Clinical Negligence and Personal Injury

Quarterly Newsletter – April 2017

The first quarter of 2017 has been a busy one within clinical negligence circles. There is a Ministry of Justice consultation on a fixed costs regime for cases under £25,000, Lord Justice Jackson's review of costs in civil litigation, a consultation on the system for providing redress in birth injury claims and on 27 February 2017 the Lord Chancellor announced, to the surprise of most, a change in the discount rate used to calculate damages. The previous discount rate of 2.5% that stood the test of time for 16 years was drastically reduced to -0.75%. The change came with an announcement that there will be a consultation on whether the current scheme for setting the discount rate is fit for purpose. One wonders what the outcome of this consultation will be. Only time will tell as to the full extent of the Government's plans.

But what about Court decisions within the discipline of clinical negligence? There have been 11 decisions this quarter – 6 on appeal, 5 at first instance. The decisions are varied and provide useful guidance to clinical negligence practitioners. The decisions are summarised by category below.

Breach of Duty (Bolam)

McGuinn -v- Lewisham and Greenwich NHS Trust was the first decision of the year. This case, which was brought to trial by way of a preliminary issue to decide breach of duty, concerned a wrongful birth claim. The Claimant underwent 10 antenatal scans during the course of her pregnancy and claimed that features revealed on the scans (including a small fetal head circumference, the decrease in growth and slightly enlarged cerebral ventricle and the presence of a single umbilical artery) should have alerted those providing care during the antenatal period that the fetus was at risk of suffering from microcephaly. It was the Claimant's case that had she been alerted of such a risk she would have been referred to a tertiary level care centre for further investigation, and it is likely that had she been advised of the risk of microcephaly she would have elected to terminate her pregnancy.

In what can only be described a thorough and well-reasoned Judgment, Mr Justice Baker assessed the framework within which a diagnosis of microcephaly is made, the importance of changes in fetal growth velocity during the antenatal period, the significance of the head circumference/abdominal circumference ratio when scanning and identifying potential microcephaly risks.

The Judge found in the Claimant's favour stating that no reasonable clinician interpreting the features seen on the 5th and 7th scans would have failed to appreciate that the fetus was at risk suffering from microcephaly. At the 5th scan the decision to refer the Claimant for further investigation and assessment at a tertiary level centre, or at the very least re-scan at 32 weeks gestation, was warranted. At the 7th scan referral for further investigation and assessment at a tertiary level centre was justified.

In conclusion the Judge stated that he preferred the Claimant's expert evidence because "*I consider that his* [the expert's] *more nuanced approach, of taking into account the whole of the relevant evidence disclosed by the*

various scan measurements and reports, rather than compartmentalising it, reflected a more rational approach, and one ultimately which reflected reasonable, rather than inappropriately high, standards of clinical care".

The second case of the year, another first instance decision, was that of **Muller -v- King's College Hospital NHS Foundation Trust**. The case concerned an interesting point of law in relation to the *Bolam* test. The Defendant's pathologist diagnosed a non-malignant ulcer on the Claimant's foot in November 2011 when in fact the lump was a malignant melanoma.

The interesting feature of this appeal was whether the correct test was the conventional *Bolam* approach. There are two types of case - the first is where a claimant's condition is unknown and what is alleged to be negligent is a doctor's diagnosis of the condition in the form of a report with no decision made or advice given about treatment or further diagnostic procedures. This is a "diagnosis" case. The second type of case is a clear "treatment" case where the nature of a claimant's condition is known and the alleged negligence consists of a decision to treat a condition in a particular manner.

Mr Justice Kerr felt bound by the law as it currently stands to approach the issue in this case with reference to a possible innovation of the *Bolitho* exception. He felt bound not to reject an expert's view unless he was persuaded that it is untenable in logic or otherwise flawed in some manner rendering its conclusion indefensible and impermissible. The judge felt he was compelled to reach the conclusion that there was a breach of duty by the doctor. This was because there were a number of features within the histopathology slides that were not consistent with a diagnosis of a benign ulcer. The judge felt it was right to say that a pathologist who is, in general, competent might have missed the malignant melanoma. It was not right to say that a normally competent pathologist would be acting competently on this particular occasion if the melanoma was missed.

