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Contents

Editorial 1

Articles 3

Cancer Waiting Times and the Implications in Negligence 3

Time for Change? 5

Alternative Solutions: Collaborative Working in Larger Clinical Negligence Cases 8

How to Ensure Your Expert Evidence Impresses the Court 12

Clinical Negligence Update 16

The Evidential Difficulties in Proving a Montgomery Case 18

The Treatment of Personal Injury Damages on Divorce: Is It Time for a More Principled Approach? 22

Member Offers 27

Patient Safety: Education and Learning at the Royal Society of Medicine 27

Journal of Patient Safety and Risk Management 28

Conference News 29

Forthcoming Conferences and Events from AvMA 29

Webinars: Medico-Legal Information at Your Fingertips 31

ACNC19 Sponsors, Exhibitors & Promotional Sponsors 32

Editorial

Lisa O'Dwyer
Director, Medico-Legal Services

Dear All,

You will recall the very recent headlines highlighting that NHS negligence payments have doubled following a steep rise in delays; Peter Walsh was quoted extensively on this issue highlighting how this has resulted in unnecessary patient suffering and in some cases, death. It is therefore very apt that this edition of the Newsletter opens with an article by **Bruno Gil**, barrister at **Old Square Chambers** on ***"Cancer Waiting Times and the Implications in Negligence"***. Bruno's article draws on data from the recent National Audit Office (NAO) report *"NHS Waiting times for elective and cancer treatment"* (20.03.19) and explores why standards are falling, what might be done to address the delays and the overall impact of the delays on clinical negligence claims.

In my March editorial I outlined some of the changes to the guidance on Exceptional funding for inquests which were introduced by the Lord Chancellor during the MoJ "Review of legal aid for inquests". **James Hargan's** article ***"Time for Change?"*** reminds us just how long the call for equality of arms between families and public bodies in the coroner's court has been running. James is a practising barrister at **Park Square Chambers**, he also sits as an Assistant Coroner.

Matthew Stockwell, is a barrister at **Exchange Chambers**, his article ***"Alternative Solutions: Collaborative Working in Larger Clinical Negligence Cases"*** argues that there is scope for claimant and defendant clinical negligence lawyers to make better use of the APIL/FOIL Guide to the Conduct of Cases Involving Serious Injury (the Guide) especially in cases where damages are expected to be in excess of £250,000. Matthew's article certainly gives us plenty to think about and is an excellent starting point for those lawyers less familiar with the Guide and its application.

"How to Ensure Your Expert Evidence Impresses the Court" by **Marcus Coates Walker**, barrister at **St John's Chambers**, Bristol, looks at how the court approached the expert witness evidence in the recent case of *Keh v Homerton University Hospitals NHS Foundation Trust [2019] EWHC 548 QB*. Marcus's article helpfully sets out the factors a judge should consider when assessing expert evidence.

Thanks go to **Bill Braithwaite QC** of **Exchange Chambers** and his ***"Clinical Negligence Update"*** which gives busy practitioners a very helpful and succinct overview of the key points derived from recent clinical negligence judgments. Bill's overview draws attention to how the decision in Montgomery continues to shape current case law. The importance of Montgomery is explored further by **Dominic Ruck Keene** barrister at **1 Crown Office Row** in his article ***"The Evidential Difficulties in Proving a Montgomery Case"***. Dominic's article focuses on two key issues, first proving what advice should have been given to the patient and second, what the patient's choice of treatment would have been, if they had been in possession of the relevant information.

Specialist claimant, clinical negligence lawyers are only too aware that even where their client has secured a substantial award of damages, money can be a blunt tool. All too often the actual human cost of living with a family member who has sustained devastating injury takes its toll and can result in the breakdown of a marriage/relationships. When this happens, there is considerable uncertainty around how the courts will treat the award of damages. This is a complicated area which is very ably tackled by **Sarah Edwards**, barrister at **7 Bedford Row** in ***"The Treatment of Personal Injury Damages on Divorce: Is It Time for a More Principled Approach?"***. Sarah has a well-deserved reputation as an experienced and respected clinical negligence and family barrister, the article offers some useful and practical suggestions on how to protect the injured party's damages in the event of divorce.

Lawyer Service members will be aware that AvMA has negotiated preferential rates for membership of the Royal Society Medicine (RSM) the enclosed article entitled "***Patient Safety: Education and Learning at the Royal Society of Medicine***" aims to give an overview of their education programmes and events.

Last, but not least, AvMA, in association with Daniel Lewis Law and Partners in Costs (PIC) are pleased to announce the finalists in the three Awards Categories. In no particular order, the finalists are:

Clinical Negligence Rising Star Award: **Wallis Crockford** (Moore Blatch LLP); **Oliver Thorne** (Slee Blackwell LLP); **Jade Elliot-Archer** (Irwin Mitchell LLP, Birmingham); **Victoria Beel** (Slater & Gordon LLP, Manchester); **Stephen Clarkson** (Slater & Gordon LLP, Manchester); **Dannielle Hart** (Slater & Gordon LLP, Cardiff); **Ania Bean**, (Irwin Mitchell LLP, London); **Heather Moore** (Slater & Gordon, London); **Katheryn Riggs** (Tees Law, Cambridge); **Chrissie Wolfe** (Irwin Mitchell LLP, Birmingham).

Court of Protection Deputy Award: **Gillian Knight** (Court of Protection Law Ltd); **Annabelle Vaughan** (Coffin Mew LLP); **Jeremy Abraham** (Dawson Cornwell); **Andrew Cusworth** (Linder Myers LLP); **Hugh Jones** (Hugh Jones Solicitors).

Outstanding Achievement Award: **Nigel Poole QC** (Kings Chambers); **Julie Hardy** (Barratts Solicitors); **Ian Cohen** (Simpson Millar); **Emma Doughty** (Slater & Gordon LLP, London); **Yvonne Agnew** (Slater & Gordon LLP, Cardiff).

Once again, the competition was fierce, the winners of each category will be announced at the dinner at the AvMA conference in Leeds on Friday 28th June.

We look forward to seeing you at the annual conference in Leeds on 27th June.

Best wishes

Cancer Waiting Times and the Implications in Negligence

BRUNO GIL
OLD SQUARE CHAMBERS

The Report

The National Audit Office (NAO), on 20 March 2019, published its report *"NHS waiting times for elective and cancer treatment"*.

This article focuses on the report's findings in relation to cancer treatment. Its results are eye catching, and clinical negligence practitioners may want to keep a weather eye out for the ramifications.

When analysing cancer treatment, there are two key standards that the report utilises as a measure of whether the NHS is working efficiently. These standards have come about through the NHS taking a policy decision to promote earlier and faster detection and treatment of cancer. These key standards are:

(i) that 93% of patients are to be seen by a cancer specialist within two weeks of a GP referral, i.e. a two-week wait from referral to first appointment; and

(ii) that 85% of patients should wait a maximum of 62 days from referral to treatment.

While there are plenty of other standards, these two are the real focus of the NAO's report.

The Findings

The overall picture is of an increasing number of people being referred through the two-week wait urgent pathway – an inevitable outcome of a drive towards early cancer detection. Numbers have gone from 1 million people in 2010-11, up to 1.94 million in 2017-18 (i.e. an increase of 94%).

Seven out of eight cancer standards were being met from 2013-14 to the end of 2017, despite patient numbers increasing. There has, however, been a decline since then. It is no longer the case that most standards are being met. Compliance with the high-profile "two-week wait" standard was breached in April 2018 and has not recovered.

The one standard that has not been met for any quarter since the end of 2013 is the 62-day wait, which is considered by the NAO to be the most important standard as it measures the entire patient pathway. By November 2018, only 38% of NHS Trusts met the standard. This is an improvement from June 2018 when only around 33% did.

Instead of 85% of patients being treated within 62 days, in July to September 2018 only 78.6% were. The NHS is not meeting this critical target.

It is, of course, wrong to speak of the NHS as though it is one entity – there is variation across the CCGs of England. Percentages of patients treated within 62 days varied from 59% in some to 93% in others.

It is also wrong to speak of cancer as though it is a single disease – there is variation across cancer types. Performance against the standards tends to be significantly lower for lung, lower gastrointestinal and urological cancers.

Why Are Standards Falling?

It is an obvious question with an obvious answer. The NHS cannot cope.

An ageing population inevitably means an increase in cancers in the population. Meanwhile, a policy of encouraging early referrals into a system with finite capacity causes a backlog. The NHS is unable to keep up with the referrals, causing performance against waiting standards to fall.

The constraints on capacity are irrefutably linked to a lack of finance and infrastructure. Persistent staff shortages in diagnostic services only compounds the problem.

Performance is also correlated with pressures from urgent and emergency activities. Trusts struggling with A&E wait times tend to perform worse with cancer wait times, again indicative of an overall lack of resources.

Interestingly, the analysis also found that the more service providers involved, the more likely it is that cancer

treatment is delayed; a particularly interesting finding in these times of prolific sub-contracting of services.

What Might Be Done?

It used to be the case that there were financial sanctions for breaching waiting times standards, but these have been gradually removed since 2015-16. The logic of monetarily penalising a financially-strained organisation always seemed dubious.

The answer appears to be that significant investment is what is required, which will allow the additional staffing and infrastructure required. The report estimates an extra £700 million would reduce the waiting list to the size last seen in March 2018. Of course, far more will be needed if the situation is to improve rather than just return to the state it was in one year ago.

Clinical Negligence Claims

The report opines that longer waiting times may lead to patient harm and clinical negligence claims. Of that there can be no doubt.

There is currently no analysis available to show the extent to which patient harm has occurred as a result of these increasing waiting times, but it stands to reason that delays are leading to cancer progression, leading to harm, leading to clinical negligence claims.

According to the report, 40% of clinical negligence claims are because of delays in diagnosis or treatment. With more cancer patients having to wait for treatment, and with no sign of a significant cash injection to address this specific issue, there will invariably be an increase in the number of these claims.

Clinical negligence practitioners (when dealing with new cancer delay and treatment enquiries) would be well advised to pay particular attention to the time taken for each stage of treatment, as well as the entire patient pathway. It is now clear that NHS Trusts are falling behind standards and patients are having to wait longer as a result, with some CCGs being worse offenders than others. These longer delays, sadly, are likely to have very serious consequences for patients.

Time for Change?

JAMES HARGAN
PARK SQUARE CHAMBERS

The need for public funding of representation for families at inquests is not a new issue.

In 2003 the report of a Fundamental Review of Death Certification and Investigation in England, Wales and Northern Ireland was published.

The review, commissioned by the Home Office in 2001, was undertaken by an eminent panel, and chaired by Tom Luce, and made a series of wide-ranging recommendations for reform of the inquest system.

Luce noted that the recommendations of a Government-commissioned Review chaired by a High Court Judge in 1971[1] had been that legal aid should be made available to interested parties for representation at an inquest, and noted that the current (ie. in 2003) provisions for assessing applications for legal aid for inquests looked at significant wider public interest, or overwhelming importance to the client, and were means-tested.

The Review had received a "considerable number of representations to the effect that it is unfair to a family if, for example, at an inquest into a hospital death, the NHS Trust is represented by a barrister or solicitor paid for from the NHS budget but the family is on its own."

It was calculated, based on survey evidence at the time, that it was just under 3% of inquests in which a public authority (ie. including an NHS Trust) was represented but the family were not.

