1 COR
1 CROWN OFFICE ROW

The 1COR Quarterly Medical Law Review

Updates and analysis of the latest legal developments

Spring 2019 | Issue 1

Editorial Team

Jeremy Hyam QC

Shaheen Rahman QC

Suzanne Lambert

Matthew Flinn

Dominic Ruck Keene

Rajkiran Barhey

Welcome to the first issue of the Quarterly Medical Law Review, brought to you by barristers at 1 Crown Office Row. In our first issue of QMLR:

Shaheen Rahman QC discusses the case of North West Anglia NHS FT v Gregg [2019] EWCA Civ 387, which concerns disciplinary proceedings against doctors and looks at whether an employer is entitled to suspend pay and proceed with a disciplinary process even when criminal proceedings are outstanding - see pages 2 to 4.

Matthew Flinn takes us through two judgments on expert evidence: Bowman v Thomson [2019] EWCHC 269; and Mays v Drive Force (UK) Ltd [2019] EWHC 5; in particular focussing on the thorny issue of 'expert shopping' and the circumstances in which the court will allow evidence on life expectancy to rebut the 'average' cohort as contained in the Ogden tables – pages 4 to 7.

Suzanne Lambert considers the relationship between the quantum of damages and the scope of the duty of care as most recently considered by the Court of Appeal in Meadows v Khan [2019] EWCA Civ 152 – pages 7 to 8 (see also the case of Paul Pomphrey in the Hot off the Press section pages 15-16).

Jeremy Hyam QC discusses interim payments, causation and the *Eeles* test in the light of the recent decision of Spencer J. in Farrington v Menzies-Haines [2019] WLUK 157 - pages 8 to 9.

Rajkiran Barhey looks at two judgments considering applications for anonymity orders and the factors which will point for and against anonymity being granted both in the clinical negligence context (Zeromska-Smith v Lincolnshire NHS Trust [2019] EWHC 552; and in the GMC context (GMC v. X [2019] EWHC 493); pages 9 to 12; and

Dominic Ruck Keene analyses three recent judgments on medical treatment and consent; Keh v Homerton [2019] EWHC 548 (QB); Kennedy v Frankel [2019] EWHC 106 (QB); and Ollosson v Lee [2019] EWHC 784 (QB) each of which illustrate the critical importance of both limbs of informed consent post-Montgomery viz. what advice should have been given, and what, as a matter of factual causation, a patient would have done if given appropriate advice. – pages 12 to 15.

Finally, see our **In Brief** and **Hot Off the Press** sections. If you would like to provide any feedback or further comment, do not hesitate to contact the editorial team at **medlaw@1cor.com.**

INJUNCTIONS

Shaheen Rahman QC

North West Anglia NHS Foundation Trust v Gregg [2019] EWCA Civ 387

A Consultant Anaesthetist obtained an injunction from the High Court to prevent his employer, an NHS Trust, proceeding with a disciplinary investigation into patient deaths whilst a parallel police investigation took place. The Court of Appeal held that the injunction was wrongly granted. The Trust was entitled to proceed with the investigation as no real danger of any miscarriage of justice in any criminal proceedings had been established. The Trust was also entitled to hold a hearing to consider whether the doctor could be dismissed on the alternative basis that his registration to practice had been subject to interim suspension by his regulator. However, there was no provision in his contract that enabled the Trust to withhold his salary during his suspension and it was unlawful for the Trust to have done so.

The judgment

The NHS Trust had concerns that the doctor had hastened the death of a patient in intensive care. Following an investigation, including a disciplinary interview, he was suspended on full pay pending a hearing. He was referred to the GMC and the police commenced their own investigation but brought no charges. Meanwhile, a second patient death was identified by the Trust as being of concern and the police commenced a further investigation. The doctor objected to being interviewed in relation to the second case by the Trust whilst the criminal investigation was ongoing. A request for a postponement was refused and the doctor sought injunctive relief.

The doctor also sought relief in respect of the Trust's actions following the Medical Practitioners Tribunal Service's ('MPTS') decision to impose an interim suspension on his registration to practice. The Trust took the view that it could revoke its own suspension of the doctor and cease paying his salary. It argued that the doctor was no longer available for work in the terms contemplated by paragraph 25 of Part II of the Department of Health document '*Maintaining High Professional Standards in the Modern NHS*' ('MHPS') which was incorporated within his contract of employment. In any event, under common law principles, he was not "*ready, able and willing to work*". The Trust also contended that it was entitled to terminate his contract on that basis and that it would convene a hearing to consider whether to do so, which the doctor also sought to prevent.

Deduction of pay during suspension

The judge had determined the issue of deduction of pay during suspension solely on the basis that paragraph 25 of Part II of the MHPS applied. She held that pay could only be deducted under this provision where an employee had become unavailable for work as a result of some self-induced cause, rather than the action of a third party.

The Court of Appeal upheld the judge's conclusion but on different grounds. It noted that the doctor's suspension by his regulator was designed to preserve the position until more was known about the allegations and to allay public concern until they were resolved. The suspension did not terminate the doctor's employment. The court held that, given the increasing complexity of contracts of employment, the issue of whether or not suspension without pay is appropriate must be determined by reference to the contract in question. The common law test of being "*ready, willing and able*" to work had been applied inconsistently in recent cases, but where the inability to work had arisen as a result of a third party decision or "*unavoidable impediment*" it may be unlawful to deduct pay, depending on the terms of the contract.

Moreover, the approach to the concept of "*unavoidability*" on the basis that it was to be "*narrowly construed*" was wrong in principle. To suggest that suspension arising from unproven allegations about an employee's actions or the bringing of criminal charges was "*avoidable*" was uncomfortably close to an assumption of guilt.

In the instant case, the express terms of the contract did not permit the deduction of pay during an interim, non-terminatory suspension. Had this been intended the contract would have said so. Such a term could not be implied - it was not necessary to make the contract work, nor was it *"obvious"* and it would, in any event, run contrary to the mandatory terms of the contract as to payment.

Paragraph 25 of Part II of the MHPS was not of direct relevance since it only applied during the period of exclusion by the Trust, which had been revoked when the MPTS interim suspension was imposed. However, it was of some assistance in supporting the court's analysis as it provided that exclusion would normally be on full pay. That was also the position under the Trust's own disciplinary policy.

There was no custom or practice or any alternative basis upon which the Trust could rely to deduct pay. There might be exceptional circumstances such as a complete or partial acceptance of guilt justifying deduction of pay during an interim, non-terminatory suspension but the default position where the contract does not address the issue would be that it should not.