The case of **Sullivan -v- Guy's and St Thomas' NHS Foundation Trust** concerned a trial on liability where the claimant failed to establish breach of duty. The claimant, who tragically had died by the time of trial, was born with a severe congenital heart disorder. In 1998 he underwent surgery to correct the disorder and while the surgery itself was successful, the claimant failed to recover consciousness in a way ordinarily to be expected after such an operation and it soon became apparent that he was showing signs of having suffered serious brain damage.

The surgery (the Hemi-Fontan procedure) involved a period of circulatory arrest of about 30 minutes whereby the patient's temperature must be reduced to 18°C to ensure that brain damage does not occur. The claimant's case was that the surgeon's method of not reducing the patient's temperature to 18°C – the temperature was instead reduced to 24°C – created an unacceptable risk of brain damage which in fact eventuated.

Mr Justice Foskett was asked to identify whether there was an established practice in 1998 concerning the temperature to which an infant patient should be reduced for the duration of circulatory arrest. Foskett J summarised "*it has seemed to me to be plain that this was an area where views (and indeed experience) may quite reasonably vary (and differ) without it being said that one or other is right or wrong (or better). I do not see how the court could resolve the differences thrown up by the competing views about the weight to be given to these various factors in deciding how best to proceed with the Hemi-Fontan procedure. At the end of the day, Professor Anderson was obviously an experienced and talented surgeon and his own judgment on these issues has*

to be accorded respect. Some of his colleagues might disagree with him, other might agree, but merely because some might disagree with this aspect of his personal balancing exercise does not make his approach a negligent approach."

It was held that there was no established consensus concerning safe practice in 1998 concerning the temperature to which an infant should be cooled for a particular period of circulatory arrest other than the general proposition that the longer the period of circulatory arrest, the lower the temperature should be.

Consent

In **Webster -v- Burton Hospitals NHS Foundation Trust,** the Court of Appeal was required to consider a discreet issue of causation with breach of duty having already been admitted. The case concerned a hypoxic-ischemic insult to the Claimant's brain caused by a relatively short period of cord compression at the time of his birth. The Claimant's mother had previously undergone an ultrasound scan on 18 November 2002 at 32 weeks and 3 days. There were a combination of abnormalities on that scan that should have prompted the obstetrician to arrange further ultrasound scanning every 2 weeks in view of the fetus being small for gestational age. The main issues before the Judge were what would have been shown if further ultrasound scanning had taken place, and what would have happened as a consequence.

The Claimant's case was that the obstetrician should have offered the Claimant's mother the possibility of induction of labour at term; and that if he had done so the Claimant's brain damage would have been avoided. The Defendant's case was that, if the two omitted ultrasound scans had been carried out they would have provided reassurance. The SGA (small for gestational age), the polyhydramnios and the asymmetry should not have given rise to the need for any heightened vigilance or advice about the dangers which might be avoided by induction.

The Judge's decision was that the Defendant had shown the obstetrician to be acting in accordance with a reasonable body of medical opinion. Even if additional scans had taken place he concluded that he did not think that anything would have been required to be discussed with the Claimant's mother that would have led to a different decision from the one that the obstetrician in fact took, namely to continue until the 42nd week in order to achieve a more satisfactory labour.

Upon considering the Montgomery case the Court concluded that in general terms the effect of Montgomery is to reinforce the doctor's obligation to present the material risks and uncertainties of different treatments, and to allow patients to make decisions that will affect their health and wellbeing on proper information. The significance of the risks and uncertainties, including the possibility of alternative treatment, being sensitive to the characteristics of the patient.

The question then became what should the obstetrician have told the Claimant's mother had further scans been undertaken. In the Court's view, the answer was to be found in the last words of the trial judge's Judgment namely that there was "*An emerging but recent and incomplete material showing increased risks of delay in labour in cases with this combination of features*".

On this basis it is clear that following Montgomery the obstetrician would have been required to discuss this information with the Claimant's mother and set out the arguments in favour of non-intervention. The Court of Appeal allowed the Claimant's Appeal and reversed the Judge's decision on the issue of liability.

