population data, a jury could not safely conclude that he or she would have fallen into the category of survivors. As Croom-Johnson LJ put it [*in Hotson v East Berkshire Area Health Authority *[1987] 1 AC 750, 769B], being a figure in a statistic does not of itself prove causation.*
>
> *In most cases, there will be other evidence as to whether the deceased probably would or would not have fallen in the group of survivors. Where there is apparently credible additional evidence of causation*

which, if accepted, together with the general statistical evidence could properly lead the jury to find on the balance of probabilities that the event or omission more than minimally, negligibly or trivially contributed to death then it will usually be proper and safe to leave causation to the jury.

Applying those principles at [60]-[63], Pepperall J rejected the submission that the evidence as to causation amounted to "*nothing more than statistics*." The expert had considered the deceased's medical records, the post-mortem findings and other evidence relating specifically to the deceased's case. He did not seek to prove that the deceased was simply "*a figure in a statistic*"; rather, he had given careful consideration to the possible causes of death and the prospects of successful treatment in the deceased's case.

Accordingly, the coroner "*fell into error in concluding that the lack of a clear cause of death prevented the jury from being able to consider the possible causal effect of the delay in treatment*." The question of causation ought to have been left to the jury at stage 2 of the Galbraith Plus test. A fresh inquest was ordered.

The recent case of R (*Smith*) fell on the other side of the line. The deceased in that case was found hanging by the neck from a bannister at her home address. In the weeks prior to her death, she had been under the care of her local mental health team. The coroner obtained an independent report from a consultant forensic psychiatrist, who was highly critical of the care provided to the deceased.

In oral evidence, the forensic psychiatrist stated that the deceased's death "*was not only predictable but preventable*" and that "*over 99% of [patients] do not go on to kill themselves in the coming few years*": see [39].

The coroner referred to *Chidlow* and held that she was not satisfied on the balance of probabilities that the deceased's death could have been prevented.

In the Administrative Court, Griffiths J (delivering the judgment of the court, which also comprised Dingemans LJ and the Chief Coroner) noted at [62] that the forensic psychiatrist's "*use of statistics was couched in very general terms, which made it particularly difficult to use them confidently in [the deceased's] case*". In other words, there was nothing to enable the coroner to safely conclude that the deceased would have fallen into the (statistical) category of survivors.

A distinction was also drawn at [63] between cases such as Chidlow about what ought to be left to a jury and cases such as *Smith* about what verdict or conclusion is open to the tribunal (the jury or the coroner sitting alone) once seized of the question.

As *Smith* was a case in the second category, the relevant question was whether the coroner's decision was irrational in its failure to accept the forensic psychiatrist's evidence about causation of death. At [70], the Administrative Court held that the coroner's conclusion "*was rational and securely based on the whole of her careful evidential enquiry.*"

Various other challenges to the coroner's decision having also failed, the application for judicial review in *Smith* was dismissed.

Conclusion

It is suggested that a number of practical conclusions may be drawn from the above:

- It is possible to use statistics to prove causation in a particular case. But statistics alone are not enough.
- There must be some evidence showing that the relevant person would have fallen into a particular category – that is, some evidence linking the general (the statistical) to the specific (the individual).
- As noted by the editors of *Clerk & Lindsell on Torts* (22nd edition) at paragraph 2-30: "*Proof of causation is almost invariably about a burden of persuasion, and sometimes statistics can be highly persuasive, when used appropriately.*"
- In the coronial context, where stage 1 of the Galbraith Plus test is met on the above basis, it will usually be proper to leave the question to the jury under stage 2.

Postscript: was W H Auden right?

In *Under Which Lyre*, Auden was addressing graduates at Harvard University and admonishing the trend of treating people as anything other than unique individuals.

This is good advice, too, for lawyers dealing with medical negligence and coronial matters. The appropriate use of statistics must always involve an evidential link between the model and the individual.

