The 1COR Quarterly Medical Law Review

Updates and analysis of the latest legal developments

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Editor-in-Chief
Rajkiran Barhey

Editorial Team
Jeremy Hyam QC
Shaheen Rahman QC
Suzanne Lambert
Matthew Flinn
Dominic Ruck Keene

Welcome to the sixth issue of the Quarterly Medical Law Review, brought to you by the barristers at 1 Crown Office Row. In this edition you will find:

Bill Edis QC considers the vexed issue of **anonymity orders,** particularly in circumstances where the Claimant is not a protected party on page 2.

Gideon Barth considers **secondary victim** claims in the **clinical negligence context** on page 4.

Marina Wheeler QC and Amelia Walker consider and summarise the findings of the **Cumberlege Review** into **medical devices** on page 5.

Rob Kellar QC explains a recent decision on **dishonesty** and **admission of prejudicial material on appeal** in circumstances where an **agreement had been made to not admit the material** on page 8.

Emma-Louise Fenelon and Jonathan Metzer explore two recent decisions on **strike-out for lack of expert evidence** on page 9.

Richard Mumford provides a fascinating and unique **analysis of judicial decisions on consent post-Montgomery,** to see if any trends can be gleaned on page 12.

Rajkiran Barhey analyses a decision which considers the distinction, or lack of, between the tests in **Bolam** and **Bolitho** on page 17.

Dominic Ruck Keene explains a recent decision on **monitoring during labour** on page 19.

Sarah Lambert QC provides an excellent summary of the **ten most useful costs cases in 2020** thus far on page 22.

Charlotte Gilmartin explains a complex decision arising from **treatment provided in a German hospital**, and the associated **international law issues** in the clinical negligence context on page 25.

Finally, see our In Brief section and follow us on Twitter at @1corQMLR. If you would like to provide any feedback or further comment, do not hesitate to contact the editorial team at medlaw@1cor.com.

"What's In a Name?" Revisited

William Edis QC

Jones v Ministry of Defence [2020] EWHC 1603 (QB)

Those who practise in the field of serious personal injury and clinical negligence will be very familiar with the principles that govern the grant of anonymity orders. The leading authority is *JXMX v Dartford & Gravesham NHS Trust* [2015] EWCA Civ 96.

Where the claimant is a protected party the making of such orders is verging on the automatic, though this does not obviate the need to set out and establish the grounds for one. The presumption in a suitable case is that an order will be made unless the court is satisfied that it is not necessary to do so. The order should be sought as soon as it is appreciated that it is necessary and the courts have repeatedly deprecated late applications. Commonly such applications are intimated in the Particulars of Claim.

Court Form PF 10 is a precedent for an "Anonymity and Prohibition of Publication" order that is sometimes employed (albeit arguably it is unsuitable in the clinical negligence context) but most practitioners, including the author, will have their own preferred form of order capable of being adapted to the needs of the case. Typically, an order will recite that consideration has been given to of the Claimant's Article 8 right to respect for private and family life and to the Article 10 right of others to freedom of expression and set out the legal basis for the order: rule 39.2(4) of the Civil Procedure Rules, section 11 of the Contempt of Court Act 1981 and rules 5.4C and 5.4D of the Civil Procedure Rules.

The order itself will provide that the identity of the Claimant and her Litigation Friend are not to be disclosed, further defining that prohibition by words such as:

"There shall be no publication in any newspaper or other media (including but not limited to the Internet and social media) or other disclosure to the public of any name, address, picture or information tending to identify the Claimant or Litigation Friend as being the Claimant or Litigation Friend in these proceedings," adding – where there has been a judgment on some contentious issue words such as *["save that it shall not be a breach of this order to publish anything contained in the public judgment of this court dated"]*

Various procedural and administrative requirements and permissible exceptions will then be set out.

Three recent cases

So much is standard but in three recent cases the Court has considered anonymity orders in circumstances that are different from the norm, though not in truth unusual.

In *Darrell Stewart Jones v the Ministry of Defence* [2020] EWHC 1603 (QB), the Claimant, who was of full capacity, sued for the consequences of a 10 month delay in diagnosing his HIV status. The trial was to be heard entirely remotely and on the first morning the Deputy Judge received an application from the Press Association for access to the hearing. When he informed the parties of his provisional intention to allow the request, he received an unheralded application on behalf of the Claimant for an anonymity order. The justification for making the order was said to be that the Claimant was a *"private man who has kept his HIV status secret from much of his social circle and his employers. He is understandably concerned about the impact that disclosure might have on his relationships with people and his employment."*

After a certain amount of justified grumbling about the timing of the application, the judge nevertheless proceeded to hear and decide it. His reasons for refusing the application were given ex tempore but he reproduced them in an Appendix to his judgment. He accepted that publication of the Claimant's HIV status would adversely affect his private life but this did not reach the level of gravity that would justify departure from the principle of open justice. At [24] of the Appendix he said:

"This is not a case, for example, where the impact of disclosure might have a profound impact on the safety of a witness or where there is evidence that it would have a profound impact on mental health. The agreed evidence of the psychiatrists in this case is that whilst the Claimant has suffered psychologically as a result of contracting HIV (the precise cause, duration and severity of which is a matter of dispute), his illness has not been very severe and he is no longer classified as suffering from any diagnosable condition. This is not a case therefore where the evidence suggests that the disclosure will cause actual physical or psychiatric harm."