Termination of employment due to interim suspension of registration

The Court of Appeal noted that the judge had taken the view that the Trust was entitled, pursuant to the express terms of Schedule 19 of the Terms and Conditions of employment, to terminate the doctor's contract on the grounds that he had not maintained his registration to practice. However, she held that, as the Trust had not terminated the contract, but had decided to hold a hearing to decide whether to do so, it had, in fact, elected to treat the contract as continuing notwithstanding the *"repudiatory"* action of the doctor in failing to maintain registration and were proposing an unfair process in seeking to hold a hearing as a *"nebulous alternative"*.

The Court of Appeal disagreed with the judge as to the proposal to hold a hearing to consider whether to terminate. The Trust was attempting to give the doctor an opportunity to address the issue at a hearing, though it was not obliged to do so, and this could not be criticised as unfair or in breach of the implied term of trust and confidence. The judge was, in any event, wrong to equate the implied term of trust and confidence with a general duty to act fairly. The test to show that an employer is in breach of that term is a *"severe"* one and must amount to conduct calculated to destroy or seriously damage the relationship of trust and confidence without any reasonable or proper cause.

The court also took the view that the judge's assumption, that the fact of the doctor losing his registration to practice amounted to a repudiatory breach of contract, may well be wrong. It noted again that this was an interim measure imposed by a third party against the doctor's will and prior to any final determination of culpability. Subsequent events were noted – criminal charges had not ultimately been brought in relation to either case, the Trust was proposing to proceed with only one of them at the forthcoming hearing and the doctor had always disputed the allegations. The court issued a *"warning"* that there must be a real risk that any future termination of the doctor's contract on the basis of the interim suspension would amount to unlawful dismissal or breach of contract. However, it was not for the judge, or for the instant court to determine this by way of an application for a pre-emptive injunction.

Postponement of the hearing pending criminal investigation

The judge considered that the Trust had failed to engage with the doctor's concerns, on the basis of privileged legal advice, about participating in an interview whilst the criminal investigation was ongoing and that this amounted to a breach of the implied term of trust and confidence.

The Court of Appeal disagreed. It considered that the principles to be derived from the case law were that an employer does not usually need to wait for the conclusion of criminal proceedings before considering whether to

dismiss an employee or proceeding with a disciplinary hearing. The court would only intervene where there was a real danger rather than a notional risk of a miscarriage of justice in criminal proceedings. Moreover, the threshold for the court to interfere with the Trust's management of its own employees was high and the case law emphasised that the court should not engage in micromanagement of employment procedures. Whilst the judge had discretion to grant the injunction, she had applied the wrong test. As above, she had wrongly equated the implied term of trust and confidence with a general duty to act fairly when it was a far more severe test. In re-exercising the discretion, the Court of Appeal held that in attempting to pursue its own disciplinary process the Trust could not be said to have taken action calculated to destroy or seriously damage the relationship of trust and confidence and there was good reason for it to wish to follow that process rather than await events in the criminal investigation.

The court also held that there was no evidence that proceeding with the disciplinary process, which it noted would be determined on the basis of a lower standard of proof, would have had any effect on the criminal investigation or given rise to a real danger of a miscarriage of justice. The doctor had already been interviewed by police and could have provided a copy of that statement to his employers, as he subsequently elected to do when the decision not to press criminal charges had been made. The fact that some privileged legal advice had been given not to participate could not be determinative of whether an injunction to prevent a disciplinary process continuing should be granted in every case. The countervailing consideration was the contractual obligation on the doctor to participate in disciplinary proceedings.

Comment

This judgment provides reassurance to healthcare professionals subject to interim suspension by their regulators on the basis of unproven allegations. Absent express provision in their contracts their employers should not usually be able to dock pay. Moreover, terminating employment on such grounds may well amount to a breach of contract or unlawful dismissal and the court's warning to this effect will no doubt trouble employers considering such a course.

Nonetheless, the judgment provides little encouragement to those considering invoking the jurisdiction of the High Court in such cases given the Court of Appeal's conclusion that the injunction should not have been granted and its emphasis upon the severe test for establishing a breach of the implied term of trust and confidence and the need to avoid micromanagement of employers' disciplinary processes by the court.

Jeremy Hyam QC appeared for the Respondent. He did not contribute to this article.

EXPERT EVIDENCE

Matthew Flinn

Jones v Taunton & Somerset NHS Foundation Trust [2019] EWHC 563 (QB)

The court permitted a Defendant NHS Trust to substitute its medical expert eleven weeks before trial where its original expert had stated that the Claimant's experts had raised matters that went beyond his expertise.

The case related to a brain injury suffered by the Claimant in utero in November 1995. It was alleged that the Claimant's mother had negligently been provided with a drug (Nifedipine). Initially, the Claimant's causation case was founded on the allegation that the drug had caused the mother's blood pressure to drop, but the Claimant later clarified in response to Part 18 requests for further information that it was also alleged that the drug had crossed the placenta and had impacted directly upon the fetus in utero.

At a CMC in January 2018, permission was given for both parties to instruct obstetric experts on breach and causation. Expert reports were exchanged in late September 2018. On 7 November 2018 the Defendant's obstetric expert wrote to the Defendant's solicitors and stated that the Claimant's reports and the

appended literature raised issues that: "*far exceed my area of expertise*" and were best addressed by an expert in fetomaternal medicine. The Defendant then sought assistance from another expert with the appropriate expertise but did not make an application to substitute the expert until February 2019, approximately three months before trial (May 2019).

The judgment

HHJ Blair QC was critical of the Defendant's conduct in that there had been a lack of full transparency and prompt action as these issues arose, but acknowledged that the case was complex and that the Defendant would be at a serious disadvantage if it was forced to proceed to trial with an expert who considered that crucial aspects of the case on causation were beyond his expertise. On the other hand, it was noted that the Claimant would be at some disadvantage if the substitution were allowed, in that the Claimant would now have to consider and respond to a new expert report shortly before trial.

Ultimately, the court allowed the Defendant's application. The key reason appears to be that it was necessary in order for the Defendant to be able to advance its case on the core issues on which the court would require substantial expert assistance. Any prejudice to the Claimant was mitigated by a direction that the forthcoming trial would deal with breach of duty only, with causation to be addressed at a further hearing at a later date.

Comment

This case underscores the principle of equality of arms, and that each party should be able to put forward the whole of their case unless there are strong reasons militating against it. It is also to be noted that, given there had already been an exchange of expert reports at an earlier stage in proceedings, there was no acute issue relating to disclosure of a previous expert in order to discourage expert shopping: (c.f. Beck v Ministry of Defence [2003] EWCA Civ 1043 and Vilca v Xstrata Limited [2017] EWHC 1582). The court rejected an argument that a possible draft report from the Defendant's new expert ought to be disclosed as a condition of permission being granted.