Amending Your Costs Budget

BARRATTS SOLICITORS | Personal Injury and Clinical Negligence Specialists

ALISON BROOKS, PARTNER
BARRATTS SOLICITORS

We all know the difficulties applying to revise a costs budget unless there have been significant developments or, at detailed assessment, it is decided that there was good reason to depart from the budget. I was recently involved in just this situation for a personal injury client. I succeeded in securing an Order which stated:

> *Upon the Court having found that the Claimant's capacity issues are a significant development, and upon the Defendant agreeing the same amounts to 'good reason to depart' from the Claimant's Budget, such costs relating to capacity are to be dealt with by way of Detailed Assessment and to be treated as outside of the previously approved Costs Budget.*

There are many cases where revision of a budget has not been allowed by the Court, so why did the Court, in this case, decide there were significant developments entitling the Claimant to revise the budget?

Background

The Claimant was a pedestrian who suffered severe brain injury in July 2014. He was aged 26 and was a Latvian national working in the UK. After discharge from hospital the Claimant returned to Latvia and was, after some years, able to obtain employment, albeit at a reduced level from pre-accident.

Liability was in dispute and the claim was robustly defended and medical facilities in Latvia were limited; brain injury rehabilitation did not exist and we were unable to access the few medical records that did exist. However, after calling and emailing the Claimant, in late 2018 it was becoming clearer that the Claimant might require an assessment of his capacity.

The liability trial was listed for February 2019 and the costs budget had been approved in July 2018. A decision was taken for the Claimant to travel to the UK for an assessment which took place in November 2018. A hearing in December 2018 had already been listed in relation to liability evidential matters and, at the time of this hearing, I only had a letter from the consultant neuropsychologist. Consequently, the capacity issue was deferred as there was insufficient evidence to rebut capacity.

Hearing January 2019

Capacity was revisited before the Master, who considered whether a change in capacity was a significant development. The Master accepted that it was and that it would involve amending pleadings, appointment of a litigation friend, advice from Counsel and the Court's approval for settlement of liability and/or quantum. There were additional costs and difficulties for a Claimant in Latvia, translation and involvement of the UK Court of Protection and identifying a litigation friend.

The Defendant argued that capacity ought to have been addressed sooner and raised at the original CCMC in July 2018. However, the sudden return of the Claimant to Latvia without seeing a medical expert in the UK, lack of medical evidence from Latvia and no face to face contact with the Claimant's solicitor, were all factors which persuaded the Court that lack of capacity was not clear cut.

This should have been the end of the matter, but the Court ran out of time to revise the budget so only the issue and pleadings phase was considered and revised.

Approval Hearing

The budget was raised in February 2019, as liability apportionment had been agreed between the parties but was now subject to Court approval.

I prepared a statement which referred the Court to caselaw making it clear that parties must apply for revision of their budgets as soon as possible; there was no doubt these attempts had been made. However, in paragraph 37-8 of the judgement in *Elvanite Full Circle Limited v AMEC Earth and Environmental (UK) Limited* [2013] EWHC 1643,

it stated that the application should be made 'immediately it becomes apparent that the original budget costs have been exceeded by more than a minimal amount' and, in paragraph 38, that the application should be made "**before trial.**"

If the budget were revised before the liability settlement was approved, the only chance to increase the budget would be at detailed assessment with the uncertainty of knowing whether the Court agreed there were good reasons to depart from the original budget. Therefore, with advice from our costs draftsman, the Court was asked to approve the revised budget before approving the liability settlement.

Again, we expected this to be the end of the matter but the Defendant, for the first time, argued that the Master's January 2019 order was final and did not entitle the Claimant to return for other phases of the budget to be revised. The approval hearing in February 2019 was adjourned with costs paid by the Defendant and an order to obtain a transcript of the January hearing. This was only received in September 2019 but did not resolve the problem as each party believed the transcript supported their position.