The second consent case of the quarter was **Thefaut -v- Johnson**, a case concerning informed consent in respect of elective spinal surgery to rid the Claimant of back and leg pain. The Claimant sustained non-negligently caused nerve injury which resulted in permanent pain and sensory loss. The Claimant failed to establish that the injuries were negligently caused; the case focused on whether the Claimant gave informed consent.

The Defendant surgeon discussed the surgery with the Claimant and followed up this discussion with a letter summarising his advice. The judge found that the process of obtaining informed consent was inadequate; the Defendant surgeon –

- Materially overstated the chances of eradicating or mitigating the Claimant's back pain and the potential outcome following surgery;
- formulated his advice in a manner that made it sound as though there was, to use the judge's words, "*a racing certainty*" that the Claimant's leg pain would be eradicated. He was optimistic in his assessment;
- failed to advise the Claimant of the inherent risk that any non-negligently performed surgery could exacerbate his condition, and
- failed to advise the Claimant of the inherent risks associated with anaesthesia.

Viewed cumulatively, a combination of a 50:50 chance of success in relation to eradication of back pain, in conjunction to a 5% risk of making things materially worse were factors considered highly material when compared and contrast with the option of no operation and a recovery trajectory of up to 12 months but thereafter gradually receding pain.

The judge concluded that being fully or properly advised, the Claimant would have either rejected the option of surgery, or at least deferred that option until she had received a second opinion. On causation, the judge held that if the surgery had taken place on another day then the damage would not have occurred.

This is an important decision that provides a further gloss on the Montgomery case. Doctors need to explain the risks and benefits of various treatment options that are material to each particular patient. In practice, when assessing these risks and benefits this is likely to involve various face to face meetings and discussions between doctor and patient to insure the patient gives informed consent. The way in which pre-operative appointments are managed and conducted will need to change in both the NHS and private sector.

Civil Procedure (relief from sanctions)

The case of **Thompson -v- Sam Reeve (1), MIB (2), Mid Essex Hospital Services NHS Trust (3)** concerned an application heard by Master Yoxall on behalf of the Claimant to ask the Court to correct a procedural irregularity relating to the withdrawal of a Part 36 offer the day after the Lord Chancellor announced the change in discount rate. The Claimant's solicitor emailed a letter to the defendants stating that their previous Part 36 offer had been withdrawn. The Claimant had not obtained confirmation from the defendants that they were willing to accept service by email. The defendants faxed acceptance of the Claimant's Part 36 offer two

days later. The initial Part 36 offer was £340,000, the change in discount rate increased the value of the claim to £602,500.

Receipt of the Claimant's written notice of withdrawal was not in dispute; it was the method of serving the notice that was said to be defective and the focus of the application. Master Yoxall allowed the Claimant's application under CPR 3.10 and made an order rectifying the procedural irregularity by making an order that the notice of withdrawal of Part 36 offer be treated as the date it was emailed to the defendants' solicitors. Master Yoxall stated "*… it would not be just or consistent with the overriding objective that a technical breach of the rules should impede the proper assessment of damages in this case.*"

Impartiality/bias

The first appeal decision in this category to be handed down was in the case of **EXP -v- Dr Giles Simon Barker**. The case related to the failure to identify an aneurism on brain MRI scans which subsequently ruptured resulting in severe neurological injury to the Claimant. The appeal centred around whether the Defendant's neuroradiology expert was impartial (it transpired at trial that the expert previously worked with, and trained, the Defendant neuroradiologist), and whether the Judge applied the *Bolam* test appropriately. The Court of Appeal rejected the appeal on the basis that a Judge was entitled to consider the impartiality of an expert and pay less weight to evidence considered to be lacking in independence or impartiality.

In the circumstances of this case the Judge had a considerable body of evidence, firmly expressed by those with proper expertise, to support the proposition that there was presence of an aneurism in the Claimant's 1999 MRI scan, and the proposition that any reasonable properly qualified neuroradiologist should, and would, have referred the Claimant for further investigation on the basis of that scan.

This decision shows the importance of the model direction within the standard clinical negligence directions Order that states, "*Experts will, at the time of producing their reports, incorporate details of any employment or activity which raises a possible conflict of interest*". This case is a sobering reminder of the importance of experts to discharge their duty when giving evidence in civil proceedings.