Luce recommended that inquests should so far as possible be conducted in a style that was accessible to unrepresented people, and considered that the criteria at the time for grant of legal aid at inquests were "broadly satisfactory". It is interesting, when considering that comment, to remember that it was those provisions which denied funding to the families at the original Hillsborough inquest.

1 Brodrick J; Committee on Death Certification and Coroners. Cmnd.4810

Luce's recommendations included that "there should be a more liberal interpretation of the criteria in cases where a public authority is represented."

It was considered that the number of inquests which would be affected by a change in funding was small, and the cost implications were estimated at around £3m per year.

The Legal Aid, Sentencing and Punishment of Offenders Act 2012 (LASPO) came into force on 1st April 2013. Sections 8 – 12 cover Civil Legal Aid. Where funding for advocacy at inquests is available, it is provided under the Exceptional Case Funding provisions. (Although Legal Help (section 8, and sch 1 pt 1 para 41) is more widely available, it does not include funding for advocacy at inquests.)

Exceptional Case Funding is currently available via two alternative narrow routes (both involve means testing[2]);

Route 1 – exceptional case determination – which means in reality article 2 cases, plus further conditions, which will be looked at briefly below.

Route 2 – wider public interest determination.

Neither route is straight forward or without hazard. LAA caseworkers determine applications in accordance with Exceptional Funding Guidance, and the burden is on applicants to show that their application satisfies the tests.

An exceptional case determination will only be made in relation to an article 2 inquest where the applicant can satisfy the LAA caseworker that, that representation is necessary in order for the state's procedural obligation to be discharged.

A wider public interest determination requires an applicant to show that the provision of funding for advocacy at the inquest (into the death of a member of their family) is likely to produce a significant benefit for a class of person, other than that individual and their family. Whether or not a benefit is significant is left to the discretion of the

2 Subject to discretionary waiver

determining caseworker. Class of person is not defined, but it probably means at least 100 people.

In the case of an application according to either route, a letter of support from a Coroner may be of assistance, but is far from determinative.

Section 51 of the Coroners and Justice Act 2009 had included public funding for advocacy at inquests into deaths in various forms of custody and detention, but that provision was repealed by LASPO before it drew breath.

Luce had thought it appropriate to highlight the claimed unfairness of families in hospital death cases facing NHS Trust funded lawyers as litigants in person, and it may be those sorts of cases the panel had in mind when recommending a more liberal interpretation of the funding criteria for cases where a public body is represented.

Following the conclusion of the fresh Hillsborough inquests in April 2017, – at which the families were accorded representation by grace of special government provision – the then Home Secretary commissioned Bishop James Jones, as Chair of the Hillsborough Independent Panel, to produce a report on the experiences of the Hillsborough families so that their "perspective [was] not lost".

Bishop James reported in November 2017, and the report covered many areas, including issues about availability of public funding for representation at inquests.

Bishop James made a clear and open plea for action to be taken to ensure that families' "perspective [was] not lost", and proposed 25 points of learning – three of which he considered crucial.

Within his three crucial points of learning Bishop James identified a "pressing need" for "proper participation" of bereaved families at inquests – calling it a "fundamental point of learning" – the state must ensure 'proper participation of bereaved families at inquest at which a public body is to be represented. This includes inquest following a disaster such as Hillsborough, but also – for example – following deaths in custody or in some cases deaths following NHS care.

"Proper participation" was separated out into four strands;

- Publicly funded legal representation for bereaved families at inquest at which public bodies are legally represented.
- An end to public bodies spending limitless sums providing themselves with representation which surpasses that available to families.
- A change to the way in which public bodies approach inquests, so that they treat them not as a reputational threat, but as an opportunity to learn and as part of their obligations to those who have died and to their family.
- Change to inquest procedures and to the training of coroners, so that bereaved families are truly placed at the centre of the process.

Bishop James' work had overlapped in time with the work of Dame Elish Angiolini whose Report of the Independent Review of Deaths and Serious Incident in Police Custody, published in January 2017, made a similar if not more strongly worded recommendation in relation to the legal aid issues involved in the area she was considering; "In order to facilitate their effective participation in the whole process there should be access for the immediate family to free, non-means tested legal advice, assistance and representation from the earliest point following the death and throughout the pre-inquest hearings and inquest hearing."

Why does it matter? An example offered by Bishop James focused on the contrast between the original Hillsborough inquest – where the families were, it is generally accepted, under-represented[3], – which arguably resulted in flaws in the original pathology evidence not being exposed until the fresh inquests many years later.

On 7th February 2019 the Government published the final report on its Review of Legal Aid for Inquests. The Report noted that, emerging from the evidence gathered during the consultation process, "in particular stakeholders referred to healthcare inquests, in which understanding of complex medical terms and the relevant case law is required, and specific documents need to be requested as part of the inquest", and how "the presence of state legal representatives can alter the perceived nature of the process and, in doing so, undermine the ability of the family to feel able to participate to the best of their abilities."

As well as the difficult and time-consuming process of applying for Exceptional Case Funding, the evidence had also highlighted the difficulties faced by families who did not have funding for representation, in making necessary representations in relation to whether the inquest should include article 2 in scope

Notwithstanding noting "growing calls from parliamentarians and members of the public to increase the availability of funding for bereaved families in inquests there the state has representation, the Government's response to Bishop James' recommendation was encapsulated in four short paragraphs;

3 *This is not a criticism of those representatives*

"We have considered this option (non-means-tested funding for families at inquests where state bodies are represented) in great detail, asking a wide range of stakeholders whether, in their experience, publicly funded legal representation should be available in cases where the state is legally represented.

"We have looked at the impact of publicly funded family representatives on the conduct of inquest hearings, and the ability of the family to participate and understand the process. In the main, responses from bereaved families and representative bodies suggested that public funding for families in these cases is required to ensure that there is an equality of arms. However, a number of stakeholders pointed out that it should not be assumed that in cases there the state has legal representation, representation for the family is necessarily required, nor that it enhances the results of the coroner's investigation. They suggested that the addition of further lawyers might actually hinder the process, by making the process more adversarial and legally complex.

"We have also looked into the financial implications of this option. We have estimated that this option would result in an additional spend of between £30 million and £70 million.

Having taken all of these considerations on board, we have decided that we will not be introducing non-means tested legal aid for inquests where the state has representation. Means testing serves to determine the allocation of taxpayers' money to those most in need. This mechanism upholds the wider policy intention of the existing legal aid statutory framework of ensuring that legal aid is targeted at those who need it most, for the most serious cases in which legal advice or representation is justified. An additional spend of £30- 70 million would run counter to this wider policy intention.

"However, we would like to explore further options for the funding of legal support at inquests where the state has state-funded representation. To do this, we will work closely with other Government Departments."

Against a backdrop of widespread, long-expressed, almost universal support for the desirability of representation of families where the state is represented, it seems that the government has been dissuaded by unidentified voices saying that it should not be assumed that representation is actually required, nor that it will enhance the inquest process, added that to the cost involved, – and has decided that nothing of substance will change. A cynic might suggest that the Government has given disproportionate weight to the voices that it wanted to hear.

It seems unlikely that this is what Bishop James had in mind as the outcome of his work.

It is a certainty that NHS Trusts and their like will continue to be represented at inquests on the basis that representation is actually required and that it will enhance the inquest process, and that families will continue to sit alone, feeling alone and unsupported at inquests, facing the ranks of professionals and their publicly-funded lawyers and wondering where is the fairness in that.

Alternative Solutions: Collaborative Working in Larger Clinical Negligence Cases

MATTHEW STOCKWELL, EXCHANGE CHAMBERS

EXCHANGE CHAMBERS

Background

There are many shared frustrations for clinical negligence practitioners. There is one which I believe can and must be addressed for the benefit of patients, other stakeholders and society as a whole.

With a mixed PI practice (i.e. between trauma and clinical negligence) focusing on larger value, complex cases, I have always had a keen interest in rehabilitation. Whilst my practice is almost exclusively on behalf of injured people, I am committed to collaborative working and looking for more effective means of dispute resolution. However, as a member of the working group for the APIL/FOIL Guide to the Conduct of Cases Involving Serious Injury (the Guide). (***http://www.seriousinjuryguide.co.uk/***), I am constantly frustrated by the difference in claims handling practice and the approach to rehabilitation in trauma cases compared with clinical negligence.

For example, I may have two cases open on my desk at the same time both involving serious spinal cord injury (this is a metaphorical example, not an admission of poor GDPR practice). The first might relate to a fall at work or a high-speed road collision, the second to negligently performed surgery or mismanagement of infection. The needs of both injured people are essentially the same: early assistance including rehabilitation and a timely and fair resolution of his or her claim. Typically, there will be early dialogue and engagement between claimant representative and liability insurer (including the making of interim payments and joint working under the Guide and Rehabilitation Code), but the same point will not be reached in the clinical negligence dispute for a number of years, if at all. There are exceptions (trench warfare in trauma cases and glowing examples of collaboration in the clinical negligence sphere), but this anomaly is replicated too frequently within my own practice and those with whom I have discussed this issue (professionals acting for injured people and compensators alike).

This difference of approach is unsustainable, particularly in the context of larger value claims where there is a greater need for and potential benefit in working together. The purpose of this article is to introduce the Guide to those who are less familiar with it and to look at the barriers and possibilities with collaborative working in clinical negligence disputes.

Serious Injury Guide – a Short History

Work in this context between APIL/FOIL began with the Multi Track Code, which was first published in March 2008. The Code was developed with the objective of parties working together, allocating tasks (to avoid duplication), and narrowing the issues throughout the claim. Not all cases would receive early admissions of liability, but there was a common aim to attempt dispute resolution as early as practicable. A pilot was introduced between supportive members of both organisations on 1 July 2008.

Following conclusion of the pilot, and subsequent discussions with member of both organisations, it was decided that a less prescriptive approach should be taken. The Guide is the result of discussion about this new approach. The Guide, like the Code, is aimed at achieving a collaborative process between claimant and defendant representatives, in larger claims where damages are expected to be over £250,000. It is now formally referenced in the Pre-action Protocol for Personal Injury Claims and work is underway to see how it might be extended or modified to assist in other cases. It does not, however, apply to clinical negligence cases.

Serious Injury Guide – What It Is (And Is Not)

The Guide is a 'guide' not a Protocol. It is a 'best practice guide designed to assist with the conduct of personal injury cases involving complex injuries, specifically cases with a potential value on a full liability basis of £250,000 and above and that are likely to involve a claim for an element of future continuing loss.'

Likewise, the Guide is not a straightjacket, but 'creates an environment that encourages positive collaborative behaviour from both sides, and will work in parallel with

the Civil Procedure Rules.' It is recognised that it may be necessary to depart from the Guide, in whole or in part, in some cases. In particular, nothing in the Guide removes a solicitor's duty to act in the best interests of the client and upon their instructions.

For me, the key benefit of the Guide is encouragement of early collaboration and joint case planning or 'route mapping' – i.e. agreeing a framework and timetable for engaging on regular basis to review progress and bring cases to a conclusion. The inherent shortcoming with traditional case management is that cases are route mapped to trial, not to an earlier resolution. The Guide focuses on the latter.

The working group have identified a number of essential ingredients to successful route mapping, along with the perils, pitfalls and opportunities.

Route Mapping: When Does It Work Well?