Final Hearing April 2020

After more than a year attempting to revise the budget, the parties were finally able to agree an order for the Court to approve. The Defendant dropped the argument that an appeal of the January 2019 order had to be submitted. Whilst the Defendant was reluctant to insert the reference to both significant development and good reason to depart, we believed this was essential to avoid the issue being raised again at detailed assessment. The wording of the Order at the start of this article now means the Claimant will merely need to ask the Court to assess the revised budget at detailed assessment; the entitlement to revise the budget in relation to capacity is no longer in dispute.

It would have been extremely difficult to assess the revised budget in April 2020 because all work relating to the capacity for the liability trial had been undertaken, leaving the Claimant with no flexibility to work within the revised costs.

Conclusion

Whilst it remains difficult to establish there has been a significant development to justify revising a budget, this case shows that it can be achieved. The combination of no access to the Claimant and assessment of his capacity outside the UK, coupled with a Claimant who had some independence, was living alone and able to work, were sufficient grounds to justify why this was investigated after the original CCMC and was a significant enough reason to revise the budget.

Claiming Enhanced Hourly Rates on Assessment of Costs

ANDREW HOGAN, BARRISTER
KINGS CHAMBERS

KINGS CHAMBERS

Wisdom hath builded her house, she hath hewn out her seven pillars.

-Proverbs, 9:1

The first point that always arises substantively in a detailed assessment, after a desultory exchange on disclosure (or not) of the receiving party's retainer is the question of hourly rates.

When a costs judge assesses hourly rates on assessment, she does so by directing herself in accordance with rule 44.4 CPR when exercising her discretion to come up with a set of figures to apply to the time claimed on the bill of costs:

(1) The court will have regard to all the circumstances in deciding whether costs were –

(a) if it is assessing costs on the standard basis –

(i) proportionately and reasonably incurred; or

(ii) proportionate and reasonable in amount, or

(b) if it is assessing costs on the indemnity basis –

(i) unreasonably incurred; or

(ii) unreasonable in amount.

(2) In particular, the court will give effect to any orders which have already been made.

(3) The court will also have regard to –

(a) the conduct of all the parties, including in particular –

(i) conduct before, as well as during, the proceedings; and

(ii) the efforts made, if any, before and during the proceedings in order to try to resolve the dispute;

(b) the amount or value of any money or property involved;

(c) the importance of the matter to all the parties;

(d) the particular complexity of the matter or the difficulty or novelty of the questions raised;

(e) the skill, effort, specialised knowledge and responsibility involved;

(f) the time spent on the case;

(g) the place where and the circumstances in which work or any part of it was done; and

(h) the receiving party's last approved or agreed budget.

These factors (a) to (h) are known as the Eight Pillars of Wisdom: formerly there were seven of them, with an obvious nod to T.E Lawrence's classic of desert warfare, but with factor (h) added after the 2013 reforms. So far so good, but in order to properly exercise any judicial discretion, it cannot operate in a vacuum.

It needs either a matrix of norms, or evidence, so that a judge has something to grapple with when making decisions. In costs, for many years, judges had access to figures, set locally, often in consultation with the profession, which permitted them to do that, particularly in the years before composite hourly rates, when the courts still dealt in A and B factors, or overhead and profit.

As the years went by, the A and B process was consigned to history, with composite hourly rates, and the practice of setting rates locally, or at least with reference to local surveys and knowledge, being superseded by the creation of guideline hourly rates on a national basis, albeit with different rates for broad categories of locality.

But since 2010, this national process has broken down: it has been frozen in amber despite the passage of time in the outside world with no updated rates set since then. Not only are the figures bound to be inaccurate, it is not even known whether the hourly rates should necessarily increase when they do change.

In the last ten years, the practice of litigation and the structure of the legal profession has changed markedly, probably with consequent changes to solicitors' overheads, which form the largest constituent part of the hourly rates.

The role of guideline rates is simply that: they are guidelines and not tramlines, and they do not oust or dictate the exercise of the court's discretion, but they serve the essential purpose of providing a starting point for an assessment of hourly rates, and a cross check at the end of that process.