Bowman v Thomson [2019] EWHC 269 (QB)

The court rejected a Defendant's application that disclosure of the Claimant's previously instructed expert's report (in whom the Claimant had lost confidence) should retrospectively be made a condition of his permission to rely on a second expert upon whom the Claimant had already been granted permission to rely.

In the substantive claim, the Claimant alleged that he had been given negligent treatment and advice by the Defendant GP during a home visit when he reported symptoms of back pain. It was alleged that, as a result, there was a delay in referring him to hospital, and consequently he underwent decompression surgery for cauda equina syndrome from which he made an incomplete recovery.

Prior to the issue of proceedings, he obtained an "advisory report" from an expert urological surgeon on causation, and a more formal report on causation once proceedings had been issued. However, by the time of the case management conference, the Claimant had lost confidence in his expert, and obtained a second opinion from a different urological surgeon. Permission was sought at the CMC to rely on the report of that second expert. The fact that another expert had previously been instructed and then abandoned had not been enquired about and not been disclosed by the Claimant at the time permission was granted. Accordingly, permission was granted without any condition attached that the first report should be disclosed.

Upon becoming aware that the Claimant had obtained previous expert evidence, the Defendant applied for a condition to be attached to the grant of permission for the second expert, specifically that the Claimant be required to disclose the evidence of the first expert.

The judgment at first instance

HHJ Roberts rejected an application for such a condition to be attached to the permission retrospectively under rule 3.1(m) of the Civil Procedure Rules (the power to "take any other step or make any other order for the purposes of managing the case and furthering the overriding objective…"). On appeal against that decision, the Defendant argued that the judge had erred in his approach to rule 3.1(m), and also that he could, and ought to have, varied the order under rule 3.1(7).

The judgment on appeal

Dingemans J dismissed the appeal. After reviewing the key authorities (Lane v Willis [1972] 1 WLR 326, Beck v Ministry of Defence [2003] EWCA Civ 1043, Vasiliou v Hajigeorgiou [2005] EWCA Civ 236, Edwards-Tubb v JD Wetherspoon Plc [2011] EWCA Civ 136) he concluded that "*if there is a principled way in which a vehicle can be identified to order disclosure of a prior privileged report, disclosure should be ordered. However, attempting to use general case management powers or making a variation of an order after the event is not permitted*." He noted that the Defendant had not asked if the Claimant had previously instructed a different expert prior to, or at the time of, the CMC, although it could have done so, and "*the time for asking was before the order was made*".

Comment

Although Dingemans J. tried to emphasise that this was a "*very fact specific decision*", it could be of great significance to the way litigation is conducted. Its effect appears to be that if one party knows the opposing party has previously instructed a different expert prior to the grant of permission to rely on expert evidence, that party can seek an order that permission is conditional on disclosure of the first report which the court will normally grant in order to discourage expert shopping.

However, if the party does not know about the previous instruction, and permission is granted to rely on the second expert without any conditions attached, the court will be unlikely to go back and vary the permission granted by attaching a condition when that party subsequently discovers the position.

It would therefore seem to be important for parties to establish whether or not any changes of experts have occurred prior to permission being sought and granted in the first instance – despite that being an outcome deplored by both the parties and the judge in this case.

Mays (by his litigation friend, the Official Solicitor) v Drive Force (UK) Ltd [2019] EWHC 5 (QB)

The court permitted the parties to adduce expert evidence on life expectancy where the Claimant had a number of co-morbidities, the claim was of substantial value, and evidence on life expectancy could make a significant difference to the quantification of the claim.

In this sad case, the Claimant had fallen from a lorry in a workplace accident and suffered catastrophic brain and orthopaedic injuries. Liability had been admitted, and a range of experts had been instructed on both sides to assist the court with quantifying damages. The Claimant had a range of co-morbidities which were unrelated to the accident, including smoking, hypertension, obesity and ulcerative colitis.

The Defendant sought permission for the parties to rely on expert evidence dealing specifically with life expectancy, in view of the Claimant's range of co-morbidities, which the instructed experts were not able to adequately address themselves.

The Claimant opposed the application, inter alia on the basis that life expectancy matters are usually dealt with by the clinical experts, and separate expert evidence on life expectancy (relying on statistics) was usually reserved for cases in which those clinicians interpreted the data in fundamentally different ways. He also raised a floodgates argument – that such experts would become common whenever life expectancy was in issue.

The judgment

The court concluded that such evidence was justified in this case. It decided that the

authorities showed that the court should consider whether factors unrelated to the accident have impacted on life expectancy "*in an appropriate case*" and that it was a matter for the trial judge as to whether or not that evidence proved to be of assistance.

Comment

The decision shows that the relevant factors in favour of admitting such evidence are: (1) where there is a range of significant co-morbidities (2) the other experts are clearly unable to deal adequately with the issue themselves (3) the size of the claim, and (4) whether or not evidence on life expectancy could potentially make a significant difference to the quantum of the claim.

DAMAGES AND THE SCOPE OF DUTY

Suzanne Lambert

Meadows v Khan [2019] EWCA Civ 152; [2019] 4 WLR 26

In this case the Court of Appeal confirmed that when considering the question of liability for damages in negligence for wrongful birth, the correct test was the 'scope of duty' test in Australia Asset Management Corp v York Montague Ltd [1997] AC 191 ("SAAMCO"), rather than the simple 'but for' causation test. The Defendant doctor should be liable only for the type of loss which fell within the scope of her duty to protect the Claimant mother against.

Facts

Before becoming pregnant, the Claimant mother had wanted to establish whether she carried the haemophilia gene. Blood tests were arranged and when she saw the Defendant doctor she was advised that the results were normal and was led to believe that any child she had would not have haemophilia. However, in order to establish whether she was a carrier, genetic testing (rather than blood testing) would have been required. When she subsequently became pregnant and gave birth to a son, who had both haemophilia and autism, she brought a claim for damages based on wrongful birth.

The Defendant doctor admitted that, but for her negligence, the child would not have been born because the mother would have undergone fetal testing for haemophilia during her pregnancy and would have had a termination. Prior to trial, the parties agreed that if the court determined that the doctor was liable for the additional losses associated with both haemophilia and autism, she was entitled to quantum in the sum of £9,000,000. However, if the court rejected the claim arising from the additional losses associated with autism, quantum was limited to the sum of £1,400,000.

At first instance, the court found that the mother was entitled to the additional costs arising from the autism, even though it was unrelated to the haemophilia. The doctor appealed against that decision.

The Court of Appeal allowed the doctor's appeal. Lady Justice Nicola Davies gave the lead judgment. She noted that the purpose of the mother's consultation with the doctor was "*directed at the haemophilia issue and not the wider issue of whether, generally, the Respondent should become pregnant.*" Given the limits of the advice sought and the appropriate testing which should have been provided, the scope of duty test identified by Lord Hoffman in SAAMCO was not only relevant but determinative of the issues.