- Knowledge of the opponent: Building positive relationships between representatives is essential to close collaboration. Logically, this should be more readily achievable in clinical negligence with specialist claimant representatives and common panel representation between trusts, the NHSR and other defence organisations.
- Stepping away from the keyboard: There can be a tendency to hide behind emails, when direct communication would be more effective. We should all be conscious of the possibility for miscommunication and other pitfalls with instantaneous communication.
- Division of labour: Separating out and allocating tasks can reduce duplication and cost, speed up investigation and case progression, whilst creating a culture of shared responsibility.
- Transparency of approach: Very little can be done covertly, that cannot be achieved in a spirit of openness, but nothing undermines collaborative working quicker than for one party (claimant or defendant) to seek to undermine or wrong foot the other outside an agreed process.
- Imagination: Nobody has the monopoly on good ideas within dispute resolution and many clinical negligence cases have their nuances and unpredictable features. Being flexible of mind and able to think outside the box helps to move cases along again when they stall or lose momentum.
- Ability to identify what matters: Sometimes there will be one or two key issues of importance for the parties. Finding and focusing on this can be the key to progress.
- Trust: This lies at the heart of the process.

Route Mapping: When Does It Not Work Well (Or at All)?

- Counsel can deflect progress: There is a natural tendency for barristers to want to advise on the basis of the best possible evidence available, but greater certainty invariably means increased cost and delay. Use of more experienced, specialist counsel and engagement at an early stage of proceedings can be key to resolving disputes on a timelier basis.
- Unwillingness to show a hand: As stated above, there is little that cannot be achieved on an open basis, provided both parties are committed to transparency and fairness. Defensiveness on both sides is a cultural problem.
- Delayed access to records: This is the bugbear of claimants and defendants alike. If technology brings no other improvements to the claims process, it should facilitate easier, more cost-effective and reliable access to patient information. But parties have to embrace technology and work together to implement and make best use of it.
- Delayed planning: If planning is not undertaken at an early stage, then cases tend to stagnate and it can be difficult to restore momentum later.
- Case treated as being on tram lines with expected staging posts: It is not uncommon to encounter an inflexible stance by one or both parties, not wishing or being permitted by internal protocol to deviate from the traditional staging posts, i.e. just going through the motions on a post box basis, as though the case were simply subject to conventional directions.
- Over reliance on experts: Placing over reliance upon expert evidence, without challenge, can have disastrous consequences. There has to be more effective quality control on both sides and no undue deference.

Barriers to Collaborative Working in Clinical Negligence

- Liability: Whilst breach of duty in clinical negligence disputes is typically more complicated than in trauma claims, the Bolam / Bolitho influence is waning,

particularly against the background of Montgomery and modern, objectively evidenced delivery of healthcare. If we move to a more modern position, consistent with the NHS Constitution, of asking 'whether a patient has been let down?' and not 'whether a claim is technically defensible?' there is scope for improvement in both patient safety and the claims resolution process.

- Causation: This is more complicated in some, but not all cases. Accepting weak causation arguments as an excuse for not engaging earlier often comes at too high a price.
- Constitutional issues: The inability of the NHS to offer timely rehabilitation, in the absence of an admission of responsibility or judgment is a real problem. Traditional liability insurers are far more likely to offer prompt assistance, against the background of comprehensive evidence that early rehabilitation is more effective, even in those cases where liability is not clear-cut. Greater flexibility would help and inevitably save money in the round.
- Co-morbidities and supervening illness: Identifying those cases where it is reasonable and proportionate to explore past medical history or comorbidities is key. A blanket approach is unhelpful.
- Experts (objective and subjective bias): Experts can be subject to bias, lack internal logic or simply be wrong on key issues. There are still far too many experts, on both sides, who trade on a hired-gun reputation. Bolam / Bolitho might be said to positively encourage such an approach.
- Poor analysis (LOC and LOR) or communication: This is a problem for both sides if present.
- Lack of trust: Lack of confidence in the good faith of an opponent will invariably stifle collaboration or derail it altogether. Trust is hard one, but easily lost, particularly within a specialist area where practitioners are more likely to encounter one another on a repeat basis.

Lost Opportunities in Clinical Negligence

There are a number specific features about clinical negligence that make the absence of closer collaboration more of a missed opportunity:

- Restoring relationships (Dr, Patient and NHS Constitution): Unlike, for example, two motorists who collide on the highway, a patient will often be in an ongoing therapeutic relationship with an individual clinician or under the long-term care of the trust against whom a potential claim is directed. There is also a broader relationship between the patient and the NHS, the latter being a much loved and prized public organisation. Preservation or restoration of these relationships is valuable in itself.
- Maximising outcomes (rehabilitation cost v. Benefit): Closer collaboration would promote more effective rehabilitation. Effective rehabilitation has the potential to reduce a patient's ultimate recourse to public funding, i.e. spending by trusts, CCGs or local authorities. Whether or not claims are successful in whole or in part, a reduction in patient morbidity and associated disability reduces cost to society as a whole. Against this background, adopting a similar approach to RTA insurers makes more rather than less economic sense.
- Reducing delay and cost: Collaborative working has the potential to significantly reduce delay and cost within the litigation process itself, supposedly a shared aim between claimant and defendant stakeholders.
- Resolving disputes without litigation: This has a benefit in terms of cost and delay, and reducing the burden on limited court resources. But it also may avoid reputational issues for clinicians.
- Creating an environment for compromise: Parties cannot litigate a case aggressively for a number of years and expect settlement discussions to be straightforward. Working on a collaborative basis, thereby promoting good faith, a sense of fairness and giving patients reassurance and a feeling of security is far more likely to create an environment conducive to discussion and compromise. This is particularly the case in clinical negligence matters, where the patient or their family may not be driven exclusively by financial motives, i.e. rather a search for the truth or concern about the safety of others.
- The 'psychological' factor: In my experience, claimants tend to do better functionally and mentally with a metaphorical 'arm round the shoulder' approach from defendants following adverse events, particularly against the background of a prior relationship. The importance of 'doing the right thing' in terms of outcome cannot be understated.

Collaboration: Relevant Factors

- Nature of the dispute: Some issues, for example a pure legal question or point of principle, may only be effectively resolved by some form of formal adjudication. Understanding the nature of the dispute,

and its suitability for resolution on a cooperative basis, is key.

- Multiplicity of issues (or Gordian knot): If there are multiple issues, collaborative working can at least help in narrowing the substance of the dispute. Often there is one central issue which, if successfully unpicked, can clear the way for compromise. Again, the key is identifying what's important.
- Merits of the case: In strong cases, the case for collaboration is clear. In weak cases, reticence on the part of defendants is more readily understood. But few cases are entirely clear-cut and the middle ground is where great opportunity lies for progress.
- Proportionality: Consideration here is being given to larger value cases, which are currently subject to an altogether different, more flexible and co-operative approach within insurance litigation. In most if not all such cases the proportionality issue weighs heavily in favour of adopting a more collaborative approach.
- Timing of engagement: Early notification and discussion of claims brings about considerable benefit within insurance litigation. The case for doing so within clinical negligence, prior to costly investigation and hardening of positions, would benefit from close examination.
- Realism: There is an obvious need for pragmatism within any collaborative process.
- Severable issues (the 'baby and the bathwater' trap): One of the key benefits of the Guide is a recognition that although road blocks may be encountered, this should not frustrate the entire collaborative process. Too often in clinical negligence cases, one issue is problematic and other aspects of engagement then falter.

Collaboration: Impasse and the Armoury

Within the Guide, the importance of communication and the availability of an escalation mechanism are emphasised. If these tools are not fully effective, an infinite number of alternatives – formal or informal – exist. These include:

- MDTs / JSMs.
- Mediation (evaluative v. non-evaluative).
- Neutral evaluation (paper or oral).
- Adjudication / Arbitration.
- External advice (including experts and counsel).
- Joint instructions to external experts.
- Binding, non-binding and hybrid solutions.

Collaboration: Learning and Improving

Personally, I would welcome an extension of the Guide to clinical negligence disputes. Whether or not this happens, I believe there is scope for closer collaborative working. These are a handful of the things that might be considered by practitioners and firms:

- Dialogue (internal and external): Claimant and defendant representatives might talk internally and externally about their practices and potential areas for greater engagement.
- Start small (firm-to-firm, less contentious issues): In any situation where the same parties readily encounter one another, practitioners might usefully consider aspects of practice that lend themselves to standardisation, streamlining or simplification, e.g. consistency of notification, management of disclosure and building in facilities for early discussion.
- Training and case studies (internal and external): In circumstances were collaboration has worked successfully, this should be reinforced through training and use of case studies. Claimant and defendant representatives might look for opportunities to work together through joint training sessions or forums to see what can usefully be learnt from the other or better understood from the other's perspective.
- Share good and bad examples (the latter without confrontation or criticism): The benefits of learning through this medium are self-evident.
- Build from common ground (e.g. patient safety): Parties will not be able to agree on everything, but it is normally possible to identify areas or topics from which it is possible to build consensus and rapport.
- Avoid exclusion or exclusivity: If something is working or at least worth exploring, excluding other claimant or defendant representatives will slow the pace of change. It is in everybody's interest that we look to improve the process for resolution of clinical negligence claims, and we are no doubt best placed to do so by working together.

We should all be fully committed to fighting our client's corner, but this core professional obligation can be discharged whilst looking for areas of greater engagement and improvement in our practices with others. It makes sense and is what clients ultimately want in most cases. As Sir Charles Darwin observed "In the long history of humankind (and animal kind, too) those who learned to collaborate and improvise most effectively have prevailed." Who would be a dodo in the clinical negligence world?

How to Ensure Your Expert Evidence Impresses the Court

MARCUS COATES-WALKER
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1. In clinical negligence litigation, the assessment of expert evidence is often fundamental to the prospects of success of a claim. However, what makes an impressive expert? How does a Court undertake such an assessment? What principles and considerations do they have in mind? The answers to these questions are worth thinking about at the start of every claim and will help in the conduct of the litigation as a whole.

2. In *C v North Cumbria University Hospitals NHS Trust* [2014] EWHC 61, Green J analysed the case law on breach of duty and distilled a number of principles and considerations that apply to the assessment of expert evidence. The following passage from his judgment is a useful touchstone for clinical negligence lawyers when assessing the likely weight that will be attached to the parties' respective expert evidence:

   "It seems to me that in the light of the case law, the following principles and considerations apply to the assessment of such expert evidence in a case such as the present:

   (i) Where a body of appropriate expert opinion considers that an act or omission alleged to be negligent is reasonable, a Court will attach substantial weight to that opinion.

   (ii) This is so even if there is another body of appropriate opinion which condemns the same act or omission as negligent.

   (iii) The Court in making this assessment must not however delegate the task of deciding the issue to the expert. It is ultimately an issue that the Court, taking account of that expert evidence, must decide for itself.

   (iv) In making an assessment of whether to accept an expert's opinion the Court should take account of a variety of factors including (but not limited to): whether the evidence is tendered in good faith; whether the expert is "responsible", "competent" and / or "respectable"; and whether the opinion is reasonable and logical.

   (v) Good faith: A sine qua non for treating an expert's opinion as valid and relevant is that it is tendered in good faith. However, the mere fact that one or more expert opinions are tendered in good faith is not per se sufficient for a conclusion that a defendant's conduct, endorsed by expert opinion in good faith, necessarily accords with sound medical practice.