The case of **Willmott -v- The Rotherham NHS Foundation Trust,** also heard by the Court of Appeal, concerned knee replacement surgery in a patient who may have had inflammatory arthritis of the knee joint at the time of surgery. The question for the trial judge was whether in these circumstances it was appropriate for the Defendant surgeon to use a cementless implant.

The Claimant made an application during the course of the trial that the judge recuse himself on the grounds of apparent bias or predetermination due to the judge's background knowledge about knee replacements (the judge informed both parties in open court that he was familiar with the science of knee replacement surgery having previously undergone such a procedure). The Court of Appeal noted the judge "*…was right to dismiss the application. A judge is not precluded from hearing a case just because he knows more about the general area than another judge might do, so long as he makes sure that he genuinely tries the case on the evidence heard in the course of the trial and explains his reasons by reference to that evidence.*" However, the Court was critical of the judge taking up too much time talking about his own knee problem with the Claimant's expert witness and asked too many questions of the expert which would have been better left for counsel. That said, there was no

objective appearance of bias or predetermination on the part of the judge. The appeal judges noted that it was "unwise" of the judge to refer so extensively to his own experience of knee treatment and to his background reading on the subject. This fuelled the application for recusal and fuelled the subsequent appeal when he had found in the Defendant's favour.

The judge was entitled to find that on balance of probabilities, at the time of the operation, in 2008 the Claimant did not have inflammatory arthritis in her left knee. On this basis it was reasonable to conclude the diagnosis of there being the presence of osteoarthritis. Therefore, no negligence on the part of the surgeon was found in respect of his decision to opt for a cementless implant.

Extent of Liability

The case of **Darnley -v- Croydon Health Services NHS Trust**, heard by the Court of Appeal, involved an issue of public significance – should the law impose a duty of care on an A&E receptionist who did not give correct information to a patient about waiting times? The trial judge felt such a duty should not be imposed, the question was referred to the Court of Appeal.

The Claimant, after sustaining a head injury and presenting to A&E, was told to wait in reception of the A&E department and informed by one of the receptionists on duty that it would be up to 4 or 5 hours before he would been seen. In fact the system at the hospital was that a triage nurse would examine the Claimant within 30 minutes. After 19 minutes the Claimant and his friend left the A&E department and did not notify the reception staff that he was leaving. Later that evening the Claimant's condition deteriorated and he was taken back to the same hospital, this time by ambulance. A CT scan revealed an extradural haematoma. Unfortunately, it was too late to prevent permanent injury. The Claimant sustained left hemiplegia and long-term disabilities.

The Court, by majority, noted that a receptionist's duties are clerical. Their function is to record details of new arrivals, to tell patients where to wait and to pass on relevant details to the triage nurses. It is not their function, or their duty, to give any wider advice or information to patients. When the receptionist in this case told the Claimant the likely waiting time, albeit wrong, she was not assuming responsibility to the Claimant in the sense of accepting responsibility for the catastrophic consequences, which he might suffer if he simply walked out of the hospital.

Furthermore, the Court held that it would not be fair, just and reasonable to impose upon the receptionist a duty not to provide inaccurate information about waiting times. Lord Justice Jackson held *"… this would add a new layer of responsibility to clerical staff and a new head of liability for NHS health trusts."* He went further, "*… there comes a point when people must accept responsibility for their own actions. The Claimant was told to wait. He chose not to do so. Without informing anyone of his decision, he simply walked out of the hospital*."

Lord Justice Sales summed up the point eloquently, "*… in my judgment, the fair, just and reasonable view is that such information [waiting times] is provided as a matter of courtesy and out of a general spirit of trying to be helpful to the public, as the judge held, and that its provision is not subject to a duty of care in law such that compensation must be paid if a mistake is made. Imposition of such a duty would be likely to lead to defensive practices on the part of NHS Trusts to forbid their receptionists to provide any information about likely waiting*

times, as the judge observed. This reflects the fact that provision of such information is not part of the core function performed by a receptionist. It also indicates that there would be a social cost of imposition of a duty of care, in terms of withdrawal of information which is generally helpful to the public when provided as a courtesy, which is not offset by consideration of justice as between claimant and defendant in this sort of case."