Relevant to the assessment of harm was his finding that the stigma of being HIV positive has reduced over time. He did not set out any evidence supporting this assertion.

An additional factor was that the Claimant's name was already in the public domain, being contained in court papers and the case having been listed without anonymising the Claimant. Given that the Court of Appeal in JX MX stipulated, at [35(i)] that applications for anonymity orders, *"…should be listed for hearing in public under the name in which the proceedings were issued, unless by the time of the hearing an anonymity order has already been made"* the judge's reasoning is perhaps slightly difficult to understand as any application, whenever made, would appear in the unanonymised name of the claimant. Equally, the Claim Form would be issued prior to the entitlement for anonymity. Thus, the claimant's identity will always be "*in the public domain*".

The case was similar in principle to *Zeromska-Smith v United Lincoln Hospitals NHS Trust* [2019] EWHC 552 (QB) where Martin Spencer J declined to make an anonymity order in a case where the negligence of the healthcare Defendant had led to the stillbirth of the baby the Claimant had been carrying. As a result, it was said, the Claimant had developed a life-changing and severe psychiatric illness that included some degree of risk of suicide. On her behalf it was argued that publishing her name would, *"risk considerable further harm to the Claimant's already precarious mental health and harm to her children and family*", judgment [8], including the fact that the Claimant's two children – and potentially their schoolmates – may come to know intimate details of her psychiatric condition.

Contrast the position in *ABC v St George's Healthcare Trust* [2015] EWHC 1394 (QB), where Claimant had negligently been kept in the dark about her diagnosis of Huntingdon's disease, an inherited neurological condition with a 50% chance of being passed on to any children the patient may have. The Claimant's argument included an assertion that her daughter would or may become aware of the diagnosis, and of her risk herself of contracting the disease, at any age where she would thereby suffer real harm. Nicol J held that this sufficed to make anonymity necessary.

In *PQ v Royal London Hospital NHS Foundation Trust* [2020] EWHC 1662 (QB) the Court considered whether an anonymity order should be made to cover a trial of liability as a preliminary issue. The Claimant was a protected party. Martin Spencer J held that a derogation from the Article 10 right of freedom of expression at the liability stage was necessary so as to make meaningful the exercise of the same right at, if, and when, there was a quantum trial. The at first glance paradoxical reasoning was that if the liability trial was reported in full and with the Claimant named, it would make it impossible to report in any useful detail any quantum trial that took place with the protection of an anonymity order since anyone juxtaposing the two judgments would easily be able to identify the Claimant.

Discussion

Anonymity orders will only be made where it is necessary to derogate from the principle of open justice. "*Necessity*" – sometimes redundantly described as "*strict necessity*" – is a condition precedent. Whilst they have become routine in cases involving protected parties, exceptional circumstances will be required before one is granted in favour of a claimant with capacity, who is deemed a volunteer in the litigation process. It seems that severe harm, perhaps to a level that arguably engages Article 2, will be required before one is granted. Embarrassment, humiliation, some degree of societal disapproval and even some psychiatric injury appear not be sufficient, see *Zeromska-Smith.* Nor is a justified claim to vulnerability enough. Perhaps the question that practitioners should ask when considering applying for such orders is: *"Is there a real danger that if the order is not made the claimant or others would come to serious harm?*" A feature of many late applications is that there

is a paucity of evidence directed specifically to the potential harm of publicising the claimant's name. This certainly was the case in Jones.

Where the claimant is a protected party, it is wrong, and dangerous, to conclude that different rules apply to preliminary trials of liability and that it is only if they will, or may, proceed to a quantum hearing that an order should be made. As soon as one accepts this one is tacitly inviting the court to make an order pending the outcome of this preliminary issue and to discharge it if the claimant fails.

Lizanne Gumbel QC and Owain Thomas QC appeared for the parties in PQ v Royal London Hospital NHS Foundation Trust. Neither contributed to this article. Readers interested in this topic would greatly benefit from reading two posts by my colleague Angus McCullough QC on 1COR's UK Human Rights Blog. They are to be found at https://ukhumanrightsblog.com/2019/04/30/straining-the-alphabet-soup-part-1-anonymity-orders-in-personal-injury-proceedings and https://ukhumanrightsblog.com/2019/05/02/straining-the-alphabet-soup-part-2-drafting-anonymity-orders. The latter post contains detailed drafting suggestions.".