   (vi) Responsible / competent / respectable: In Bolitho, Lord Brown-Wilkinson cited each of these three adjectives as relevant to the exercise of assessment of an expert opinion. The judge appeared to treat these as relevant to whether the opinion was "logical". It seems to me that whilst they may be relevant to whether an opinion is "logical", they may not be determinative of that issue. A highly responsible and competent expert of the highest degree of respectability may, nonetheless, proffer a conclusion that a Court does not accept, ultimately, as "logical". Nonetheless, these are material considerations... The following are illustrations... "Competence" is a matter which flows from qualifications and experience. In the context of allegations of clinical negligence in an NHS setting particular weight may be accorded to an expert with a lengthy experience in the NHS... This does not mean to say that an expert with a lesser level of NHS experience necessarily lacks the same degree of competence; but I do accept that lengthy experienced within the NHS is a matter of significance. By the same token an expert who retired 10 years ago whose retirement is spent expressing expert opinions may turn out to be far removed from the fray and much more likely to form an opinion divorced from current practical reality... A "responsible" expert is one who does not adopt an extreme position, who will make the necessary concessions and who adheres to the spirit as well as the words of his professional declaration (see CPR 35 and the PD and Protocol).

(vii) Logic / reasonableness: By far and away the most important consideration is the logic of the expert opinion tendered. A Judge should not simply accept an expert opinion; it should be tested both against the other evidence tendered during the course of a trial, and, against its internal consistency… There are two other points which arise in this case which I would mention. First, a matter of some importance is whether the expert opinion reflects the evidence that has emerged in the course of the trial. Far too often in cases of all sorts experts prepare their evidence in advance of trial making a variety of evidential assumptions and then fail or omit to address themselves to the question of whether these assumptions, and the inferences and opinions drawn therefrom, remain current at the time they come to tender their evidence in the trial. An expert's report will lack logic if, at the point at which it is tendered, it is out of date and not reflective of the evidence in the case as it has unfolded. Secondly, … it is good practice for experts to ensure that when they are reciting critical matters, such as Clinical Notes, they do so with precision… Having said this, the task of the Court is to see beyond stylistic blemishes and to concentrate upon the pith and substance of the expert opinion and to then evaluate its content against the evidence as a whole and thereby to assess its logic. If on analysis of the report as a whole the opinion conveyed is from a person of real experience, exhibiting competence and respectability, and it is consistent with the surrounding evidence, and of course internally logical, this is an opinion which a judge should attach considerable weight to."

3. A recent practical example of the application of these principles is illustrated in *Keh v Homerton University Hospitals NHS Foundation Trust* [2019] EWHC 548 (QB). The key facts can be summarised as follows:

   (a) On 16 September 2013, the Deceased (who was 40 years old, a Jehovah's Witness and in her third trimester) was re-admitted to the Defendant's hospital. A Consultant Obstetrician and Gynaecologist concluded that an induction of labour (IOL) was the safest option for the Deceased.

   (b) On 18 September 2013, an emergency caesarean section (C-section) was performed and the Deceased's child was delivered.

   (c) On 9 October 2013, the Deceased died as a result of sepsis caused by an infection in the operation wound in her uterus. The cause of death was also recorded as 'the refusal of a transfusion on religious grounds'.

4. The Claimant, the Deceased's widower, brought a claim in negligence against the Defendant under the Law Reform (Miscellaneous Provisions) Act 1934 on behalf of the estate, and under the Fatal Accidents Act 1976 on behalf of the dependents, namely the Claimant and their child. Damages were agreed, subject to liability, in the sum of £150,000. The Claimant's claim was premised on three grounds:

   (a) The Deceased: (i) should have been warned of the risk that IOL would be unsuccessful; (ii) should have been warned that labour would result in an urgent C-section; and (iii) should have been offered a C-section at the outset. In those circumstances, the Claimant's case was that the Deceased would have elected to opt straight for a planned C-section.

   (b) The Deceased should have been offered a C-section on 18 September 2013 (at least) an hour earlier than had been the case. Further, the C-section had negligently taken 18 minutes longer than it should have done.

   (c) Between 22 September 2013 and 5 October 2013, there had been a negligent failure to consider and perform a hysterectomy.

5. The Court considered evidence from the parties' respective Obstetric experts: Professor Steer (for the Claimant) and Mr Tuffnell (for the Defendant). Stewart J specifically cited the passage above from *C v North Cumbria* before conducting his assessment of the experts' evidence as set out below.

6. In respect of the Defendant's expert (Mr Tuffnell), the judge stated that although there were questions suggesting he should have put in more detail on some matters, he did not find that there was any shortcoming in that regard. His evidence was given in an objective and measured way. It is of note that he had from the outset accepted that there were some failings by the Defendant which were below the level of acceptable practice.

7. In closing submissions, Defendant's Counsel made a number of criticisms of Professor Steer's evidence. The judge found that these criticisms carried weight and *must affect* the court when assessing the reliability of the expert's evidence:

   (a) Professor Steer had not been in regular clinical practice (on call and on the labour ward) since August 2007. This was a factor which must be

taken into account in evaluating his ability to give reliable evidence of the range of acceptable clinical practice, notwithstanding his continued involvement in research and teaching (including teaching junior doctors about aspects of clinical practice).

(b) Professor Steer gave his views without acquainting himself with the pleadings or witness statements. On the first day of his evidence, he said he had not been supplied with these documents by those instructing him. He was unable properly to explain why he took no steps to obtain them, either: (i) from his knowledge as an experienced expert that they must have existed by the time that he came to sign his report; (ii) when he received the report from Mr Tuffnell, whose report made reference to those documents; (iii) before he met Mr Tufnell, in order to be properly prepared for the joint meeting; or (iv) at any point before stepping into the witness box.

(c) At the outset of the second day of his evidence, he said that he had checked and had in fact been supplied with some, but not all, of the witness statements and pleadings. However, he did not feel that they added anything factual or material to his view of the events.

(d) The bulk of Professor Steer's professional career had been spent at the Chelsea & Westminster Hospital, which has a very high C-section rate. In 2012 / 2013, it had the highest of any hospital in the country. Professor Steer did not seem to accept that this might affect his view as to the likelihood of Mrs Keh requiring a section following IOL.

(e) Professor Steer gave his view on the factual question of the decision that Mrs Keh would have taken if offered a C-section on the basis of all the risk factors that he considered were applicable. This was not merely evidence of what proportion of women would and would not elect for C-section on the basis of the advice he would have given.

(f) He appeared on a number of occasions to be unable to recognise a range of obstetric opinion extending beyond his own. This was illustrated by his criticism of not performing a vaginal examination before the plan to induce labour was agreed. The paper that he himself had cited demonstrated that even in 2015 there was a range of opinion (based on apparently reputable studies) as to the utility of the Bishop Score in decision-making in relation to IOL. Even having been taken to that paper, he seemed unwilling to acknowledge the existence / reasonableness of the alternative view.

(g) It was unexplained how an allegation that it was negligent to induce labour could have been pleaded and reasserted in Reply if it was based on a misunderstanding of Professor Steer's view.

(h) In cross-examination he sought to advance (for the first time) criticisms of one of the clinicians in relation to her attendance on 23 September 2013. He stated that there should have been: (i) a vaginal examination; and, potentially, (ii) an examination under anaesthetic. He stated that these examinations would have led to a conclusion that the uterus should have been removed. These criticisms had not been put to the clinician even though Professor Steer had been present throughout the trial. Despite them being obstetric matters, no satisfactory explanation as to why they had not been mentioned previously was forthcoming. It was an inadequate explanation to suggest that they were in some way included in his criticism of the lack of a formal multidisciplinary meeting.

8. Having considered the evidence, the Court ultimately found for the Defendant for the following reasons:

(a) The Deceased had not been told that she was at significantly higher risk than the average woman of having to have a C-section nor that she could have had the option of a planned C-section. That constituted a breach of duty.

(b) However, had the Deceased been properly advised, on the balance of probabilities, she would not have chosen to have a planned C-section on 16 September 2013. Further, she would not have opted for a C-section at the IOL stage unless it had been positively recommended. There was no evidence that it had been or would have been recommended.

(c) The evidence was insufficient to prove a negligent 18 minute delay in carrying out the Deceased's C-section (based on the difference between the target of 75 minutes and the actual time taken of 93 minutes).

(d) There had been no breach of duty in failing to remove the uterus. Mr Tuffnell's opinion that it had not been negligent to fail to carry out a hysterectomy at any stage was accepted. In all the circumstances, it had been reasonable that the clinicians had not removed the uterus.

It is clear that the assessment of the obstetric evidence in *Keh* formed an important part of the rationale behind the Court's decision on breach of duty in this case. From a practical perspective, clinical negligence lawyers ought to have the principles identified by Green J in *C v North Cumbria* and their application in *Keh* firmly in mind when dealing with experts at each stage of the litigation process (whether it is opening a report for the first time or holding a pre-trial conference). Experts must give their evidence in good faith. They must be responsible, competent and respectable. However, most importantly, their opinion must be reasonable and logically sound. Each case will turn on its own circumstances, but experts must properly engage with the claim, apply their minds to the detail and be prepared to adapt to the factual evidence as it evolves. If they do not, then they must be challenged. Ultimately, if your expert fails to approach their evidence as set out above, then the claim is at risk of being dismissed.

Clinical Negligence Update

EXCHANGE CHAMBERS

BILL BRAITHWAITE QC
EXCHANGE CHAMBERS

1. Up-dating in clinical negligence is not always easy, because the principles usually stay the same, and only the facts change. However, *Montgomery* was a huge change, and we've got recent examples of how judges need to re-think in the light of that decision.
2. The case of *Webster v Burton NHS Trust [2017] EWCA Civ 62* seems to have been straightforward negligence because, at no time prior to the appellant's birth, did Mr Hollingworth note that the foetus was small for gestational age, nor did he note the recorded asymmetry nor the polyhydramnios. He treated the pregnancy as being without these features. It was agreed that he acted negligently. The Judge followed the *Bolam* approach of basing his judgment on whether Mr Hollingworth acted in accordance with a responsible body of expert medical opinion, whereas it is now clear from *Montgomery* that this is no longer correct. The doctor's obligation (apart from in cases where this would damage the patient's welfare) is to present the material risks and uncertainties of different treatments, and to allow patients to make decisions that will affect their health and well-being on proper information.
3. The Court of Appeal had to consider a judge's decision that the surgeon had not been negligent in *Duce v Worcestershire NHS Trust [2018] EWCA Civ 1307*, on the 7th June 2018; Montgomery was said to undermine the judge's decision. The appellant, after consultation with her surgeon, was insistent that she wanted a total abdominal hysterectomy, notwithstanding that he had explained it as a "major operation which has associated risks". She wanted it "all taken away". The operation was carried out non-negligently, but the Claimant was left with pain due to nerve damage.
4. In *Montgomery*, the Supreme Court highlighted the importance of patient autonomy and the patient's entitlement to make decisions whether to incur risks of injury inherent in treatment, highlighting a fundamental distinction between the doctor's role when considering possible investigatory or treatment options, as against the role in discussing with the patient any recommended treatment and possible alternatives, and the risks of injury which may be involved. The former role is an exercise of professional skill and judgment, whereas in the latter role one cannot leave out of account the patient's entitlement to decide on the risks to health which he or she is willing to run. However, those principles did not invalidate the trial judge's decision against the Claimant.
5. Another *Montgomery* case is *Hassell v Hillingdon NHS Trust 2018] EWHC 164 (QB)*, in which the judge decided as a fact that the spinal surgeon did not warn the patient about the risk of paralysis, and that, if he had done, she would not have undergone the operation. Therefore, even though he performed the operation competently, he was liable.
6. For those like me, who see the tragic results of traumatic birth leading to cerebral palsy, it's always disappointing that families aren't considered very much in the resulting claims. On the 5th November 2018, though, the Claimant in *Yah v Medway NHS 2018 EWHC 2964 (QB)* recovered £76,000 damages for psychiatric injuries associated with the traumatic birth of her child.
7. In *Clements v Imperial College NHS Trust [2018] EWHC 2064 (QB)*, the baby stopped breathing within an hour of birth because her mouth and nose were obstructed and her breathing was compromised by her mother's breast during skin to skin contact. It was held that the midwife should have advised mother to keep her baby's nostrils free at all times, and failure to do so was negligent. I must say that that seems a surprising result.
8. A decision where a judge was less willing to see fault was *H v Southend Hospital NHS Trust*, Lawtel, in which the midwives had been observing properly, but failed to record anything for the critical 20 minute period. The judge said that "neither a positive nor negative inference could be drawn from that fact". Without that piece of evidence, the claim in breach failed. That

also seem to me to be a surprising result. The judge also held that, even if bradycardia had been observed earlier, the claimant would not have been delivered quickly enough to avoid the hypoxic ischaemic event.