Otherwise, the danger is that a costs judge will simply pluck figures out of the air, usually nice round numbers ending with a "0", which may result in very rough justice to the paying or receiving party.

One of the vexed questions that has been created by the lack of an up to date national or local survey of hourly rates, is uncertainty about how the court should assess hourly rates and in order to provide a partial answer, various arguments can be put forward, with varying degrees of detail, and it has to be said, varying likelihood of success.

The first and most obvious argument is to uplift the 2010 hourly rates by inflation, and to put the figures forward on detailed assessment. It is not hard to calculate what those figures should be. Simple tools online, enable the 2010 figures to be calculated to date, or to an anterior point, and the increase flagged up in tabular form. See for example:

https://www.bankofengland.co.uk/monetary-policy/inflation/inflation-calculator

The counterblast is to point out either that RPI is not necessarily a reliable indicator of for example, wage inflation, which might be a better index for calculating any increase, as the largest part of a solicitor's firms overheads, will be salaries, but also that inflation is of necessity only one factor. How can a judge take that into account, but leave out of account, hot desking, reduced floorspace, IT driven efficiencies, declining numbers of support staff and so on?

Another argument, which has some support in the authorities is to seek to put forward an evidence based argument for a particular set of hourly rates, by putting forward calculations based on **The Expense of Time** or similar methodology, which show the expense rate for the fee earners in question, seeks a certain level of profit upon that that expense rate, and thus produces a specific hourly rate ostensibly grounded in quantitative data, or as lawyers, like to call it "evidence".

The conceptual difficulty with such calculations is that the courts have never been concerned with the expense rate of a particular firm, but only with averages across a locality, or indeed nationally, when setting guideline rates. Otherwise, each and every detailed assessment might become a mini trial of a particular firm's expense rate, and whether the partners really needed Rolls Royces', funded by the firm.

The point is illustrated in **L. v. L. (Legal Aid Taxation) [1996] 1 F.L.R. 873** where Neill L.J., having considered recent authorities as to the principles to be applied by the taxing officer, discerned five propositions which he listed thus, at p. 877:

> *"(1) The general principle of taxation is that a solicitor's remuneration should consist of two elements—first, a sum computed on the basis of an hourly rate which represents what is called the 'broad average direct cost' of undertaking the work; and secondly, a sum, usually expressed as a percentage mark-up of the broad average direct cost, for care and conduct ...*
>
> *(2) The broad average direct cost is to be assessed by reference to an average firm in the relevant area at the relevant time ...*
>
> *(3) The relevant time means the time at which the work was done. No allowance should be made for the consequences of later inflation ...*
>
> *(4) The district judge can draw on his own experience and on information which is provided to him by local firms ... The district judge can also take account of surveys ...*
>
> *(5) An artificially inflated figure for uplift should not be used to correct or compensate for inadequate hourly rates ... Accordingly the appropriate hourly rates should be the rates which 'represented the actual cost to the solicitor at the relevant time doing the relevant work (assuming always that the solicitor has acted reasonably and the costs are incurred at the appropriate level) ...' "*

This approach to using averages, not particular, expense rates was confirmed in the seminal decision of **Wraith v Sheffield Forgemasters Ltd** [1998] 1 WLR 132 where the Court of Appeal cited with approval the formulation of principle by Mr Justice Potter at first instance:

When giving judgment in Wraith v. Sheffield Forgemasters Ltd. [1996] 1 W.L.R. 617 , 624–625 Potter J. said