Application of the SAAMCO test

The court accepted that, in applying the SAAMCO test, the court had to establish: (i) the purpose of the procedure/information/advice which was alleged to have been negligent; (ii) the appropriate apportionment of risk; and (iii) the losses which would have been sustained if the correct information had been given.

In the instant case, the purpose of the consultation was to establish whether the mother was a carrier of the haemophilia gene to enable her to make an informed decision in respect of any child which she conceived. Given the specific purpose of her enquiry, it would be inappropriate and unnecessary for a

doctor at such a consultation to volunteer any information about other risks of pregnancy including the risk of autism. That was a decision for the mother to take having considered a number of factors. The case was therefore different from the wrongful birth cases such as Parkinson v St James and Seacroft University Hospital NHS Trust [2001] EWCA Civ 530, and Groom v Selby [2001] EWCA Civ 1522, where the duty was to prevent conception/birth of a child and the respective defendants were held to assume responsibility for all of the problems associated with those unwanted pregnancies.

As to the apportionment of risk, the doctor would be liable for the risk of giving birth to a child with haemophilia. The mother would take the risks of all other potential difficulties of the pregnancy and birth, including the risk of having a child born with autism, an unrelated risk which was not increased by the doctor's negligent advice.

Therefore, the loss which would have been sustained if the correct information had been given and appropriate testing performed would have been that the child would have been born with autism.

The incorrect application of the 'but for' causation test

Nicola Davies LJ explained that, in concluding that the doctor should be liable for the losses associated with autism - a type of loss that did not fall within the scope of her duty to protect the mother against - the trial judge did not apply the SAAMCO 'scope of duty' test but reverted to the 'but for' causation test.

The SAAMCO test required there to be an adequate link between the breach of duty and the particular type of loss claimed. It was not enough to find there was a link between the breach of duty and a stage in the chain of causation – in this case, the pregnancy itself - and then conclude the Defendant was liable for all the reasonably foreseeable consequences of that stage, i.e. the pregnancy.

The trial judge had erred in drawing an analogy with Chester v Afshar [2004] UKHL 41, where the misfortune which befell the claimant was the very misfortune which was the surgeon's duty to warn against and therefore was within the scope of defendant surgeon's duty. In contrast, in this case, autism was a coincidental injury and not within the scope of the doctor's duty. It was closer to the analogy of the mountaineer's knee in SAAMCO or Lord Walker's example of the speeding taxi-driver in Chester.

SAAMCO was determinative

Nicola Davies LJ made clear that it was not necessary for the court to consider whether it was fair, just and reasonable to impose liability for the additional costs associated with autism. The established principles in SAAMCO encompassed those concepts and it was neither necessary nor desirable for the court to express a subjective view. Moreover, it was not a novel type of case where the established principles do not provide an answer and required the courts to go beyond those principles in order to decide whether a duty of care should be recognised.

INTERIM PAYMENTS AND EELES

Jeremy Hyam QC

Farrington v. Menzies-Haines [2019] 3 WLUK 157

This was a brain injury claim following an RTA. Liability, subject to an argument on contributory negligence, was admitted. As to causation, the Defendant disputed the extent to which the Claimant's injuries were attributable to any brain damage caused by the accident. The trial date was set for 2020. The imaging of the Claimant's brain demonstrated a significant recovery. The argument at trial was going to be that any continuing problems the Claimant suffered were not as a direct result of the brain injury but to do with other life-changing events in the Claimant's life and/or his excessive cannabis use. The Defendant's insurer had been funding the Claimant's care and rehabilitation since the accident but from September 2018 had expressed reservations about the care and stopped making payments to cover it.

The Claimant's case on the interim payment application under CPR 25.7 was that a recent neuro-psychiatrist's report supported the case that the Claimant suffered dysexecutive syndrome from frontal lobe damage which he contended established the necessary causal connection between the accident and his condition. It was therefore argued that, applying Eeeles, the court should assume that a figure for past losses and general damages would be around £900,000 on a conservative estimate, and therefore total interim payments of £710,000 (£260,000 had already been paid) would be well within that figure. The Defendant opposed the application on causation grounds arguing that it could not be assumed that the neuro-psychiatrist's evidence would be accepted at trial and, if it was rejected, the Claimant had already received more than the claim was worth.

The judgment

Spencer J rejected the interim payment application. Where there were genuine and substantive challenges to causation, the court could not award an interim payment by assuming that causation issues would be decided in the Claimant's favour. Otherwise, interim payment applications would be mini-trials on causation and the court would have to hear evidence. CPR 25.7 was not intended to cover the situation where significant issues of causation were at large.

Comment

This restatement of principle by Spencer J is welcome and highly relevant to all interim payment applications made in brain injury cases where causation remains live. In clinical negligence, particularly birth injury claims, even where liability is admitted (and thus the prospect of an interim payment arises) there are frequently arguments as to causation of that injury, whether it is divisible and if so, what proportion, if any, of the Claimant's injuries are attributable to the index negligence.

As Spencer J has observed the court will not conduct '*mini-trials'* with evidence to determine causation issues at the interim payment stage. The case might usefully be compared with Goose J's decision in Sym v. Buckinghamshire Healthcare NHS Trust [2018] EWHC 2947 a back causation case last August, where although the defendant maintained causation arguments with respect to the claimant's chronic back pain, it was accepted that the claimant would recover 'something', and the judge held that after a 60% reduction to reflect the Trust's '*concerns*', the claimant would be awarded an interim which incorporated a 40% estimated sum for past loss of earnings, equipment, travel, therapies etc.

CPR 25.7(4) provides that the court must not order an interim payment of more than a reasonable proportion of the likely amount of the final judgment. As Eeles recognises at paragraph 43, the judge's first task is to assess the likely amount of the final judgment leaving out of account the heads of future loss which the trial judge might wish to deal with by PPO. If the causation evidence is such that the court cannot say with any degree of certainty what the likely amount of that final judgment sum is going to be because the issue of causation is very much at large, there is, in this commentator's view, no proper basis for a substantial interim payment application even where 'liability' is admitted. 'Liability' in such a context simply means: breach of duty and some causation (some damage being an essential ingredient of the tort of negligence). Thus where there is a real rather than fanciful dispute on the issue of causation which means that the likely amount of final judgment could be less than the interim payment sought, it is no part of the court's role to seek to engage in a preliminary determination of the causation issue. That is a matter which must be left to the trial judge.