9. The case of *TW v Burton NHS Trust 2017 EWHC 3139 (QB)* reminds me very much of one of mine which was finalised late last year for just under £20 million. The only breach of duty of care alleged was in failing to invite or advise the Claimant's mother to come into hospital when the first telephone call was made to the midwifery unit. She was told that she should not come in ie she was **positively discouraged** from attending hospital. No evidence was called by the Defendant as to why the midwife made that decision. Had mother been advised less negatively, the Claimant would have been spared his injuries by an earlier delivery.

10. *DS v North Lincs and Goole NHS Trust 2016 EWHC 1246 (QB)* was one of those sad cases where the midwives had been negligent, but it was not possible to prove causation. Labour lasted 13 hours, and the Claimant suffered a period of acute, damaging hypoxia around the time of birth, which caused brain damage resulting in spastic cerebral palsy. The judge decided that, given that low risk pregnancies are midwife led and decelerations in fetal heart rate occur frequently towards the end of labour whereupon spontaneous recovery is usual, it was not mandatory for the midwives to call for an obstetrician until later in the process. Until then, the midwives could have reasonably instituted continuous monitoring, determined whether the mother was fully dilated, tried to make adjustments to enable the FHR to recover, and seek to determine for themselves what the cause of the deceleration was and whether it could be counteracted. However, by a certain time a deceleration of the fetal heart lasting at least 4 minutes had to be assumed (in the absence of continuous monitoring), and it was mandatory to obtain obstetric assistance. The delay thereafter was in negligent breach of duty. I have to say that I really wonder about those findings, but one cannot be sure without more detail. Given those findings, there was a maximum of three minutes of negligent delay, which was not enough to establish causation. Yet again, that seems to me to be a surprising result, because the midwives could, on the face of it, have avoided the catastrophe simply by calling a doctor.

11. Mrs Justice Yip is giving some really good judgments, and *Welsh v Walsall NHS Trust 2018 EWHC 1917 (QB)* is one of them, in relation to the scourge of experts being presented with more than one agenda for their discussions. "It certainly should not become routine to provide two versions which, as here, travel over much of the same ground. That approach tests the patience of the experts (and frankly of the court); produces a lengthier joint statement; potentially increases costs and is simply not the best way to focus on the issues. I do not think that anything further needs to be said or done in this case. However, if this worrying trend continues, parties may find that courts begin considering costs consequences."

12. Another of her decisions is *Kennedy v Frankel 2019 EWHC 106 (QB)*. Mrs Kennedy was diagnosed with Parkinson's disease and advised to take dopamine agonist medication. It caused her psychiatric side effects, including an impulse control disorder and eventually psychosis. She sued Dr Frankel, alleging that he failed to advise her of the risk of impulse control disorder associated with dopamine agonist medication, and that he failed to respond in a timely or appropriate way when she developed the condition. It was agreed that levodopa probably would have controlled her symptoms, but without the side effects, but Dr F did not explain that to the Claimant, or recommend a change in medication.

13. Even though the judge found that failure to be a breach of duty, she held that, at first, it was not causative. However, when the specialist ignored the Parkinsons nurse, who alerted him to the possibility of changing medication, the judge held him to be in causative breach. As always, the evidence was the deciding factor. Once the nurse's consultation and advice was established, the judge was effectively bound to find that the Defendant was liable.

14. There are two consistent features running through all clinical negligence litigation. First, evidence, both lay (sometimes) and expert, is supremely important. Secondly, the identity of the judge is determinative, which makes the whole process a lottery!

The Evidential Difficulties in Proving a Montgomery Case

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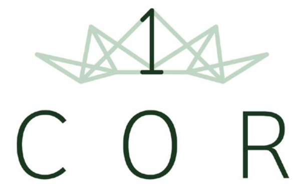

Introduction – the World of Montgomery

As all legal practitioners in the field and increasing numbers of clinicians are aware, *Montgomery v Lanarkshire Health Board* [2015] AC 1430 marked an important paradigm shift in the legal and practical relationships between patients and those medical professionals advising them as to their treatment options. The Supreme Court held that a clinician must take reasonable care to ensure that a patient is aware of any material risks and of any reasonable alternative treatment. In doing so, the Supreme Court placed a significantly greater practical burden on clinicians to prove in the event of challenge that they had both *considered* what all the reasonable alternative treatment might be, and also the full spectrum of potential risks, but also that they had *communicated* those options and risks in an appropriate manner. On its face, the judgment in *Montgomery* therefore offers a powerful alternative route for claimants to argue that there should be liability imposed even for the consequences of treatment that in and of itself was not negligent, provided that treatment was not properly consented to.

It is the case that in reality the number of cases where liability has been found in a failure to ensure informed consent has been very much lower than was initially anticipated following *Montgomery*. However, potential allegations of a lack of consent are doubtless a factor in a material number of settlements: in my own experience very often due to the difficulty of satisfying evidential burden on clinicians to prove that informed consent was in fact given when they often only have their notes and 'standard practice' to rely on rather than an individual memory of the critical consultation.

The parameters of the post *Montgomery* principles and practicalities of successfully running an informed consent continue to be worked out, and two recent cases provide helpful illustrations of how this important area of practice is being considered by the courts. In particular they demonstrate which illustrate the critical importance of both limbs of proving a lack of informed consent post *Montgomery* – proving what advice should have been given *and* what as a matter of a causation a patient would do if given appropriate advice.

Lucy Diamond v Royal Devon & Exeter NHS Foundation Trust [2019] EWCA Civ 585

Background

The Claimant alleged that she had not given informed consent prior to proceeding to a mesh repair of a post-operative abdominal hernia. HHJ Freedman's judgment in the High Court had held that the surgeon had not given appropriate information for the purpose of informed consent, however the judge concluded that had she been so informed the appellant would have chosen to proceed with the mesh repair which in fact took place. That was on the basis that "looking at the matter both objectively and subjectively in the face of the advice which would have been given to her, it would have been irrational for her to opt for a suture repair; and I find that she is not a person who would act irrationally." Further, HHJ Freedman rejected a claim that a negligent non-disclosure of information by a doctor of itself creates a right for the patient to claim damages.

Both the experts had agreed that the surgeon should have discussed the potential implications of a mesh repair in terms of any future pregnancy, and further that he should have mentioned the possibility of a primary suture repair.

The Issues Before the Court of Appeal

The primary ground of appeal was that in considering the issue of causation the judge was wrong to apply a test of 'rationality'. Alternatively, having held that the respondent was under a duty to offer a sutured repair by way of an alternative treatment option, the judge erred in holding that it would have been *"objectively and subjectively... irrational"* for the appellant to have accepted that offer.

The Claimant relied on both *Chester v Afshar* [2005] 1 AC 134 and *Montgomery* to argue that a fundamental purpose of the requirement for properly informed consent was to ensure that respect was given to a patient's autonomy, dignity and right to self-determination. Such a right included the choice to make decisions that others, including the court, might regard as unwise, irrational or harmful to their own interests.

The Defendant argued that the judge had not applied a rationality test in the sense of imposing on the Claimant the actions of a hypothetical rational person, but had reached a finding of fact about the decision which the Claimant would have made as to her preferred method of surgery if properly advised.

An alternative ground of appeal had been that where there has been a negligent disclosure of information, that could of itself create a right of the patient in question to claim damages. The Claimant accepted that the issue had been determined in *Shaw v Kovac* [2017] EWCA Civ 1028 and *Duce v Worcestershire Acute Hospitals NHS Trust* [2018] EWCA Civ 1307, and she had to prove that the breach of duty had caused her to suffer injury. However, the Claimant sought to persuade the Court of Appeal that if the claim for psychiatric injury could not succeed on conventional foreseeability principles she could succeed under the principle identified in Correia v University Hospital of North Staffordshire NHS Trust [2017] EWCA Civ 356. This was said by the Claimant to be that her shock, distress and consequential depression was, at least, "intimately connected" to the failure to obtain properly informed consent.

The Judgment

Nicola Davies LJ began her analysis by emphasising that that *"the conventional 'but for' test for causation applies to consent cases in that it is for the patient to prove that had he or she been warned of the risks, the patient would not have consented to the treatment."* She went on to hold with respect to the test of materiality under *Montgomery* that *"in considering what a reasonable person in the patient's position would attach significance to, account must be taken of the particular patient."*

Nicola Davies LJ described with approval the approach taken by HHJ Freedman: noting that he had *"considered the clinical facts in the context of the appellant's character and circumstances."* He had taken account of hindsight and noted that it would be *"quite impossible"* for the Claimant to divorce her thinking about what she would have chosen to do from the subsequent events and that the *"sad outcome"* had coloured and informed her view of what she would have done had she been appropriately warned. She noted that HHJ Freedman had concluded that the Claimant *"genuinely believes and has convinced herself that she would have opted for the suture repair had she been provided with all the relevant information. Critically he held that her evidence accorded with her honestly held belief, however it did not follow that what she now believes would in fact have been the position at the material time."*

She concluded that the judge had *"met the requirement set out in Montgomery in that he took account of the reasonable person in the patient's position but also gave weight to the characteristics of the appellant herself. He did not apply a single test of "rationality" without more to the issue of causation."*

With regards to the alternative argument as an 'intimate connection' between the shock and depression to the alleged failure to obtain informed consent, Nicola Davies LJ noted that *"Montgomery lends no support for the proposition that a failure to warn of a risk or risks, without more, gives rise to a free- standing claim in damages."* She cited with approval passages in *Correia*, *Shaw* and *Duce* holding that that the majority decision in *Chester* did not negate the requirement for a claimant to demonstrate a 'but for' causative effect of the breach of duty, and that there was no reasonable interpretation of the decision of the House of Lords in *Chester* which justified extending liability for negligent failure to warn of a material risk of a surgical operation to a situation where it has been found as a fact that, if she had been warned of the risk, the claimant would still have proceeded with the operation when she did. Nicola Davies LJ found given the finding of fact that even if the Claimant had been warned of the relevant risk she would have still proceeded with the mesh repair at the material time, there was no factual basis for any argument as to an 'intimate connection.'