Costs & Funding

On 24 February 2017 judgment in the case of **Merrix -v- Heart of England NHS Foundation Trust** was given. It was an appeal from District Judge Lumb sitting as a Regional Costs Judge in Birmingham. The appeal related to the determination of a preliminary issue formulated by District Judge Lumb as follows: "*to what extent, if at all, does the cost budgeting regime under CPR Part 3 set the powers and discretion of the costs judge at a detailed assessment of costs under CPR Part 47?*"

Mrs Justice Carr's answer to the preliminary issue was "*where a costs management order has been made, when assessing costs on a standard basis, the costs judge will not depart from the receiving party's last approved or agreed budget unless satisfied that there is good reason to do so. This applies as much where the receiving party claims a sum equal to or less than the sum budgeted as where the receiving party seeks to recover more than the sums budgeted.*"

In reaching this decision Mrs Justice Carr gave judicial interpretation to the meaning of CPR 3.18. She stated that the words used within this provision were clear. The Court will not (the words are mandatory) depart from the budget, absent good reason. On a detailed assessment on a standard basis, the costs judge is bound by the agreed or approved cost budget, unless there is good reason to depart from it. No distinction is made between the situation where it is claimed that budgeted figures are or are not to be exceeded. It is not possible to square the words of CPR 3.18 with the suggestion that the assessing costs judge may nevertheless depart from the budget without good reason and carry out a line by line assessment, merely using the budget as a guide or factor to be taken into account in the subsequent detailed assessment exercise. The obvious intention of CPR 3.18 was to reduce the scope of and the need for detailed assessment.

Notwithstanding this decision, there will still be a need for a detailed assessment. The question becomes how the detailed assessment should be conducted. There remains room for detailed assessment outside the budget – for example, in relation to pre-budget incurred costs not subject of the cost budget; costs of interim payments which were reasonably not included in a budget; where costs are being assessed on an indemnity basis; where the costs judge finds there to be a good reason for departing from the costs budget.

What is clear from this decision is that the parties to litigation need to bear the budget in mind at every step of the litigation process. Budgets should not be prepared in haste; instead considered in detail during the cost budgeting stage. With proper, realistic co-operation and agreement between the parties the costs management hearings should be focused and tailored to the specific circumstances of the case. If costs budgeting is conducted properly, cost budgets will give both parties to litigation a legitimate expectation as to their potential costs liability.

Will Merrix be the final word on this matter? The simple answer is, no. The case of **Harrison -v- Coventry NHS Trust,** which was decided by Senior Costs Judge Master Gordon-Saker on 16 August 2016 has been

leapfrogged to the Court of Appeal. Within that case Master Gordon-Saker concluded that CPR 3.18 meant that there would not be a line by line detailed assessment absent good reason otherwise cost budgeting would serve no meaningful purpose. It is anticipated that the Court of Appeal will hear the Harrison appeal in May 2017. Watch this space!

The Supreme Court in **Plevin -v- Paragon Personal Finance Limited** handed down their decision on 29 March 2017 by way of a majority decision given by Lord Sumption. The case concerned whether a pre-LASPO CFA and ATE insurance premium had been validly assigned, and whether the success fee and ATE premium were still recoverable on an interpartes basis.

Based on the interpretation of the transitional provisions within section 44 of LASPO the Court held that the two variations of the CFA were provided for litigation services in relation to the same underlying dispute as the original CFA, albeit at the appellate stages. Whether a variation amends the principle agreement or discharges and replaces it depends on the intention of the parties. For a discharge and replacement, the intention should have been clear that the aim was a complete extinction of the first and formal contract, and not merely the desire of an alteration.

As for the ATE policy, this was topped up for the appeals at Court of Appeal and Supreme Court level. The top ups did not give rise to fresh insurance policies. The top up for appeal proceedings is part of the litigation process, part of defending what the Claimant had won by virtue of being funded under the original policy. The effect, if the top-up premium was deemed not to be recoverable, would retrospectively alter the balance of risks on the basis of which the litigation began.

If you have been affected by the issues discussed in any of these cases, please contact Richard Lodge or a member of our Clinical Negligence team. Alternatively, you can contact us on 020 7814 1200 or email us at enquiries@kingsleynapley.co.uk.

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