> *"in relation to the first question 'Were the costs reasonably incurred?' it is in principle open to the paying party, on a taxation of costs on *142 the standard basis, to contend that the successful party's costs have not been 'reasonably incurred' to the extent that they had been augmented by employment of a solicitor who, by reason of his calibre, normal area of practice, status or location, amounts to an*

unsuitable or 'luxury' choice, made on grounds other than grounds which would be taken into account by an ordinary reasonable litigant concerned to obtain skilful competent and efficient representation in the type of litigation concerned … However, in deciding whether such an objection is sustainable in practice, the focus is primarily upon the reasonable interests of the plaintiff in the litigation so that, in relation to broad categories of costs, such as those generated by the decision of a plaintiff to employ a particular status or type of solicitor or counsel, or one located in a particular area, one looks to see whether, having regard to the extent and importance of the litigation to a reasonably minded plaintiff, a reasonable choice or decision has been made. If satisfied that the choice or decision was reasonable, it is the second question 'what is a reasonable amount to be allowed?' which imports consideration of the appropriate rate or fee for a solicitor or counsel of the status and type retained. If not satisfied that the choice or decision was reasonable, then the question of 'reasonable amount' will fall to be assessed on the notional basis of the costs reasonably to be allowed in respect of a solicitor or counsel of the status or type which should have been retained. In either case, solicitor's hourly rates will be assessed, not on the basis of the solicitor's actual charging rates, but (in a case where the decision to retain was reasonable) on the basis of the broad costs of litigation in the area of the solicitor retained or (in a case where the choice made was not reasonable) of the type or class of solicitor who ought to have been retained" That in my judgment is right.

There is however room to argue that where a firm is a specialist firm, that firm is able to put forward evidence of its own expense rates in a quasi-Expense of Time exercise: because the "average" firm in the context of the above decisions, is a notionally generalist firm. It can be argued that particular specialisms require particular and different levels of overhead.

Thus, the argument was approved, though it failed in its application in the case of **Jones v Secretary of State for Wales [1997] 1 WLR 1008** where the court noted:

There are obvious disadvantages in departing from the well-established rule that the hourly rate is to be calculated largely by reference to the local average and nothing I say is intended to encourage such a departure in ordinary cases. However, in a case such as this and providing the master is satisfied that the firm in question is clearly outside the range of local solicitors that go to make up the average rate, I can see nothing wrong in a higher rate. I stress that the higher rate would not be appropriate if the firm had engaged in a case which could reasonably have been handled by other local firms. The costs would not then have been reasonably incurred. In other words, it must have been reasonable to instruct such a firm for the particular case. This point was confirmed, albeit in a different context, in Wraith v Sheffield Forgemasters Ltd [1996] 1 WLR 617, [1997] 1 Costs LR 23 .

I am certainly not suggesting that in routine taxations the solicitor must attend with evidence of all his overhead expenses. If he did, it should cut little ice because the touchstone is usually the local average or comparable rate as was underlined in Johnson v Reed Corrugated Cases Ltd , L & L and many other cases. However, where a solicitor wishes to challenge what may have become the going rate in any area or, as here, to make a special case, he certainly should be required to produce evidence. The master's apparent acceptance of Mr Valentine's assertion that "the expertise which his firm held itself out as providing inevitably created higher expense rates", without evidence was wrong. It also seems to me that the matters he appeared to rely on, relating to Mr Valentine's skill and expertise, should properly have been considered in the percentage mark up and not in the hourly rate.

And:

Of course, I can accept that a specialist firm such as Pitmans, acting for commercial clients will probably have higher overheads than the average Reading firm. They may have to pay their assistant solicitors and other staff higher salaries. It may be reasonable to provide extra facilities for demanding clients. More sophisticated equipment may be required. However, if a master is to assess a reasonable figure he will need sufficient evidence of these matters. There was none in this case. I have nevertheless asked my assessors whether, based on their own knowledge and experience, they could advise me that £100 was, on any view, bound to be reasonable. They could not. They felt it was high. In circumstances I allow the appeal. Since £75 was offered by the respondent that figure will be substituted for £100. For the avoidance of doubt, I accept that if evidence were provided on some future occasion a higher figure might be allowed.

It follows that solicitors undertaking certain specialisms, such as clinical negligence, can rely upon their specialism

to unpick the broad averages that underpin the general approach on the basis of existing authority.