Ollosson v Lee [2019] EWHC 784 (QB)

Background

The Claimant alleged that he had not given informed consent to an elective vasectomy as he had not been given adequate information about the risk of chronic testicular pain. He had been given an advisory booklet which stated that *"there is a small possibility of post-vasectomy pain, which can be chronic."*

The Judgment

Stewart J. cited Simon LJ's judgment in *Webster v Burton Hospitals NHS Foundation Trust* [2017] EWCA Civ 62 as authority for the core principles from Montgomery being:

"i) a change of approach as to the nature of the doctor and patient relationship;
ii) the extent of the patient's right to information;
iii) whether a risk is material cannot be reduced to percentages;
iv) the importance of dialogue between patient and doctor as part of the doctor's advisory role;
v) the Bolam approach is no longer appropriate in cases of informed consent."

With respect to the final principle, he also cited Hamblen LJ in *Duce v Worcester Acute Hospitals NHS Trust* [2018] EWCA Civ 1307 to the effect that it was a matter for expert medical evidence as to what risks associated with an operation were or should have been known to the medical professional in question, but that it was a matter for the court as whether the patient should have been told about such risks by reference to whether they were material, with this issue not being the subject of the Bolam test.

Stewart J. set out the evidence of the Claimant and his wife as to what advice he had been given orally, and in the form of information leaflets, prior to the procedure, and commented that while both the Claimant and his wife, and also the treating GP had been honest *"honesty does not necessarily equate to reliability, especially when people are trying to recall facts through the prism of later events."*

Stewart J. noted that the issue was not whether no warning had been given of a material risk, namely that of chronic pain, but whether the warning given was adequate. The Claimant argued that he needed to have been given information that gave a proper indication of the magnitude of the risk, i.e. the percentage chances of it occurring, and also of the range of consequences if it did occur. He also stated that he thought that because there was no figure given for the risk of post vasectomy pain, he thought it was less than 1:2000 since figures were given for the two other stated risks in the booklet provided to him. Stewart J. held that the Claimant was mistaken in his memory. He also commented that it was not a *"logical conclusion"* as *"If anything, the adjective 'small' would suggest a greater, not a lesser risk, than the adjectives 'rare' and 'remote'."* While the illogicality did not mean that the Claimant could not have formed that view, it made it less likely.

Stewart J. held that following the Claimant's reading of the booklet *"he did know was that there was a small risk of (in his words) long-term bad pain, described in the blank consent form as "Serious or frequently occurring"*. The risk was unquantified, but had not been interpreted by him as less than 1:2000." He went on find that the Claimant had been told by the GP that chronic testicular pain was a potential complication and that the risk was referred "in terms that conveyed that it was a small risk, but greater than the rare and remote risks of early and late failure."

Stewart J. concluded that "In terms of the quality of the risk, it was communicated to Mr Ollosson that it was a risk of long term persisting pain which could range from mild to severe. That is sufficient information."

He then went to consider *"In terms of the magnitude or quantification of the risk, was it sufficient for Doctor Lee to say that it was small, adding that it was greater than the rare/remote risks of early or late failure?"* He held that it was not necessary to give *"percentages of the risk of chronic post vasectomy pain, unless asked."* Further, that while the risk of chronic pain appeared to be about 5%, the risk of pain at the level suffered by the Claimant was very much smaller. Accordingly, he concluded that it was adequate to describe that level of risk as *'small'* – *"the word 'small' is clearly an everyday word which encompasses and satisfactorily conveys the level of risk involved…. While adequate information must be given to a patient without him having to ask a question, a patient told of a 'small' risk can ask for further clarification."*

Comment

The *Lucy Diamond* judgment shows that the Court of Appeal has once again emphasised both that there is no free standing 'right to be informed' cause of action that is capable of sounding in damages without more. It therefore also serves as another reminder of the critical importance of the causation limb of an informed consent case and the difficulties of proving causation of the injury in question. A court will almost inevitably wish to seek to test rigorously a claimant's assertion that they would have made a different choice in light of any effect of hindsight. This is particularly so where the first limb of the test as to what additional information should have been given to them may well be relatively.

The test is ultimately what this particular claimant would have made of the information given to them at that particular moment in time, not what a hypothetical reasonable claimant would have done. As an aside, it

is worth noting that the post *Montgomery* focus on individual patient choice also can weaken a claimant's argument that they would have listened to the advice of their partners or families in such a way. Even while that is very often the case, and other witnesses may be able to give their own evidence as to what advice they would have given the patient, the defendant will often seek to undermine that evidence by emphasising that absent any issues as to capacity, it is for the claimant to give the informed consent, not their family.

While the judgment in *Ollosson* may reassure doctors concerned about the adequacy and accuracy of the advice that they give to patients about the likelihood of particular risks as stating a percentage risk is potentially significantly harder than using everyday language to describe a risk, this case does illustrate the difficulties for claimants in proving that the material risks were communicated in an effective way. The more latitude that is given to doctors to use 'everyday' language, and arguably language that is open to varied and subjective interpretation, the greater the potential for miscommunication and misunderstanding that in part *Montgomery* sought to alleviate.

As demonstrated by the number of cases that have come before both the High Court and the Court of Appeal over the last year, the boundaries and practical implications of the decision in *Montgomery* are still being worked out. Successfully establishing a lack of informed consent combined with causation of a material injury has become something of a chimera for many claimant. The first limb is understandably significantly easier to satisfy that the second.

What these two cases illustrate once again that while not impossible to win a case solely on the basis of a lack of informed consent those representing claimants must ensure that they apply a honest and dispassionate assessment as to the realistic prospects of establishing what their client would have done if given more information. What were their preconceptions and their expectations? What did they want to hear or not hear? What other information could they reasonably have been expected to ask for? How much would they have listened to the advice given by the clinician as to the 'best' or the 'safest' option? How much would they have listened to the advice of non-clinicians?

Ultimately, requiring a client to try to put aside their hindsight and their natural wish to put the clock back to a point where there might have been an another alternative road taken, and to give an objective consideration as to what they would actually have done with sufficient information to make an informed choice can be uncomfortable, yet is unavoidable.

The Treatment of Personal Injury Damages on Divorce: Is It Time for a More Principled Approach?

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In 2010, James Cracknell, the Olympic rowing gold medallist, suffered devastating brain injuries when cycling across the United States. In a 2012 interview with the Telegraph, Cracknell and his wife revealed that a neuropsychologist told them as they were leaving hospital that 75% of people with brain injuries divorce. They vowed not to be part of that statistic for the sake of their children, but sadly, this year they announced that their 17-year marriage was over.

Whether or not the statistics provided to the Cracknells are correct (and there are conflicting studies), most clinical negligence practitioners are all too well aware of the impact that serious injuries can have on the uninjured spouse and the family as a whole. The strain on the uninjured spouse can be immense, caring for their injured husband/wife, who is sometimes a very different person from the one they married, and taking on roles previously done by the other. Serious injury brings with it financial worries, uncertainties about the future and shattered dreams. It is not surprising serious personal injuries can often lead to family breakdown and divorce.

There is a dearth of recent authorities on the way that personal injury damages are treated in financial remedy proceedings on divorce. The leading case remains *Wagstaff v Wagstaff*[1], decided in November 1991, before the decisions of the House of Lords in *White v White*[2] and *Miller v Miller; McFarlane v McFarlane*[3] heralded in a new era for "ancillary relief" proceedings. The approach to the assessment of damages in personal injury cases has become far more complicated; when *Wagstaff* was decided, the approach was "rough and ready" and the use of actuarial multipliers to calculate future loss was in its infancy.

The purpose of this article is to review the law on the treatment of personal injury damages on divorce and to consider what steps can be taken both by the family lawyers and the personal injury lawyers to reduce the impact of divorce on their client's damages award.

Financial Remedy Proceedings

For the benefit of personal injury practitioners, a gallop through the relevant principles may be helpful. The starting point, in deciding what (if any) financial orders to make, is section 25 of the Matrimonial Causes Act 1973. This provides that the court must have regard to all the circumstances of the case, with the first consideration being given to the welfare of any children of the family, and taking into account the eight "section 25 factors". These include the parties' income, earning capacity, property and other financial resources, the financial "needs, obligations and responsibilities which each of the parties to the marriage has, or is likely to have in the foreseeable future", any physical or mental disability, and the parties' respective contributions.

The court's objective, when exercising its wide discretionary powers, is to "achieve a fair outcome", but as Lord Nicholls observed in *Miller, McFarlane*, fairness is an elusive concept, ultimately grounded in social and moral values. *White v White* established that the court must exercise its discretionary powers in a manner which is not discriminatory between the roles of husband and wife, and that fairness was to be measured against the "yardstick of equality".

In *Miller* the House of Lords identified three principles that govern the exercise of the court's discretion: financial needs, which in in many cases will override all other considerations, compensation (which rarely if ever arises) and sharing. Sharing reflects marriage being "a partnership of equals" with each spouse "being entitled to an equal share of the assets of the partnership, unless there is good reason to the contrary", per Lord Nicholls at [16]. Lady Hale referred to "the sharing of the fruits of the marital partnership". Following *Miller*, it is now clear that the equal sharing principle will almost invariably apply to

1 [1992] 1 All ER 275, [1992] 1 FLR 333. CA.
2 [2001] 1 AC 596, [2000] 2 FLR 981
3 [2006] UKHL 24, [2006] 2 AC 618.

matrimonial property, except where displaced by other factors such as need.

Matrimonial and Non-Matrimonial Property

There is a common misconception that on divorce all property will be divided equally, regardless of its source. This is not correct. The court draws a distinction between matrimonial property and non-matrimonial property. In *Miller* Lord Nicholls said:

"This does not mean that, when exercising his discretion, a judge in this country must treat all property in the same way ... One of the circumstances [of the case] is that there is a real difference, a difference of source, between (1) property acquired during the marriage otherwise than by inheritance or gift, sometimes called the marital acquest but more usually the matrimonial property, and (2) other property. The former is the financial product of the parties' common endeavour, the latter is not: The parties' matrimonial home, even if this was brought into the marriage at the outset by one of the parties, usually has a central place in any marriage. So it should normally be treated as matrimonial property..."

As matrimonial property is property built up by the spouses' joint (but different) efforts, it should usually be divided equally. In *S v AG [Financial Orders: Lottery Prize]*[4] Mostyn J summarised the position:

"Therefore, the law is now reasonably clear. In the application of the *sharing* principle (as opposed to the needs principle, matrimonial property will normally be divided equally... By contrast, it will be rare case where the sharing principle will lead to any distribution to the claimant of non-matrimonial property. Of course, an award from non-matrimonial property to meet needs is common-place..."

In the Privy Council decision of *Scatcliffe v Scatcliffe*[5], Lord Wilson suggested that the proper approach is to apply the sharing principle to matrimonial property and then consider whether the principles of needs and compensation require additional property to be transferred even if that evades non-matrimonial property. But even where property is matrimonial, it is not an invariable rule that it will be divided equally. For example, where one party brings assets into the assets which become part of the economic life of the marriage (the concept of "mingling"), the original non-marital source of the money may justify a departure from equality. Even the matrimonial home may not be divided equally if there have been unequal contributions to its purchase.

This issue can be difficult and has generated a great deal of case law. As Moylan LJ pointed out in *Hart v Hart (CA)*[6] it is not always possible to categorise an asset as matrimonial or non-matrimonial, because it can be a combination of both. He decided that the court was not required to adopt a formulaic approach in every case and the extent to which it is necessary to evaluate and reflect the non-matrimonial element depends on the facts of the case.

Categorisation of Personal Injury Damages as Non-Matrimonial?