ANONYMITY ORDERS

Rajkiran Barhey

Justyna Zeromska-Smith v United Lincolnshire Hospitals NHS Trust [2019] EWHC 552 (QB)

Spencer J refused an application for an anonymity order by the Claimant, who had suffered a stillbirth and psychiatric injury and

was bringing a clinical negligence claim against the NHS Trust.

The Trust conceded liability for the stillbirth and part of the Claimant's damages claim. The only issue was the claim for the Claimant's alleged pathological grief reaction combined with intractable depression.

The application

On the first day of the trial, the Claimant applied for an anonymity order to prohibit publication of her name. In support, the Claimant's solicitor made a statement noting that identification of the Claimant could cause irreparable damage to the family unit, interfere with the Claimant's private life and lead to a risk of suicide. She further stated that the public interest could be served without the need for disclosure of the Claimant's name.

Counsel for the Claimant further argued that the trial included deeply personal matters concerning her mental health and medical history and that identifying her would inevitably lead to identification of her children. It was also argued that she might face the risk of receiving online abuse and that, given her Polish background, this might even extend to racial abuse.

The Claimant had full capacity, but she was described as a "*highly vulnerable individual.*"

The resistance to the application

The NHS Trust took a neutral stance on the application. However, the Press Association argued that, although the Claimant's Article 8 ECHR rights to private and family life were engaged, the court also had to consider Article 10 – the freedom of the press.

They argued that it was exceptional for the court to grant anonymity orders in cases where the Claimant is not a protected party. They added that in such cases anonymity orders should only be made where necessary in the interests of the administration of justice.

Furthermore, they stated that they were signatories of the Independent Press Standards Organisation Code of Conduct which set out guidance on how to responsibly report on the issues raised by the case, and that the Claimant's concerns about privacy would be met by their adherence to the guidance in the Code.

The judgment

Spencer J refused to grant the anonymity order.

He began his judgment by emphasising the general principle of open justice. He noted that it was important for two main reasons: (1) to protect the rights of the parties and (2) to maintain public confidence in the administration of justice.

He then looked at Part 39 of the Civil Procedure Rules which emphasise that proceedings must be open unless privacy is necessary to protect the interests of party or for the administration of justice-: 'the open justice principle'.

Spencer J also looked at two previous cases in which the courts had recognised that Article 10 does not just protect the substance of ideas and information but also the form in which they are conveyed. Both cases acknowledged that being able to report the names of individuals makes a press report more compelling.

Spencer J also rejected the Claimant's attempt to rely on the case of JX MX v Dartford and Gravesham NHS Trust [2015] EWCA Civ 96 concerning an approval hearing. He agreed with the Defendant that approval hearings were not comparable with the present case for two main reasons:

1. In approval hearings, the court is exercising a protective function which is fundamentally different from its normal function of deciding disputes between parties.

2. A child or protected party in an approval hearing has no choice but to go before the court to have the settlement approved. They cannot settle the case privately and avoid court proceedings in the same way as an adult with full capacity.

Spencer J also distinguished another case which the Claimant attempted to rely on - ABC v St George's Healthcare Trust [2015] EWHC 1394 (QB).

In ABC the claimant was an adult woman with full capacity bringing a 'wrongful birth' claim against an NHS Trust over its failure to tell her that her father had Huntingdon's disease – a genetic inherited disease. She wanted to protect her child from inadvertently finding out through the media that they had a 50% risk of carrying the disease. It was accepted that the child could suffer serious consequences if they found out. Spencer J found that the circumstances of ABC were wholly different and exceptional from the present case. In particular, he noted that:

"In the present case, the revelation of the matters personal to this Claimant and her family are inherent and intrinsic to a claim of this nature, relating as it is to psychiatric injury suffered by the Claimant from the stillbirth of her daughter. Having chosen to bring these proceedings in order to secure damages arising out of that tragedy, the Claimant cannot avoid the consequences of having made that decision in terms of the principle of open justice and the consequent publicity potentially associated with such proceedings being heard in open court."

Timing of application

The application was made at the start of day 1 of the quantum trial. Spencer J noted that this did not give the Press Association enough time to make properly considered submissions.

He also noted that it effectively denied the Claimant of an important choice – had the Claimant known before the trial that she would not be granted anonymity, this may have affected her decision to settle the claim out of court.

He thus warned claimants and their advisers against assuming that a court will 'nod through' such applications.

General Medical Council v X [2019] EWHC 493 (Admin)

The High Court considered an application for anonymity made by Dr X.

The Medical Practitioners Tribunal Service ('MPTS') had upheld allegations of sexual misconduct and dishonesty made against Dr X, a neonatologist. The allegations arose out of an online sexual conversation which occurred between Dr X and an adult in a paedophile vigilante group who had pretended to be a child aged 15.

The MPTS imposed a 12-month suspension on Dr X's registration subject to further review. Dr X then requested the GMC not to publish any part of the determination other than the fact of the suspension for 12 months on the grounds of misconduct.

There was little dispute between the parties as to the legal principles. It was agreed that Article 2 ECHR (right to life) is engaged where there is a real and immediate risk to the life of an identified individual, and it is known or ought to be known to the relevant authority (the Osman duty). The GMC also accepted that its duty to publish MPTS findings *"in such manner as they see fit"* was subject to its obligations under the Human Rights Act 1998 as a public authority.

The application

On behalf of Dr X it was argued that the psychiatric evidence showed that Dr X suffered from depression and was at a significant and continuing risk of committing suicide. In particular, Dr X was concerned about the public disclosure his/her sexuality and the reaction from family members. This was later expressed as a more general concern about publication of the sexual misconduct allegations. Further it was argued that the medical evidence demonstrated that Dr X's risk of suicide was so high that publication would be a breach Article 2 and that a fair balance could be struck because the GMC would retain the power to provide specific information to specific persons (e.g. an employer) about Dr X's misconduct findings.

GMC's resistance to the application

The GMC accepted that the psychiatric evidence showed that Article 2 was engaged. However, it submitted that the court must balance the risk of suicide against the public interest in publication. In particular, there was a very strong public interest in maintaining public confidence in the integrity of the

register. If the register simply stated that Dr X had been suspended but provided no reasons, confidence in the integrity of the register would be damaged. Further, it was argued that redactions as to gender and sexuality were sufficient. Finally, the GMC argued that an anonymity order might prejudice the position on publication of the further review in 12 months.

The judgment

Soole J agreed that the court must carry out a balancing exercise and accepted that there is a weighty public interest in the integrity of the register. However, this was not absolute and he ultimately found that, in this case, there was clear and cogent medical evidence in support of the real and immediate risk of Dr X's suicide if publication occurred. On the particular facts of this case, this risk outweighed the public interest and publication would therefore breach Article 2.