The further interesting point is to what extent the courts will be prepared to entertain more evidenced base arguments because of the lack of any alternative way of calculating rates.

As was observed in the recent case of **Ohpen Operations UK Limited v Invesco Fund Managers Limited [2019] EWHC 2504 (TCC)**

> *As to the first point, the hourly rates of the defendant's solicitors are much higher than the SCCO guideline rates. It is unsatisfactory that the guidelines are based on rates fixed in 2010 and reviewed in 2014, as they are not helpful in determining reasonable rates in 2019. The guideline rates are significantly lower than the current hourly rates in many London City solicitors, as used by both parties in this case. Further, updated guidelines would be very welcome.*

Welcome indeed.

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

(Not The) ACNC – online event

25 June 2020 (09.45 – 13.00)

On the morning of 25 June 2020 – what would have been the first day of the 32nd Annual Clinical Negligence Conference - we will bring some of ACNC speakers directly to you by hosting '(Not the) ACNC2020', an online event featuring the following sessions planned for ACNC 2020, and providing a chance to ask questions to the speakers:

- **AvMA Update**

  Peter Walsh, Chief Executive, AvMA
- **The Legal Update 2020**

  Richard Booth QC, Barrister, 1 Crown Office Row
- **Sepsis, NEWS and Intensive Care**

  Dr Chris Danbury, Consultant Intensive Care Physician and Visiting Fellow in Health Law, Royal Berkshire NHS Foundation Trust
- **Early Neutral Evaluation in Clinical Negligence Cases**

  Rhiannon Jones QC, Barrister, Byrom Street Chambers

Medico-Legal Issues in Surgery

16 September 2020, Outer Temple Chambers, London (rearranged from 18 March)

This one day conference has been designed for solicitors and barristers to illustrate the key medico-legal issues in surgery, and is an excellent opportunity to learn from leading surgeons and develop your understanding to assist you in cases. The medico-legal issues in cholecystectomy, gynecological, ENT and colorectal surgery will all be examined, along with hospital acquired infection and consent and causation. A day not to be missed and essential for your clinical negligence caseload.

Court of Protection conference

30 September 2020, Hilton Leeds City Hotel (rearranged from 26 March)

Since its inception in 2007, the Court of Protection has made crucial decisions to try to protect the well-being of vulnerable individuals. In a rapidly-evolving legal environment, AvMA's third annual Court of Protection conference will examine the current state of litigation and the challenges and responsibilities facing those who work in this important area.

Medico-Legal Issues in the Care of Older People

22 October 2020, 39 Essex Chambers, London (rearranged from 19 May)

Join the 'Medico-Legal Issues in Older People Care' conference to recognise the issues impacting on older people's care, differentiate expected complications from negligent treatment and understand the legal and costs implications for bringing a claim. This is a must-attend conference for clinical negligence solicitors and barristers and healthcare professionals specialising in older people care and clinical governance and will provide the most up-to-date practical and legislative information to help ensure older people get the best care possible and are properly represented.

Medical Negligence & Access to Justice in Ireland Today

5 November 2020, Morrison Hotel, Dublin

We are delighted to return to Dublin for our essential one day conference covering the major issues currently affecting medical negligence litigation and patient safety in Ireland. At such an important time for those working in medical law and patient safety in Ireland, this is a very timely event that you cannot afford to miss.

AvMA Specialist Clinical Negligence Panel Meeting

3 December 2020, 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. This year's meeting will take place on the afternoon of Thursday 3rd December. Registration and a networking lunch will commence at 12.30, with the meeting starting at 13.30 and closing at approximately 17.15.

AvMA's Christmas Drinks Reception, which is also open to non-panel members, will take place immediately after the meeting. The event provides an excellent opportunity to catch up with friends, contacts and colleagues for some festive cheer! Booking will open in September but put this date in your diary now!

32nd AvMA Annual Clinical Negligence Conference

29-30 April 2021, Bournemouth International Centre (rearranged from 25-26 June 2020)

Join us in Bournemouth for the 32nd 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 **obstetrics**, whilst also covering many other key medico-legal topics at such an important time for clinical negligence practitioners.