PROXIMITY IN SECONDARY VICTIM CASES

Gideon Barth

Paul & Anor v The Royal Wolverhampton NHS Trust [2020] EWHC 1415 (QB)

Following a series of secondary victim claims being struck out or dismissed on the grounds that there is insufficient proximity as required by the *Alcock* control mechanisms (see, most recently, the strike out decision of DJ Lumb in *Purchase v Ahmed* [2020] 5 WLUK 249, applying *Taylor v A Novo (UK) Limited* [2013] EWCA Civ 194) this judgment changes the way in which proximity should be understood.

Facts

In January 2014, Mr Paul was out shopping with his daughters, then aged 12 and 9, when he had a heart attack, collapsed, fell backwards and hit his head on the floor. Sadly, he was declared dead later that day. The heart attack was caused by ischaemic heart disease and occlusive coronary artery atherosclerosis. The Claimants argued that there was a failure to perform coronary revascularisation in November 2012 (14 ½ months earlier) which would have prevented the heart attack.

Strike out

Master Cook allowed the Defendant's application to strike out the claim. In particular, he noted that the facts could not be distinguished from *Taylor v Somerset Health Authority* [1993] PIQR 262, approved by the Court of Appeal in *Taylor v A Novo.* In his judgment:

"To focus simply on the death of Mr Paul as being the first point at which the consequence of the Defendant's negligence became apparent is not an approach which is supported by the authorities. To do so overlooks entirely that there must be a proximate connection between the initial negligence and the shocking event. It is this proximity in space and time that allowed Lord Oliver to impose the duty of care in Alcock…" [40].

Appeal

Following a thorough and detailed review of the authorities, Mr Justice Chamberlain allowed the Claimant's appeal, and clarified what can constitute an 'event' following *Taylor v A Novo*.

Importantly, he stated that the 'event' need not be at the same time as the negligence which gives rise to it [63]. The proximity required by the House of Lords authorities is between the psychiatric injury and the shocking

event (caused by negligence), not the shocking event and the negligent act or omission. This was not an argument pursued by the Defendant but appears to be the basis for the initial strike out.

The Defendant had argued that the secondary victims must be present at the 'scene of the tort'. The tort became actionable shortly after the negligence as Mr Paul's heart condition continued to deteriorate, thereby damage was immediately caused and the tort was complete. This analysis is consistent with the approach of Auld J in *Taylor v Somerset* who held, on very similar facts, that the death was *"the final consequence of Mr Taylor's progressively deteriorating heart condition which the health authority, by its negligence many months before, had failed to arrest"* [267].

The Claimant asserted that, as a matter of fact, Mr Paul suffered no damage until the collapse. As this was a strike out, the Court had to proceed on the factual basis most favourable to the Claimant. On that basis, the tort was not complete until the collapse in January 2014 and the secondary victims were present at that scene [66].

But the judgment goes on to say that even if the Claimant was wrong and there was damage, it is only at the point that the damage becomes *"evident"* or *"manifest"* that the tort is complete [78]-[79].

The two Taylor cases

Chamberlain J delicately tackled the two *Taylor* cases, which have caused such difficulties for claimants in recent years.

In *Taylor v Somerset*, Auld J held that a secondary victim claim requires *"an external, traumatic event caused by the defendant's breach of duty which immediately causes some person injury or death"* [267], a sentence which was approved by the Court of Appeal in *Taylor v A Novo* [33]. This was understood to be an event external to the primary victim (such as a car accident, or stadium crush). But this sits uncomfortably with the Court of Appeal in *North Glamorgan NHS Trust v Walters* [2002] EWCA Civ 1792 in which a negligent omission in the clinical negligence context resulted in the serious illness and death of a baby; there was no external, traumatic event and yet the Claimant succeeded.

Chamberlain J aligned these contradictory authorities. In his view, a *"plausible"* interpretation of Auld J's analysis was that this external event means an event external to the *secondary* victim [72]. This nullifies the effect of the comment because secondary victim claims, by their very nature, are founded on events external to them.

The ratio in *Taylor v A Novo* has also been narrowed to apply only to cases where there are two subsequent events [73]. For example, where negligence causes an 'event' (such as a car crash or other accident), it is that event which can give rise to a secondary victim claim and no subsequent event, such as a later deterioration in hospital. The requirement for proximity in secondary victim claims is that the psychiatric injury arises close in time and space to the event, not to the negligence.

Comment

This judgment is good news for claimants, removing the hurdle imposed since *Taylor v A Novo.* It clarifies the law on proximity which has at times appeared incongruous and inconsistent. The way in which the proximity requirement has been applied was, in the author's view, unsupported by the House of Lords authorities, and was an unprincipled extension of the control mechanisms in an already difficult area of law.

However, it may be that this judgment now imposes a slightly different hurdle for claimants to overcome. In cases where there is a delay between the negligence and the shocking event, careful consideration must be given to when the damage or injury first becomes evident or manifest (per [78]-[79] of the judgment).