Comment

These two interesting decisions on anonymity orders highlight a range of interesting issues. Perhaps the most important factor in explaining the differing outcomes in each case is the difference in medical evidence. In Dr X's case, they had provided specific, compelling and clear evidence as to Dr X's risk of suicide were the anonymity order not granted. By way of contrast, in Zeromska-Smith, the Claimant's solicitor had asserted in a witness statement that the Claimant would be at an increased risk of suicide were the order not granted but there did not appear to be any medical evidence adduced to support this claim. The Claimant could therefore not engage Article 2 which would have likely provided a much heavier counterweight to the public interest considerations than Article 8.

MEDICAL TREATMENT AND CONSENT

Dominic Ruck Keene

Three recent consent cases illustrate the critical importance of both limbs of an informed consent post-Montgomery - what advice should have been given, and what, as a matter of causation, a patient would do if given appropriate advice.

Keh v Homerton University Hospitals NHS Foundation Trust [2019] EWHC 548 (QB)

The Claimant's wife died as a result of sepsis following an emergency Caesarean section.

With regards to breach, the Claimant alleged that there had always been a high risk that induction would be unsuccessful, and that labour would result in an urgent C-section. His wife should accordingly have been warned of the risk and offered a C-section at the outset, and had she been so warned she would have elected to go straight to a C-section.

In respect of causation, the Claimant alleged that as most C-sections do not result in infection, then in reliance on Chester v Afshar [2004] UKHL 41 it was sufficient to establish that, had the C-section taken place at a different time to when it actually did, then infection would probably have been avoided, even if the risk of infection was unaltered by the timing of the operation.

Stewart J gave a concise and helpful summary of the relevant case law concerning both the relevant test for breach of duty in clinical negligence cases; the factors that should be taken into consideration when assessing what weight should be given to an expert's opinion as to whether particular treatment was reasonable; as well as Chester v Afshar itself.

He made a number of telling criticisms of the reliability of the Claimant's expert. This included that he had not been in regular clinical practice since 2007; that he had not looked at the pleadings or witness statements either at all or sufficiently; that he had taken no account of the fact that his own hospital had the highest elective C-section rate in the country; that he had commented on the factual question as to what the deceased would have in fact chosen to do if given the option; and "*appeared on a number of occasions to be unable to recognise a range of obstetric opinion extending beyond his own.*"

Having considered the evidence of the consultant who had treated the deceased (which was entirely based on notes that were so brief he accepted they amounted to shorthand) and also on his 'standard practice', Stewart J concluded that he had not communicated to the deceased that she was at a higher than average risk of ending up with a C-section in any event, and had not, as he ought to have done, offered an elective C-section. That represented a breach of duty. However, Stewart J found that, even if offered it, the deceased would not have chosen to have had an elective C-section. There was therefore no causation between the breach and the fatal infection that followed the emergency C-section that became necessary in the course of labour.

Comment

The judgment is worth reading both as a distillation of the key principles in clinical negligence cases, but more usefully as a demonstration of the pitfalls of choosing the wrong expert.

Kennedy v Frankel [2019] EWHC 106 (QB)

The Defendant agreed to see the Claimant privately and did so without charge as a favour to the Claimant's husband who was a recently retired colleague of the Defendant.

The Claimant was advised by the Defendant to take Dopamine agonist medication as treatment for Parkinson's disease. She later developed psychiatric side effects, including an impulse control disorder (ICD) and eventually psychosis.

The Claimant claimed that she had not been warned of the risk of impulse control disorder. She accepted that an appropriate warning would not have deterred her from taking the medication initially but contended that, properly advised, she would have ceased taking it far earlier and would have avoided the serious effects that developed.

Yip J set out the relevant legal principles: first, that a specialist is required to "*exercise the ordinary skill of his specialty*": here the standard of care to be expected of the Defendant was that of a consultant neurologist with a subspecialty in movement disorders including Parkinson's disease. Secondly, that the test in respect of consent was whether the patient had been made aware of any material risks involved in any recommended treatment, and of any reasonable alternative or variant treatments. The risks were a matter falling within the expertise of medical professionals, but whether the patient should have been told about such risks was by reference to whether they were material. That was a matter for the court to determine without reference to the Bolam test and was not something that could be determined by reference to expert evidence alone. With respect to causation, the Claimant had to establish that, if she had been given the appropriate warning/advice she would have come off or reduced the dopamine agonist medication earlier, thereby reducing the severity and/or duration of the side effects.

Yip J, when considering the relative expertise of the two experts, noted that the appropriate standard of care was that of a consultant neurologist with a sub-specialism in movement disorders, which the Claimant's expert was, but the Defendant's expert was not.

She held that the risk of behavioural changes should have been discussed with the Claimant, and that: "*In this case, I am satisfied that the Claimant, an intelligent woman, and her neurologist husband would have asked for further details and would have learnt that the sort of behavioural problems the drug might produce included impulsive behaviour.*" The risk of developing compulsive behaviour was a material risk, and accordingly the Defendant had been in breach of his duty to the Claimant not to have discussed it. Further, when symptoms of ICD emerged, he should have clearly explained that taking an alternative medication instead was likely to abolish symptoms of ICD while still providing good control of the symptoms of Parkinson's disease.

The Claimant did not argue that had the risks been appropriately discussed she would not have undergone Dopamine agonist medication treatment, but solely that a warning given at that stage would have made her more alert to ICD behaviours as they became manifest in

2010. Yip J held that the Claimant was aware that other medication was available to control her Parkinson's symptoms and that it was the specific medication that she was taking that had caused her ICD symptoms. She held that even with additional information about alternative medication, the Claimant would still have followed the Defendant's advice to continue with her existing medication until October 2011. However, after that point, with appropriate advice, the Claimant would have agreed to her medication being changed and would have recovered from her ICD within a short time. She would not therefore have gone on to develop psychosis.

Comment

This case is another illustration of the importance of choosing an expert who has the appropriate specialist expertise. Further, it demonstrates that even if there has been a failure to advise or gain informed consent (which is arguably a significantly easier hurdle for claimants to surmount post-Montgomery), there is still a critical requirement to establish what causal consequences flow from the identified breach.

Ollosson v Lee [2019] EWHC 784 (QB)

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."* 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 to 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. He 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 *"what 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 to find that the Claimant had been told by the GP that chronic testicular pain was a potential complication and that the risk was referred to *"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

This case will perhaps give some comfort to doctors concerned about the adequacy and accuracy of the advice that they give to patients about the likelihood of particular risks. Stating a percentage risk is potentially significantly harder than using everyday language to describe a risk.

Angus McCullough QC appeared for the Defendant in Keh. He did not contribute to this article.