Networking is also a big part of the ACNC experience. On the evening of Wednesday 28 April, we will be holding the conference Welcome Event at Level8ight The Sky Bar at the Hilton Hotel in Bournemouth, and the Mid-Conference Dinner will be held on the Thursday evening at the Bournemouth International Centre. Our **Charity Golf Day will take place on Wednesday 28 April at Meyrick Park Golf Club.**

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.

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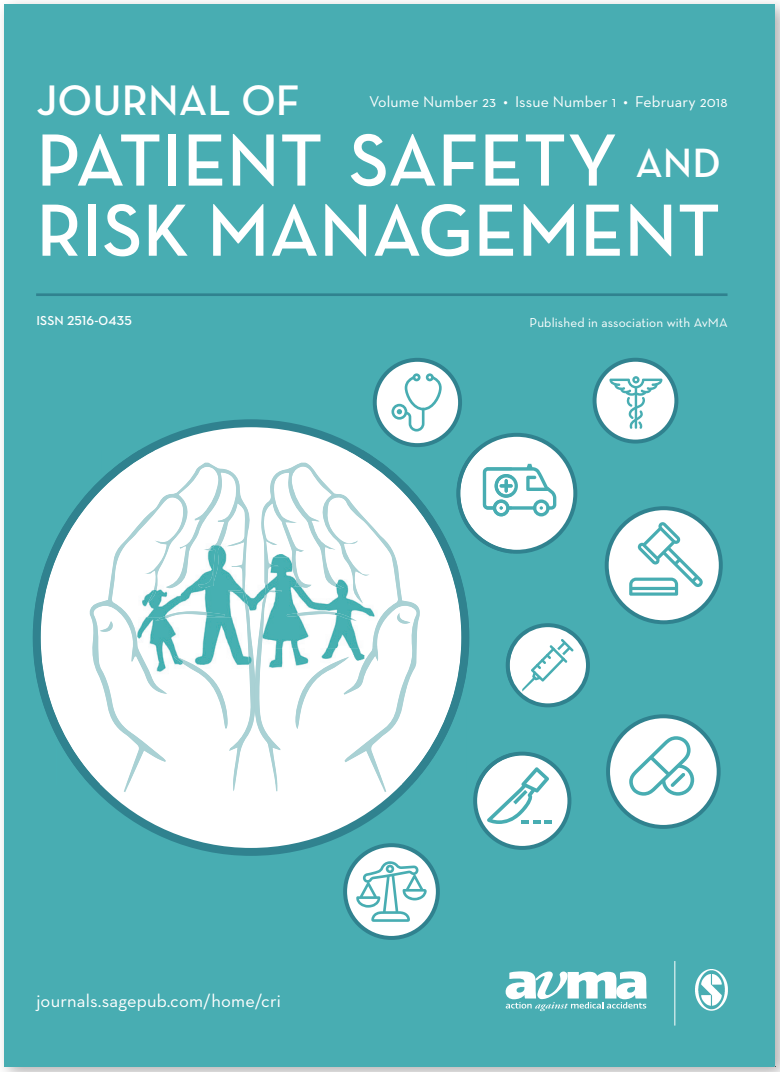

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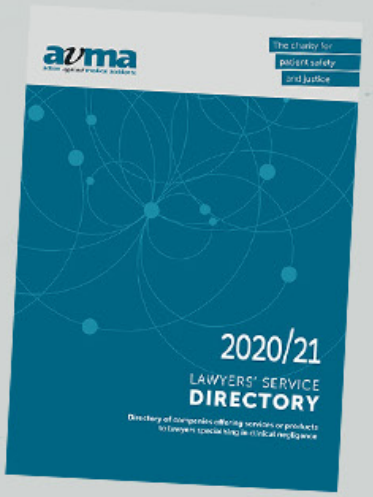

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