Gideon Barth discusses secondary victim claims in Episode 121 of Law Pod UK which can be found here.

"First Do No Harm"

Marina Wheeler QC and Amelia Walker

The Independent Medicines & Medical Devices Safety Review (The Cumberlege Review)

"*We have been astonished*," wrote the authors of the Cumberlege Report, "*how the healthcare system – which includes the NHS, private providers, the regulators and professional bodies, manufacturers, and policymakers – is disjointed, siloed, unresponsive and defensive. It does not adequately recognise that patients are its sole purpose".*

Over two years Baroness Cumberlege and her small review team looked at three medical interventions: the pelvic mesh; sodium valproate (prescribed to treat epilepsy and bipolar disorder) and a hormone pregnancy test (HPT), Primodos. Each intervention caused, or was associated with, life-changing harm to tens of thousands of women and in the case of sodium valproate and Primodos, to their unborn children. Many lives were destroyed. The Review came after decades of battling to be heard.

The Review's report is a shocking, dispiriting read. These women, or their children, suffered avoidable harm. That these interventions continued for decades unchecked, exposes serious flaws in the regulatory and complaints systems, in data collection processes, in obtaining informed consent, in applying the duty of candour and in managing conflicts of interests between drug companies, consultants, hospitals and even regulators.

These failures comprise the Review's overarching findings and were common to each of the interventions. Another central theme is loss of the patient voice. Affected patients struggled to navigate a fragmented, confusing system for raising concerns. The women who managed to do so were simply not listened to. The response was defensive. They were 'gas lighted' - made to feel they were unstable, that their symptoms were all in their heads. They were told "*these are women's issues*" or "*it's that time of life*". The report is not the first to highlight dismissive attitudes towards women's health, (particularly where thought to relate to menstruation or the menopause), but it is certainly one of the starkest.

Patient safety, the report declares, must be given a higher priority. Innovation in medicine is a great thing but it has to be managed safely.

A vein of frustration runs through the text. Similar failures have occurred before. Systems were put in place to address them but in practice change is slow. For example, obtaining informed consent is fundamental to the safe working of a healthcare system. The 2015 landmark case of *Montgomery v Lanarkshire Health Board* made clear: consent needs to be framed around what information an individual patient requires. In response to the case, patient information leaflets proliferated, found the Review. These were often "*bewildering*". Many of the women affected had not been informed of the risks and did not know what had been done to them. The Review team were "*appalled*". And despite past public inquiries, there remains *"a persistent culture of reluctance to speak out".*

Primodos was an oral HPT – in the form of a pill - containing both an oestrogen and a progestogen, used from the 1950s until it was withdrawn in 1978. If a women was not pregnant she would have a period-type bleed a few days after taking the HPT, if she did not bleed she was pregnant. Use of the HPT was associated with miscarriage, stillbirth, baby deaths, along with conditions including spina bifida, limb defects, deafness, blindness and mutism, congenital heart defects, intelligence disability, genito-urinary defects, dysmorphic facial features, digestive and bowel issues, skeletal problems, spinal issues, and seizures.

The first study to find a statistically significant association between HPT use and malformations (teratogenicity) was in 1967. Despite the existence of a risk-free alternative test, the drug was not withdrawn and continued to be prescribed. The regulator issued a warning in 1975 which proved ineffective. Women were not informed of the risks. In 1977 litigation was launched but discontinued due to concerns about proving causation in an environment where legally-aided claimants had difficulties in securing experts. The 2019 Expert Working Group

("EWG") found that evidence did not support causation, but this conclusion, and the EWG's process, have been heavily criticised by campaign groups.

Children with defects born to mothers who took Primodos require on-going care. The report also highlights improvements needed in EWG processes, around participation, transparency, perception of independence and declarations of interest.

Sodium valproate is used by about 27,000 women of child-bearing age in the UK, despite being a known teratogen. From the 1980s, data suggested an association with physical malformations, and later with neurodevelopmental problems now referred to as Foetal Valproate Spectrum Disorder (FVSD). Mothers of child sufferers reported feeling guilt and struggling to access services, particularly to support their children's special educational needs.

The Review recommends specific actions to improve the safety of prescribing and to ensure better information and advice is given to women about their epilepsy treatment and contraceptive choices. Better data is also essential, and the report proposes a new system for collating data from those already affected (to ensure they are adequately supported) and from those on antiepileptic drugs who become pregnant.

The pelvic or vaginal mesh is a surgically inserted device, usually made of polypropylene, to relieve pelvic organ prolapse and urinary incontinence. Many women have found the procedure helpful. Many others found it ruined their lives. Still it was used, for decades, until 2018 at the outset of the Review, when the procedure was paused.