The issue of whether personal injury damages are non-matrimonial has yet to be determined by the courts, but logically, in the view of the author, most personal injury damages should be categorised as non-matrimonial. This is because damages are not assets comprising the product of the parties' joint marital endeavour during the marriage. Instead, personal injury damages are brought into the marriage unilaterally by one of the parties as a consequence of their injuries and are therefore "akin to external donation" from a source external to the marriage.

There is some scope to treat different heads of damage differently. It is difficult, for example, to see how general damages for PSLA could ever be properly categorised as matrimonial property, whereas damages for loss of earnings awarded for the period that the marriage subsists may well be matrimonial and subject to the sharing principle. Similarly, damages for reimbursement of past losses such as aids and equipment, if paid initially from matrimonial funds as opposed to an interim payment, may well be matrimonial in nature. Damages for care are provided gratuitously to an injured spouse by their husband/wife during the marriage of course belong to the spouse providing the care[7] and are arguably matrimonial. In contrast, damages for future care provided after the end of the marriage are clearly non-matrimonial.

In general terms, future losses are likely to be categorised as non-matrimonial. The issue of whether a husband's earning capacity is capable of being a matrimonial asset to which the sharing principle applies was recently considered by the Court of Appeal in *Waggott v Waggott*[8]. The Court of Appeal held that the clear answer was that it is not. Moylan LJ stated:

4 *[2011] EWHC 2637 (Fam), [2012] 1 FLR 651*

5 *[2017] AC 93*

6 *[2017] EWCA Civ 1306, [2018] 2WLR 509*

7 *Hunt v Severs [1994] 2 AC 350.*

8 *[2018] EWCA Civ 727*

"The sharing principle applies to marital assets, being the property of the party generated during the marriage otherwise than by external donation (*Charman v Charman (No 4)*)[9]. An earning capacity is not property and ...it results in the generation of property *after* the marriage."

Waggott was followed in *C v C*[10] in which Roberts J made it clear that post-separation earnings can be ring-fenced as non-matrimonial property. Applying these principles to personal injury damages, it must follow that future pecuniary losses that relate to the period *after* the marriage has broken down, are non-matrimonial, including damages for future loss of earnings.

The argument that personal injury damages are non-matrimonial and should not be subject to the sharing principle, has yet to be tested by the courts. But in order that family lawyers can advance arguments that personal injury damages should be "ring-fenced" they need evidence to establish the dividing line between what is, and what is not, non-matrimonial. Thus, where the claim has been settled by payment of a single lump sum award of damages, the family lawyers, and the family court, needs to understand how the award has been calculated. The personal injury lawyer can assist simply by providing a detailed breakdown in writing to show how they calculated the award, including their assessment of general damages, the breakdown of past losses, their assessment of the multiplicand for future losses and the multiplier.

Needs

The fact that assets, including personal injury damages, are non-matrimonial will count for little where the needs of the uninjured spouse without recourse to such assets. In *Miller* Lord Nicholls observed:

"When the marriage ends, "fairness requires the assets of the parties should be divided primarily so as to meet provision for the parties' housing and financial needs, taking into account a wide range of matters... most of these needs will have been generated by the marriage, but not all of them. Needs arising from age or disability are instances of the latter."

The Family Justice Council issued Guidance of "Financial Needs" on Divorce in April 2018, which provides a useful summary of the law:

- Need will be measured by assessing available financial resources.
- The court will strive to stretch finite resources and where resources are modest, the children's need may predominate.
- Need will be measured by assessing the standard of living during the relationship, but a party may be expected to suffer some reduction in standard of living on divorce.
- To measure need, and the ability to meet it, both parties will be expected to present detailed budgets.
- Needs may be met from non-matrimonial resources.

Personal injury practitioners often question how it is that the family court can invade the personal injury damages, particularly where damages for future losses have been carefully calculated to meet the claimant's ongoing care and other needs. The short answer is that the court must also balance the needs of the non-injured spouse, particularly where there are children involved, and attempt to stretch the financial resources to meet their needs, principally for a home.

Personal Injury Case-Law

The existing case law will be summarised briefly. In *Wagstaff v Wagstaff* the parties were married. The wife had two children, who were treated by the husband as children of the family. 5 years after the marriage, the husband suffered very serious injuries in a road traffic accident that rendered him paraplegic and confined to a wheelchair. The husband's claims for damages was settled for £418,000, which was used to purchase a property, adapted for his special needs. He invested the remainder in a health club, which was loss making and retained about £70,000 in bank accounts. The wife had purchased the family home, a council property, which she then sold to purchase a property jointly with a work colleague.

The Court of Appeal upheld the order of the Registrar which was for a modest lump sum of £32,000. The court made clear that there was "no argument but that damages fall to be considered as part of a spouse's financial resources under s25(2)(a) of the 1973 Act", and this is obviously correct. The court's reasoning is consistent with the approach that the court would take today, in placing considerable importance on the source of the assets. Butler-Sloss LJ stated:

"The reasons for the availability of the capital in the hands of the spouse, together with the size of the award, are relevant factors in all the circumstances of s25. But the capital award is not sacrosant, nor any part of it

9 [66]

10 [2018] EWHC 3186 (Fam)

secured against the application of the other spouse. In some cases, the needs of the disabled spouse may absorb all the available capital, such as the requirement of residential accommodation ... In general, the reasons for the availability of the capital by way of damages must temper the extent of, and in some instances may exclude the sharing of, such capital with the other spouse."

In *C v C*[11] the parties had one child and lived modestly in council accommodation. The husband suffered severely disabling and permanent brain damage in a road traffic accident, restricting his mobility and ability to communicate. The husband was awarded damages by way of a structured settlement. Had he been awarded damages on a conventional basis, he would have expected to receive about £950,000. Following the breakdown of the marriage, he moved to Cyprus to be cared for by his parents and a specially adapted house was built for him, leaving him with no spare capital. The balance of the structured settlement was used to purchase four annuities, but the annuity income produced broadly equalled his outgoings, including his care costs. On appeal, Singer J held that bearing in mind the husband's circumstances, and his "very considerable" needs, there was in reality no readily available or realisable capital and ordered a clean break. He took into account and that the wife was securely housed.

In *Mansfield v Mansfield*[12] H received £500,000 for a personal injury claim prior to the marriage. He invested the money in a bungalow and an investment flat. The bungalow was specially adapted for him, partially funded from the sale of the wife's pre-marital flat. The parties had 4-year-old twins. At first instance, the court awarded £285,000, more than half the assets in the case. The Court of Appeal upheld the amount awarded on the basis of the district judge's finding that this was the minimum required to meet the needs of the wife and the children (whilst commenting it was on the high side), but converting the order to a *Mesher* order, whereby one-third of the capital awarded to the wife would revert to the husband upon the children reaching their majority.

Although the decision in *Mansfield* caused consternation among practitioners, it was clearly based on the needs of the wife as primary carer to provide a home for the children. But Thorpe LJ stated that "in many instances the application of the general sharing rule must be tempered to reflect the particular needs of the recipient and the very nature of the acquisition of capital, namely by way of compensation for personal injuries." It should also be noted that in this case the husband's personal injury damages had been "mingled".

Attempts to Protect the Damages on Divorce

Although personal injury damages are not sacrosanct, there are steps that can be taken in an attempt to preserve the damages on divorce.

1. *Provide a Breakdown of the Damages*

It is important that the personal injury solicitor provide a detailed breakdown of how the damages have been assessed in every case. As set out earlier in this article, this should enable the family lawyers to argue that at least majority of the award is non-matrimonial or relates to future loss after the end of the marriage. Perhaps more importantly, a detailed breakdown provides evidence of the injured spouse's future needs. When, as is so often the case in clinical negligence cases, a discount is applied to the damages to take into account the risks of litigation, this should be clearly set out, as it follows that the damages received are less than required to meet the claimant's future needs. All too often, all the family lawyer knows is the total quantum of the award, without any information as to how it was calculated, making it much easier for the court to share the award with the uninjured spouse.

2. *Periodical Payments*

As the readers of this article are well aware, whenever the court is considering a claim for future pecuniary loss, the court must consider whether or not to make an order for periodical payments as opposed to a lump sum. One advantage of a PPO is that it can provide considerable protection for the claimant in the event of divorce and avoid the very real concern that should a substantive order be made against damages in financial remedy proceedings, this will lead to the damages running out during the claimant's life-time. Just as in *C v C (above)*, the available capital will be limited. The family court could make an order for ongoing spousal maintenance from the PPO, but only by reference to needs. In practice it may be difficult for the family court to award spousal maintenance where it can be demonstrated that the entirety of the PPO is needed to meet the future care and other needs of the injured spouse.

3. *Marital Agreements*

The decision of the Supreme Court in *Radmacher v Granatino*[13] has led to a fundamental change in the approach to the enforceability of marital agreements,

11 *[1995] 2 FLR 171*

12 *[2011] EWCA Civ 1056, [2012] 1 FLR 117*

13 *[2010] 2 FLR 1900*

giving them much greater weight. Lord Phillips held that "The court should give effect to a nuptial agreement that is freely entered into by each party with a full appreciation of its implications unless in the circumstances prevailing it would not be fair to hold the parties to their agreement." Although *Radmacher* concerned a pre-nuptial (antenuptial) agreement, it established that the same approach should apply to both pre-nuptial and post-nuptial agreements, made after the marriage. In the context of section 25 of the MCA 1973, the existence of an agreement is a very important price of conduct and a very important factor in considering what is a just outcome of the proceedings.

In the view of the author, practitioners should advise their married clients to enter into a post-nuptial agreement setting out how their assets and the personal injury damages should be dealt with if they subsequently divorce. Unmarried clients should also be advised that they should enter a pre-nuptial agreement should they get married in the future.

4. *Personal Injury Trust*

Finally setting up a personal injuries trust should be considered. This is a complex area beyond the scope of this article. In short, the assets of the trust may well be considered a resource available to the injured spouse. Further, the court has power to vary both ante-nuptial and post-nuptial settlements under section 24 of the Matrimonial Causes Act 1973. Although a personal injury may therefore not succeed in protecting the damages on divorce, at the very least it keeps the damages separate, and this may persuade the court that the sums in the trust should be kept for the benefit of the injured party as the personal injury trust intended.

Patient Safety: Education and Learning at the Royal Society of Medicine

KEN SAVAGE-BROOKES
ROYAL SOCIETY OF MEDICINE

Lawyers who are members of AvMA are eligible for membership of the Royal Society of Medicine. One of the UK's leading providers of postgraduate medical education, the Society is made up of specialty sections focusing on different areas of medicine, including Clinical Forensic and Legal Medicine and Patient Safety.

Dr Elizabeth Haxby, President of the RSM Patient Safety Section, is the lead clinician for clinical risk at the Royal Brompton Hospital. A consultant adult and paediatric cardiothoracic anaesthetist until 2002, she now devotes her time to clinical risk management, patient safety and medico-legal work, including inquests.

As Section President, Dr Haxby oversees delivery of an education programme providing comprehensive and topical information related to patient safety and ensures the Section plays a leading role in promoting the development of the patient safety agenda.

She says: "As well as providing education, the Section serves as a forum for discussion and debate concerning all aspects of the delivery of safe care. We work to increase understanding of the challenges of delivering safe healthcare in a high risk, complex environment, including how we can improve quality of care, reduce adverse events and support patients and staff including managing complaints and resolving clinical disputes and legal claims.

RSM membership can be taken out by individual lawyers or on a group basis through their practices or chambers.

RSM Education

Here is a flavour of the patient safety educational events hosted by the RSM.