IN BRIEF

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

Informed consent - concerns: (a) principles applicable to appeals (rationality test); and (b) informed consent (a failure to warn of a risk, without more, does not give rise to a freestanding claim in damages).

David Price v Cwm Taf University Health Board [2019] EWHC 938 (QB)

Informed consent - concerns: (a) principles applicable to appeals on a finding of fact; and (b) informed consent (is it limited to a failure to warn properly about risks of harm when that harm was then sustained, or does it extend to a failure to inform properly as to the absence of a benefit and as to non-compliance with NICE Guidelines).

Mills v Oxford University Hospitals NHS Trust [2019] EWHC 936 (QB)

Another informed consent case: failure to advise as to reasonable alternative or variant treatments.

Buckley v Guys & St Thomas' NHS Foundation Trust [2019] 4 WLUK 104

Application to vacate a trial date granted in circumstances where the evidence showed that the claimant's imminent transfer to secondary school was a watershed event that could have a significant effect on his long-term prognosis and future needs.

PXW v. Kingston Hospital NHS Foundation Trust [2019] EWHC 840

CP case in which the Claimant failed on breach of duty and causation. Underlines the importance of selecting appropriate experts and explains how a Root Cause Analysis report which was critical of the midwifery care had to be understood in the context that it was directed at different issues to those which must be established in an action for negligence.

Inglis v MOD [2019] EWHC 1153 (QB)

PI claim from a Royal Marine discharged early, now earning more than he would have done had he not been prematurely discharged due to MOD's negligence. The court found that it was appropriate to make a deduction from the Claimant's future loss of earnings award.

HOT OFF THE PRESS…

Paul Pomphrey v. Secretary of State for Health (2) North Bristol NHS Trust (3) [2019] 4 WLUK 483

Jeremy Hyam QC

This case concerned an alleged failure to diagnose compression of nerve roots leading to cauda equina and alleged delay in operating urgently. It raises an important issue in relation to causation and the applicability of Chester and is a companion piece to be read alongside Meadows v. Khan above.

The Claimant advanced a range of arguments on breach of duty against a number of individuals in respect of a failure to refer for earlier surgery for symptoms of early onset cauda equina, all of which failed having regard to a careful analysis of the factual and expert evidence.

The judge did, however, find that there was a breach of duty in respect of the delay between seeing the consultant neurosurgeon on 14 December 2011 and the actual operation which took place on 24 January 2012. The negligent period of delay was found to be 10 days.

That breach of duty opened the door to the Claimant running an argument based on Chester v. Afshar [2004] UKHL 41; and Crossman v. St George's NHS Trust [2016] EWHC 2878 that the same dice rolled on another day would not have resulted in 'snake eyes'; viz. an injury which was an accepted complication of the operation, estimated at around 5%. This being a case where the consultant in question accepted that the injury had been "*inadvertent*" and therefore not one that necessarily would have occurred.

Dismissing the claim on the facts but also, *obiter*, on the law, the judge found that the operation, if performed 10 days earlier, would not have changed the risk profile of the operation. It would have been performed with "*the same surgeon, physiology, difficulty with depth, technique, and use of punch in the same spot*." The crucial reasoning of Judge Cotter at [274] was that:

"*A general risk of a particular complication which is based on the statistical cohort of a large number of different surgeons (and usually containing a range of different causes and circumstances) must yield to more refined evidence of the risk of the complication arising from the technique of the particular surgeon undertaking the same operation on different days. So the focus must be on the particular operation in question.*"

The judge therefore found that, "*had there been no delay the operation would still have been carried out by Mr P. and the same dural tear would have occurred.*"

In his *obiter* remarks at the end of the judgment the judge also accepted the Defendant's case on the law, and rejected the Claimant's argument that Chester represented a change to the basis of establishing causation in a case where the starting point is that the breach of duty did not affect the risk inherent in the procedure. In reasoning in this way the judge was obliged to, and did, distinguish the decision of HHJ Peter Hughes QC in Crossman, explaining that, in his view, HHJ Hughes QC had not considered the question of the scope of duty of care (see *inter alia* Meadows v. Khan (see Suzanne Lambert's case comment above); nor addressed the approach of the court in Chester to establishing causation on conventional principles, saying at [290]:

"*given that there was no direct link between the admitted negligence and the risk arising from the surgery (which he would have undergone in any event) and no material alteration in the risk had the operation been performed three months later it is difficult to reconcile the learned Judge's* [HHJ Hughes'] *approach with the unanimous view of their Lordships* [in Chester] *as to the problems with reliance upon conventional causation in such circumstances.*"

His conclusion on the law was essentially that, given that the scope of the relevant duty which was breached was a duty to avoid unreasonable delay, he would have declined to follow the approach in Crossman, and would have found that simple 'but for' causation, based solely upon the operation taking place on different day would not have been sufficient, without more, for the Claimant to establish

causation. Indeed he said that to do so would "*drive a coach and horses*" through well-established causation principles.

Comment

This case is particularly interesting for two reasons. First, because of what the judge says on factual causation at [274] about the general risk of a particular complication yielding to more refined evidence of the risk of the complication arising from the technique of the particular surgeon undertaking the same operation on different days.

Second, because of his careful analysis of the speeches of the House of Lords in Chester and his distinguishing of HHJ Hughes QC's decision in Crossman. The judge's analysis is that Crossman has been impliedly overruled by the Court of Appeal's decision in Meadows v. Khan [2019] EWCA Civ 152 (see case comment above) not least because the Court of Appeal has re-affirmed in Khan the limitations of the but-for test for causation given 'scope of duty' considerations. The net result of the judge's conclusion was that, as the Defendant cogently argued:

"the risk that the Claimant would sustain a dural tear was a risk inherent in that surgery and the delay in operating did not alter the magnitude of the risk; the injury was liable to occur whenever the surgery was performed…. It would be wrong to permit the Claimant to recover damages by changing the scenario in an irrelevant detail which has no bearing on the probability of the injury occurring i.e. by bringing the time of the surgery forward (absent any deterioration in condition). Moreover, the Defendant's scope of duty did not extend to avoiding a risk inherent in the surgery that he was to undergo. The fact that the Claimant sustained a dural tear was coincidental and not within the scope of the Defendant's duty."

Andrew Kennedy appeared for the Defendant. He did not contribute to this article.

R (on the application of Maughan) v Her Majesty's Senior Coroner for Oxfordshire [2019] EWCA Civ 809

Rajkiran Barhey

In this judgment, handed down on 10 May 2019, the Court of Appeal considered the standard of proof to be applied by a coroner in deciding whether the Deceased intended to kill himself. The court also considered whether the answer depended on whether the conclusion was delivered in short-form or narrative form.