The report explains how historically, medical devices have been less regulated than medicines. The product was marketed, under an EU-wide regime, as being equivalent to other existing products but with little long-term testing of its effects. When the devices proved difficult to insert, their design was simplified (as opposed to ensuring surgeons doing so were sufficiently skilled).

When women reported pain (often excruciating, like having razors inside their bodies) and loss of mobility and sexual function, these were rarely reflected in the adverse event reports produced by manufacturers. The reports adopted a narrow definition of a product's performance: if it relieved incontinence, it was a success. Since pain and problems during intercourse didn't feature in formal evaluation of the device, doctors were unaware of these outcomes and many disbelieved patients who reported them. The women were thought to be exaggerating or hysterical and were brushed off. So, the report finds, "*current data does not reflect complication rates*". Incredibly, given the scale of the complications, the Review found no medical consensus on how to remove problematic pelvic meshes or whether removal should be full or partial. The manufacturers must research and develop a "*remedial strategy*", says the report, to address severe complications caused by their product.

The Cumberlege Review makes nine core recommendations and proposes further actions for improvement. A "*fulsome apology*" on behalf of the healthcare system is the first recommendation. This was delivered by the Health Secretary on 8 July 2020, the day of the report's publication.

The remaining eight recommendations focus on care for those still suffering the effects of these disasters (including specialist centres to undertake complex remedial mesh surgery) and on better regulation to prevent future failures.

The report rejects the idea of further NHS re-organisation or a new regulatory body. What the system lacks and needs, it says, is a Patient Safety Commissioner. A "*person of standing*" answerable to Parliament who will listen to patients, advocate for them, monitor trends and demand action. An essential tool for the Commissioner will be good data. The system is currently "*flying blind*", the Review found. No one knows, for example, how many women had pelvic mesh implants, who their surgeons were, what products were used or the outcome. Better recording must collate this type of information.

The report notes how little litigation seemed to do for the affected women. Some successful claims were made against individual doctors but no product liability cases succeeded, leaving tens of thousands without meaningful redress. In the immediate, the Review recommends that schemes be set up to meet the cost of

additional care and support for those who experienced avoidable harm (and are eligible to claim), funded by a levy on manufacturers. These should be administered by a Redress Agency, which adopts a "*no-blame", "non-adversarial"* approach.

Meanwhile, the Medicines and Healthcare Products Regulatory Agency (MHRA) needs "*substantial revision*" says the report, especially in relation to adverse event reporting and regulating devices. The movement of staff between the MHRA and the industry is a concern and the MHRA needs to engage patients much more in its work. Leaving the EU regulatory regime may be an opportunity to create a more transparent system with a publicly accessible database of adverse event reports.

To address potential or perceived conflicts of interest, the Review recommends expanding the General Medical Council (GMC) register to include financial and other links doctors have with manufacturers. Likewise, manufacturers should declare payments made to teaching hospitals, research institutions and individual clinicians as required in the US.

An Implementation Task Force is the Review's final recommendation, to ensure the necessary changes are made. Many bodies within the healthcare system are urged to work better, in the interests of patients. Individual Trusts will need to strengthen their quality assurance systems to make sure clinicians follow NICE Guidance. Trusts must act on information which patients convey and address the persisting culture of defensiveness.

The report concludes by underlining the heavy responsibility on Government and the healthcare system to ensure that the Review's advice is heeded. If it is not, the Review Chair warns, and another intervention causes damage on such a scale, they "*will not and should not be forgiven*".

GMC Not Bound by Erroneous First Instance Concession on Appeal

Robert Kellar QC

General Medical Council v Zafar [2020] EWHC 246

In *General Medical Council v Zafar* [2020] EWHC 246 a Divisional Court of the High Court affirmed two propositions: one surprising, one not. Unsurprisingly, the court affirmed the proposition that doctors who prepare dishonest medical reports for use in civil litigation can expect to be struck off. More surprisingly, the court held that the GMC was entitled to admit prejudicial material on appeal notwithstanding a clear agreement at first instance that such material would not be admitted.

Background

Dr Zafar was a GP who provided medical reports for use in low level personal injury claims. He initially provided a medical report stating that the Claimant had mild symptoms of pain and stiffness in his neck which had resolved after about 1 week. At the solicitor's request, he later amended the report – without seeing the Claimant - to say that there was persistent neck pain that would resolve within 6 to 8 months. After both reports were disclosed to the Defendant in error the Defendant's insurer initiated contempt proceedings against Dr Zafar.

The contempt proceedings initially came before Garnham J. He committed Dr Zafar to prison for 6 months, suspended for 2 years. The Defendant's insurer appealed that sentence to the Court of Appeal on the basis that it was unduly lenient. The Court of Appeal agreed. In its judgment, it indicated that an immediate sentence of between 9 and 12 months' imprisonment would have been appropriate. The Court of Appeal gave detailed guidance as to the factors that were relevant when passing sentence in such cases.