In early May a conference titled *Human Factors in Patient Safety, Comparative lessons from human and animal healthcare* took place in collaboration with the RSM's Comparative Medicine Network. The aim was to encourage ongoing dialogue and collaboration to reduce harm and improve quality of care for both animals and humans based on current innovations, education and research. The programme can be seen in full **here**.

On Friday 14 June a conference titled *Working with patients for safer care* will give delegates the opportunity to understand the cultural shift required to support the implementation of the NHS Long Term Plan and give an enhanced view of how personalised and integrated care could work from multiple perspectives.

The primary focus will be on how modern systems, technology, care co-ordination and a patient-centred approach provide an environment where personalised care can be delivered and flourish.

Clinicians from across the acute and primary care sectors, patients and carers will discuss how working together effectively informs and facilitates better and safer care for all. Expert speakers will give presentations on safety culture, systems, information, diagnosis, patient involvement and lived-experience.

Click here to see the full programme for the event.

How to Join

The AvMA has negotiated a special deal for its members to join the Royal Society of Medicine on special terms – a saving of £50 on the first year of membership.

RSM members save 40% (sometimes free) on all RSM conferences and events, including those run by its Patient Safety and Clinical Forensic and Legal Medicine Sections. In addition, RSM membership also provides access to 5,500 full-text ejournals, a world class medical library – open 24/7, exclusive members' only club facilities in central London including a hotel, and access to over 50 reciprocal clubs around the world.

For full details of all the benefits of RSM membership and to take advantage of the special £50 AvMA discount visit: **www.rsm.ac.uk/become-a-member** and enter promo code "AVMA50".

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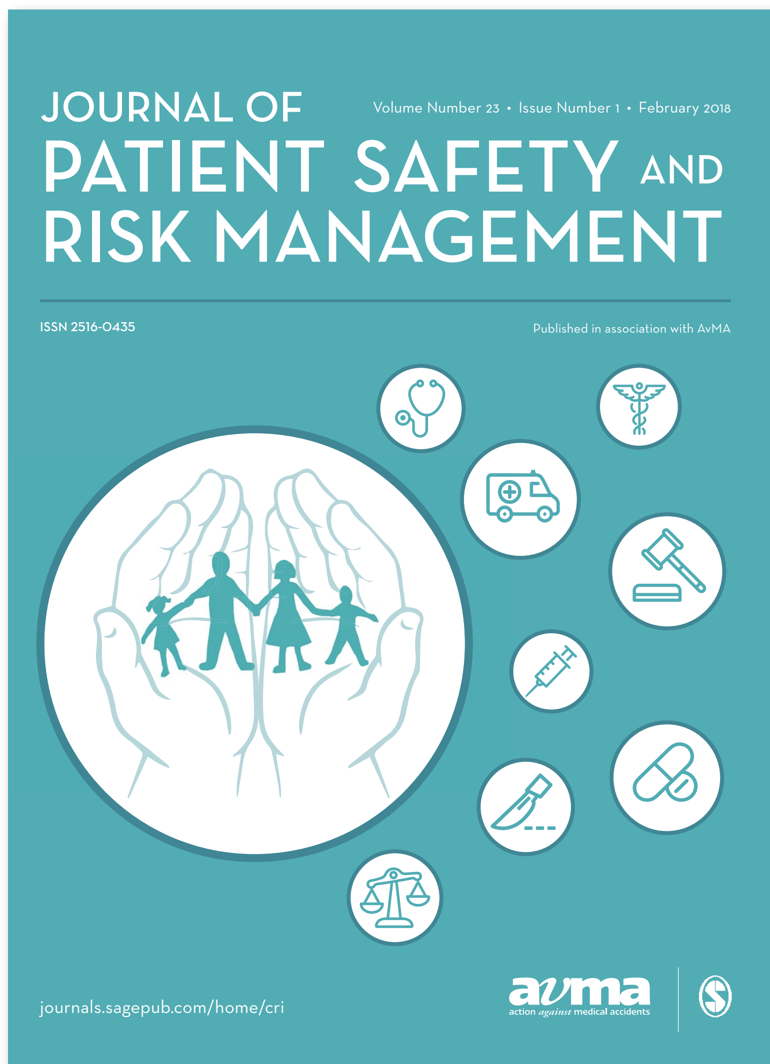

The Journal of Patient Safety and Risk Management, published in association with AvMA, is an international journal considering patient safety and risk at all levels of the healthcare system, starting with the patient and including practitioners, managers, organisations and policy makers. It publishes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

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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

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31st Annual Clinical Negligence Conference

28-29 June 2019, Royal Armouries Museum, Leeds

Join us in Leeds for the 31st 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 has a focus on acute medicine, 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. The Golf Day will take place on Thursday 27th June at Moor Allerton Golf Club, Leeds, prior to the conference Welcome Event at the Doubletree by Hilton Hotel SkyLounge later that evening. The Mid-Conference Dinner will be held on the Friday evening at the Royal Armouries Museum.

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

Medico-Legal Issues in Orthopaedic Surgery

19 September 2019, Slater & Gordon Lawyers, Manchester

This essential conference brings together leading experts in the field of orthopaedics and gives you an in-depth insight into the conditions relevant to your caseload. Topics include upper limb surgery focusing on the shoulder, hand and wrist surgery, spinal, foot and ankle surgery, knee surgery as well as joint replacement of the hip and knee. Types of injury and fracture will be looked at within each area as well as highlighting where negligence may occur within each condition. This popular conference is not to be missed and is ideal for solicitors and barristers with a limited or intermediate knowledge of orthopaedics who wish to expand and update their expertise in this area. The programme will be available and booking will open in June 2019.

Medico-Legal Issues in Oncology

16 October 2019, 39 Essex Chambers, London

This vital course will provide in-depth knowledge and understanding of Oncology in a medico-legal context relevant to your case load. The day will feature presentations from leading experts on medical treatment of breast tumours; abdominal tumours focusing on cancer of the colon; breast surgery; gynaecological surgery; and an orthopaedic persepctive on oncology. A barrister will also examine causation issues arising in cancer claims. The programme will be available and booking will open in June 2019.

Medical Negligence & Access to Justice in Ireland Today

6 November 2019, Morrison Hotel, Dublin, Ireland

We are delighted to return to Dublin for an 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. The conference programme will be available and booking will open Summer 2019.

Representing Families at Inquests: A Practical Guide

21 November 2019, Hard Day's Night Hotel, Liverpool

The important work conducted by AvMA's inquest service is the basis for this conference, which is designed to be a comprehensive guide to the practice and procedures when representing a family at an inquest. Leading legal experts will take you through the preparation process, helping you to understand the complex issue of disclosure, management of expert evidence and Article 2. An update on case law, funding issues and post-inquest remedies will also be discussed. The event is aimed at intermediate to advanced level solicitors, junior barristers and healthcare professionals. The programme will be available and booking will open in Summer 2019.

AvMA Specialist Clinical Negligence Panel Meeting

Afternoon of Thursday 5th December 2019, RSA House, 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 5th 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, also at RSA House. 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!

AvMA Christmas Drinks Reception

Evening of Thursday 5th December 2019, RSA House, London

AvMA's Christmas Drinks Reception will this year take place at the at the beautiful, award-winning RSA House, just off The Strand in central London (https://www.thersa.org/hire-rsa-house). The event will start from 17.15 and 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!

Clinical Negligence: Law Practice & Procedure

30-31 January 2020, Birmingham

This is the course for those who are new to the specialist field of clinical negligence. The event is especially suitable for trainee and newly qualified solicitors, paralegals, legal executives and medico-legal advisors, and will provide the fundamental knowledge necessary to develop a career in clinical negligence. Expert speakers with a wealth of experience will cover all stages of the investigative and litigation process relating to clinical negligence claims from the claimants' perspective. The conference programme will be available and booking will open in October 2019.

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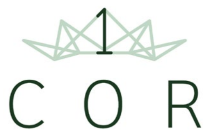

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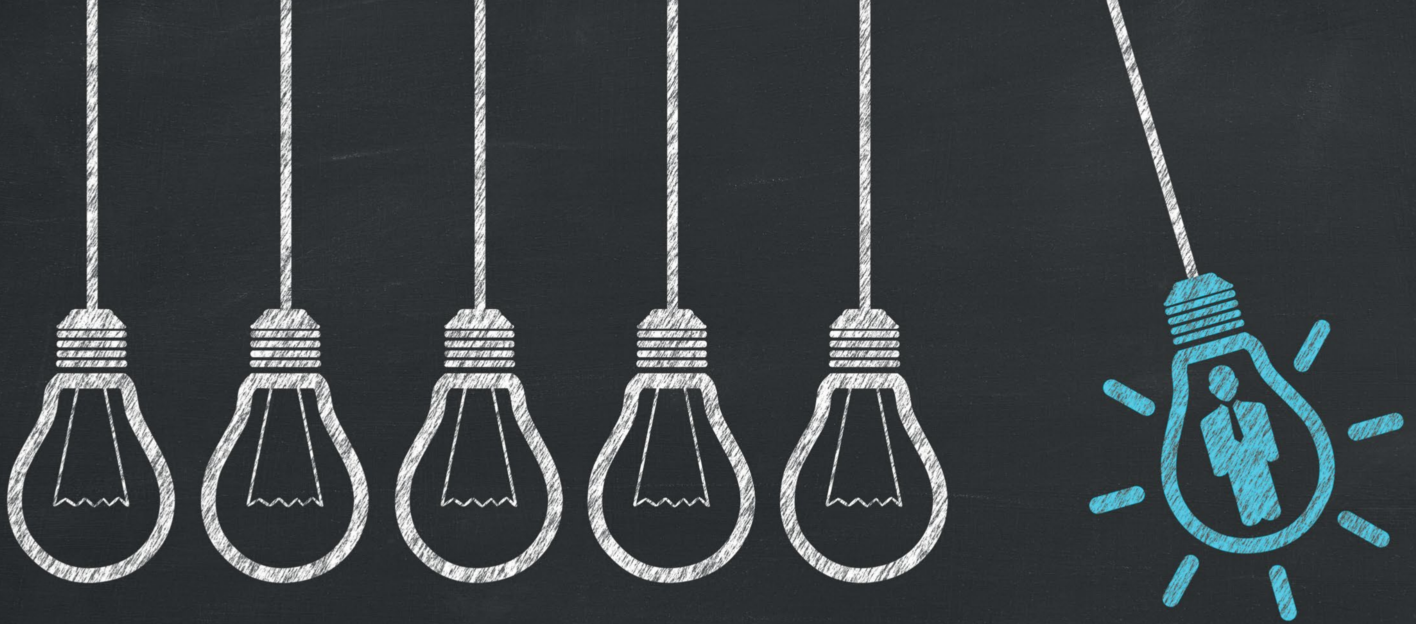

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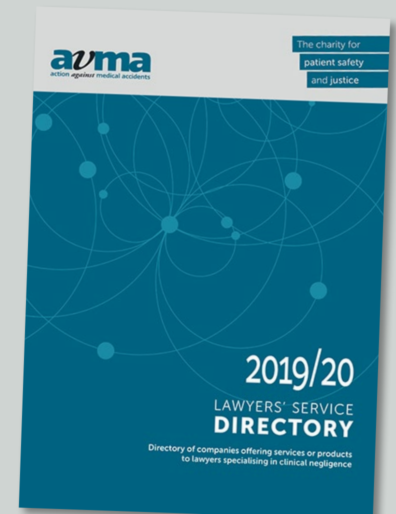

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