The court affirmed the decision of the Divisional Court and concluded that the appropriate standard of proof, for both short-form conclusions and narrative conclusions of suicide, was the civil standard of proof. In *obiter* remarks the Court recommended that the juries should continue to be directed by reference to the criminal standard of proof for a conclusion of unlawful killing.

Davis LJ's reasoning, set out at paragraph 74, was as follows:

"In the absence of authority, I would be of the clear view, in agreement with the Divisional Court, that the appropriate standard of proof to be applied throughout in cases of suicide should be the civil standard. I say that for a number of reasons:

(1) First, the essence of an inquest is that it is primarily inquisitorial, that it is investigative. It is not concerned to make findings of guilt or liability (even though I accept that not infrequently a narrative conclusion may in practice, to an informed participant, operate to identify individuals as potentially at fault). The underpinning rationale for the need to have a criminal standard of proof in criminal proceedings simply has no obvious grip in inquest proceedings, given their nature.

(2) Second, since 1961 suicide has ceased to be a crime. Suicide will of course be dreadfully upsetting to the family of the deceased; it may perhaps in some quarters also carry a stigma (although one would like to think that the predominant feeling of most observers in modern times would be acute sympathy); it may have other adverse social or financial consequences. But it is not a crime.

(3) Third, whatever the prevarications in the past, the civil courts nowadays generally apply in civil proceedings the ordinary civil standard - that is, more probable than not – even where the proposed subject of proof may constitute a crime or suicide (see re B; Braganza). There is no sliding scale or heightened standard. There is no discernible reason why a different approach should apply in coroner's proceedings, at all events in relation to suicide (which is not even a crime).

(4) Fourth, the importance in Article 2 cases – although in my view there actually is no reason in principle to distinguish between standards of proof in suicide cases depending on whether or not Article 2 considerations arise – of a proper investigation into the circumstances of death under s.5(2) of the 2009 Act strongly supports the application of the (lower) civil standard. The approach intended to be applicable, viewed objectively, surely would be expected to be inclined towards an expansive, rather than restrictive, approach. That also would enhance the prospects of lessons being learned for the future: one of the functions of such an inquest. I accept Ms Monaghan's point that Article 2 procedural requirements are not incapable of being met by the application of a criminal standard of proof. But context is all: and the present context of an inquest relating to suicide, and the answer to the question "how?", strongly favours the imposition of a lower standard of proof than the criminal standard.

(5) Fifth, the application of the civil standard to a conclusion of suicide expressed in the narrative conclusion would cohere with the standard which is on any view applicable to other potential aspects of the narrative conclusion (for example, whether reasonable preventative measures should or could have been taken and so on).”

Davis LJ went on to say that previous authorities provided no real rationale for the application of the criminal standard.

He further distinguished the case of unlawful killing, primarily on the basis that, unlike suicide, a conclusion of unlawful killing connotes a crime. He also noted that previous authorities were clear on the question of the applicable standard of proof in unlawful killing cases. In his obiter remarks he acknowledged, however, that there were powerful arguments in favour of adopting the civil standard.

This important judgment raises a wide range of interesting issues, to be analysed further in future issues, no doubt.

UPCOMING EVENTS & NEWS

Seminar

‘Scope of Duty and Causation: Chester v Afshar revisited’ on the evening of **6th June 2019** in London. It will be chaired by **Clodagh Bradley QC** with an update on the law by **Dominic Ruck Keene** and **Jonathan Metzer** followed by a discussion of case studies. **Robert Kellar QC** will lead a team for the Claimant and **Sarabjit Singh QC** will lead a team for the Defendant. Please email **Olivia Kaplan at events@1cor.com** for more details.

Podcast

Podcast enthusiasts can also listen to barristers from 1 Crown Office Row on **Law Pod UK.**

Listen along to interviews on cutting edge legal topics with luminaries including **Frances Gibb, Judge Anton Steenkamp** and **Dame Philippa Whipple** on your favourite podcast platform (iTunes, Audioboom etc). If you like what you hear, please rate us on iTunes and leave us a review with any topics you want covered or feedback.

Further news and events information can be found on our website.

Letters to the Editor

Feel free to contact the team at **medlaw@1cor.com** with comments or queries.

CONTRIBUTORS & EDITORIAL TEAM

Jeremy Hyam QC (Call: 1995, QC: 2016)

Jeremy is a specialist in clinical negligence, administrative and public law, inquests, public inquiries, and professional regulatory work. He has particular experience in all aspects of health law and has appeared in a number of leading cases in the field at all levels including in the Supreme Court and Privy Council.

Shaheen Rahman QC (Call 1996, QC: 2017)

Shaheen Rahman QC specialises in public law, clinical negligence and professional discipline. Recognised by the legal directories as a leading practitioner in multiple areas, she is instructed in complex and high value clinical negligence matters including catastrophic brain injury cases, has particular expertise in judicial review challenges to healthcare funding decisions, appears at inquests involving detained or otherwise vulnerable patients and acts for healthcare professionals in regulatory and MHPS proceedings.

Suzanne Lambert (Call: 2002)

Suzanne has a broad practice, with a particular focus on healthcare/medical law. She has experience mainly in clinical negligence and inquests, but also in disciplinary law and judicial review. Suzanne is instructed by claimants and defendants in a wide variety of cases involving serious and catastrophic injuries e.g. cerebral palsy, spinal injuries, loss of fertility, and delayed diagnosis of cancer. She has experience with complex legal issues such as contributory negligence, apportionment between defendants, and consent.

Matthew Flinn (Call: 2010)

Matt's practice spans all areas of Chambers' work, including clinical negligence, personal injury, public law and human rights. He is developing particular expertise in inquests, and clinical and dental negligence claims, acting for both claimants and defendants. He undertakes a wide range of advisory and court work. He also has experience in information law and has advised in private litigation stemming from the Data Protection Act 1998.

Dominic Ruck Keene (Call: 2012)

Dominic has considerable experience of acting in clinical negligence claims for both claimants and defendants: drafting pleadings, advising on merits, quantum and settlement; successfully representing parties at RTMs and at mediation; as well as appearing in case management hearings, application hearings, and at trial in both the county and High Courts. As a result of his background in the Army, Dominic has a particular interest and expertise in all nature of cases involving service personnel and national Security. He is on the Attorney General's C Panel.

Rajkiran Barhey (Call: 2017)

Rajkiran accepts instructions in all areas of Chambers' work and is developing a broad practice, particularly in clinical negligence, personal injury, inquests and public law and human rights. Kiran joined Chambers as a tenant in September 2018 following successful completion of a 12-month pupillage. She is currently instructed by the Grenfell Tower Inquiry and is also undertaking a secondment at a leading clinical negligence law firm.