The GMC Proceedings

Dr Zafar subsequently referred himself to the GMC. When the matter came before the MPT it was agreed between Dr Zafar's legal team and the GMC's legal team that the MPT would not see a copy of the Court of

Appeal's decision. The reasons for that agreement were not entirely clear. It was presumably on the basis that the allegation was drafted in such a way as to refer only to Garnham J's judgment. The MPT's determination, which was thus delivered in ignorance of the Court of Appeal's guidance, was that Dr Zafar's registration should be suspended for a period of 12 months.

The GMC's Appeal to the Divisional Court

The GMC, joined by the Professional Standards Authority for Health and Social Care, appealed on sanction. They contended that the only proper sanction was erasure. Both appellants relied heavily upon the contents of the Court of Appeal's judgment. In response, the doctor argued that the GMC could not rely upon the Court of Appeal's judgment; the GMC was bound by the agreement below that this judgment would not be admitted into evidence. The PSA could be in no better position.

The Judgment of the Divisional Court

The Court held that there was both a short answer and a long answer to the doctor's 'binding agreement' point. The 'short answer' was that the PSA was not party to the proceedings below. It followed that the PSA was not bound by the agreement for the purposes of their statutory appeal.

The 'long answer' was as follows. In ordinary civil litigation the parties would usually, in the interests of finality, be held to their compromises, be they wise or unwise. However, this was not ordinary civil litigation. These were proceedings conducted in the public interest with the object of protecting the public. The fact that regulatory proceedings were conducted in the public interest did not displace the usual need to satisfy the *Ladd v Marshall* principles when adducing 'fresh evidence' on appeal. However, the public interest was *"certainly a factor relevant to the overall exercise of discretion".*

The GMC's first instance agreement to exclude the Court of Appeal's judgment was *"wholly erroneous and should never have been made*". It operated to "*distort the hearing before the MPT and its attempt to achieve a fair and just outcome"*. Taking into account the Court of Appeal's judgment the court concluded that the only proper sanction was erasure: "*What he did, exploiting his position as a doctor and as an expert witness, struck at the very heart of the administration of justice and involved an abuse of the trust which the Court have to accord to experts".*

Comment

On the face of it, the principle affirmed by the Court of Appeal may look harsh or unfair. The GMC was permitted to go behind an ill-judged but nonetheless clear agreement with the doctor's legal team that prejudicial material would not be admitted at first instance. Moreover, it is clear that the *Ladd v Marshall* principles apply as much to regulatory proceedings as to other types of case: see *GMC v Adeogba* [2016] EWCA Civ 162. This includes Lord Denning's principle that: "*it must be shown that the evidence could not have been obtained with reasonable diligence for use at the trial".* It is difficult to see how that principle could be satisfied where available evidence was excluded by agreement below.

However, in the author's view, the decision is best viewed as one that is confined to its own peculiar facts. First, the material being admitted on appeal was not aptly characterised as "*fresh evidence*": it was a reported decision of the Court of Appeal. Second, the decision by the GMC to allow the MPT to proceed on the mistaken assumption that the Garnham J's judgment remained authoritative was plainly and conspicuously wrong. Third, the PSA was a party to the appeal. The Divisional Court was clearly right to find that the PSA was not bound by an erroneous concession below, to which it was not a party and was contrary to the public interest.

A LACK OF EXPERT EVIDENCE: WHEN TO STRIKE OUT?

Emma-Louise Fenelon and Jonathan Metzer

Quaatey v Guy's & St Thomas' NHS Foundation Trust [2020] EWHC 1296 (QB)

Magee v Willmott [2020] EWHC 1378 (QB)

Introduction

"I eventually became proud of my strikeouts, because each one represented another learning experience."

– Willie Stargell, World Series Major League Baseball champion in 1971 and 1979.

The requirement that clinical negligence claims be supported by expert evidence regularly vexes practitioners, all of whom will be familiar with the dicta in *Pantelli Associates Limited* [2010] EWHC 3189 that *"it is standard practice that, where an allegation of professional negligence is to be pleaded, that allegation must be supported (in writing) by a relevant professional with the necessary expertise*."

CPR Practice Direction 35 reminds us that experts should provide opinions "*on matters within their expertise*" and should make clear when an issue falls outside their expertise (para 2.2, 2.4). Similar guidance is contained in the Guidance for the Instruction of Experts in Civil Claims (see paras 12, 16, 23, 24).

So far, so straightforward. And yet this requirement has provided fertile ground for strike out applications, such applications being permitted where a statement of case:

(a) discloses no reasonable grounds for bringing or defending the claim;

(b) is an abuse of the court's process or is otherwise likely to obstruct the just disposal of the proceedings; or where

(c) there has been a failure to comply with a rule, practice direction or court order.

The QMLR covered the judgment in *Bot v Barnick and Others* [2019] EWHC 3704 (QB) here. [Issue 4, page 25] That case concerned a successful strike out application granted in the face of the Claimant's failure to serve *any* supportive evidence despite numerous extensions.

Two further decisions provide more guidance on considerations practitioners ought to bear in mind when contemplating strike-out applications for lack of expert evidence. Overall, these decisions reaffirm that strike-out may be appropriate if the evidence does not properly support the claim or has been served late.

Unsupportive expert evidence

In *Quaatey v Guy's & St Thomas' NHS Foundation Trust* [2020] EWHC 1296 (QB), Lambert J upheld the decision of Master Cook to strike out a clinical negligence claim. Strike-out had been granted by the Master on the basis that (i) the expert report relied on by the Claimant had only been served following a *"generous extension of time"* (para 10); (ii) there were significant problems with limitation; and (iii) the expert report did not support the allegations that were pleaded in the Particulars of Claim. The High Court was prepared to consider the appeal in the context of a further expert report which had also been made available [14], [20]-[21].

Lambert J upheld the strike-out, concluding that the expert evidence (even the updated evidence) did not properly support the allegations: *"an allegation of professional negligence must be supported by a written report by an appropriately qualified professional"* [22].

The decision essentially reaffirms the existing law, but also raises for discussion the appropriate avenue under the CPR for a defendant to have a clinical negligence claim dismissed at an early stage for want of supportive expert evidence.

It may be appropriate for an application for strike-out to be made on the grounds of an abuse of process under CPR 3.4(2)(b) if the claim was pleaded in the absence of supportive expert evidence (an option indicated at [8] and [14], citing *Pantelli*. Alternatively, strike-out may be made on the basis that the Claimant has no reasonable grounds for bringing the claim under CPR 3.4(2)(a).

Summary judgment may also be granted in the alternative, an option indicated at [14] of the judgment. But defendant lawyers will want to push for strike-out as their primary application, as if this is granted on the basis of 'no reasonable grounds' or 'an abuse of the court's process' it would disapply QOCS protection and allow the defendant to enforce an order for costs without permission of the court (see CPR 44.15).

Finally, it is notable that the Claimant in this claim was a litigant-in-person – but nonetheless subject to the rules on strike-out for want of expert evidence under the CPR.

Late service of expert evidence

In *Magee v Willmott* [2020] EWHC 1378 (QB), Yip J considered the correct approach toward late service of expert evidence.

The Claimant had sought to introduce expert evidence, fully pleading a case on causation for the first time, at a late stage in proceedings and just over a month before a full liability trial was due to take place. The Defendant unsuccessfully sought to strike out the claim at the PTR, following which the Recorder granted the Claimant's relief from sanctions application.

On appeal, Yip J found that the Recorder had erred in his approach. Per *Denton v TH White Ltd* [2014] EWCA Civ 906, the breach was serious and had resulted in the loss of the trial date. Relisting would have produced further significant delay, leaving the matter hanging over the parties.

Yip J drew particular attention to the conduct of the Claimant's solicitor, which she described as *"particularly egregious"*. He had not been frank with the Defendant or the court, had delayed in making the application and in giving full disclosure while he attempted to obtain the necessary evidence to support the claim advanced; he had sought that evidence after the time for service had passed, and in response to the Defendant appropriately identifying the difficulties in maintaining the pleaded claim.

Yip J held that to allow the application for relief would not only fail to do justice between the parties but also serve to discourage the sensible, proactive and efficient approach to litigation exemplified on the Defendant's side. Further it was not clear that the Claimant was significantly prejudiced by the refusal of relief given the weak position she would have found herself in anyway given the piecemeal development of her expert evidence so late in the course of the litigation. Relief from sanctions was therefore refused.

In relation to the Defendant's strike out application, Yip J underlined that it was an abuse of process, per *Pantelli*, to put forward a claim not founded on appropriate expert evidence. The claim was not completely struck out, however, with Yip J having found that in respect of some of the allegations of breach, it was not a case where it could be said that there was *no* expert support.

Conclusion

These cases are a reminder of the importance of ensuring – from the point of view of the claimant – that the expert report actually supports the allegations pleaded in the Particulars of Claim, and that any issues are remedied early on. Where there has been a failure to serve *any* evidence (*Bot*), any *supportive* evidence (*Quaatey*) or any supportive evidence *on time* (*Magee)*, claimants run the risk of being struck out.

In this regard, do not forget that the expert evidence must support the claim according to the relevant legal principles. This may include ensuring that the experts' reports properly address the two-stage test for a breach

of duty in a pure diagnosis case, as required in *Brady v Southend University Hospital NHS Foundation Trust* [2020] EWHC 158 (QB), see QMLR Issue 5, pages 15-16 here.

When considering an application, defendants would do well to remember the emphasis on conduct in the above cases and the CPR commentary which states: *"[i]n many circumstances such a strike-out* [under CPR 3.4.2(c)] *would seem unduly harsh unless the party concerned was warned (possibly in writing by another party) of the risk of their statement of case being struck out if they did not comply with the rule, practice direction or court order in question"*. Therefore, from the perspective of the defendant, it is sensible for a strike-out application to point out any conduct by the claimant or their lawyers which is worthy of the court's criticism.

But it is also important to think strategically about the timing of any application for strike-out. Unless a claimant has actually served the expert evidence that is relied on, there is a significant risk that the court will find that the application has been made prematurely. In *Hewes v West Hertfordshire Hospitals NHS Trust* [2018] EWHC 2715, Foskett J stated that *"there will be few cases, in my view, where such an application could ordinarily be contemplated before the relevant experts' reports have been exchanged"* (para 45). However, strike-out may be granted if the claimant's lawyers serve the liability expert evidence early and it does not properly support the pleaded allegations.

Finally, for a detailed discussion about how to help your expert stay out of trouble in clinical negligence cases, listen to Neil Sheldon QC in Episode 100 of Law Pod UK available here.

Montgomery v Lanarkshire Health Board; 5 years on – an Impact Assessment in Numbers

Richard Mumford

Introduction

On 11 March 2015 the UK Supreme Court gave judgment in *Montgomery v Lanarkshire Health Board* [2015] UKSC 11. For both medical professionals and lawyers practising in the field of clinical negligence it is a landmark judgment and the first port of call in any claim where the adequacy of patient consent to treatment is in question. The aim of this article and appended table is to quantify the impact of the *Montgomery* judgment on clinical negligence litigation by analysing the subject matter and outcomes of reported cases.

Method

In order to attempt as comprehensive analysis as possible of the reception and impact of *Montgomery*, the author adopted the following method in the identification of relevant cases. First, a Westlaw search of "All cases citing" returned 85 results. A search of cases Lawtel for the terms "*Montgomery v Lanarkshire*" returned 25 results, all of which were already captured by the Westlaw results. A search of Bailii's Case Law Search page returned 72 results, of which all but 5 were already captured by Westlaw. Finally, a LexisNexis search of "*Find Related Cases*" returned 122 results (this number was artificially inflated by multiple reports of the same case and the inclusion of case commentaries); this added a further 4 cases. The starting 'pool' was therefore 94 reports. 25 of the 94 reports concerned jurisdictions outside England & Wales (Scotland, Northern Ireland, Singapore and ECtHR variously), which are excluded from further consideration.

Notwithstanding the significant number of case reports, it is apparent that not all decided cases find their way into these online databases; for example, the first instance (County Court) decision in *Duce* is not available in these resources. It seems likely that there are other decided cases, particularly at County Court level, also in this category.

Of particular interest to the author were examples of the 'focal case', defined as where there is an issue before the court in a clinical negligence action as to the necessary content of advice given to a patient about treatment options. Identification of these 'focal cases' requires a line to be drawn; for example, cases where the judge has noted reliance by one of the parties on *Montgomery* but has considered it to have no bearing on the issues

would, in the judgment of the author, be excluded. In so doing, the author hopes to bring focus on those instances where the Montgomery approach to adequacy of consent was truly in play. Typically this involves a determination by the court as to whether the advice given (the factual substance of which may have been disputed) was adequate and, if not, whether the claimant suffered loss as a result. One case, *Metcalf*, extends this pattern slightly in that the court was required to adjudicate a dispute as to the content of a hypothetical discussion of treatment options that would have taken place had diagnosis been made.

The result is a cohort of 36 reports of cases decided in England & Wales between 11 March 2015 and 8 April 2020; in fact this represents 34 distinct actions since two cases (*Diamond* and *Shaw*) are reported at first instance and on appeal.

Impact of Montgomery in numbers – the focal cases

The table below sets out the 36 reports of 'focal cases' (as defined above). Please note that in summarising the result according to whether breach of duty and causation are established, the attention is on the consent issue; some cases may have failed on the consent arguments but succeeded on other grounds (e.g. *Richardson*) or vice versa (e.g. *Thefaut*). Some thoughts on what is shown:

- The stream of litigation in this area is relatively steady with reports in the calendar years 2015 to 2020 numbering 8, 5, 7, 6, 8 and 2 respectively (the last of these being not only a 'short year' to April 2020 but also subject to the effects on the judicial process of Covid-19).
- There is a reasonable spread of areas of clinical practice represented, perhaps reflecting a cross-section of clinical negligence litigation generally; 7 cases came from the field of obstetrics (as of course did *Montgomery* itself), 4 from neurosurgery/spinal surgery, 3 general surgery, 3 orthopaedic surgery and the rest making up the numbers. Perhaps notably, 2 cases (*Correia* and *Keane*) involved the more esoteric area of podiatric surgery leading to chronic pain.
- Issues arising from the proper approach to obtaining patient consent have come before the Court of Appeal on 6 occasions (*Worrall*, *Webster*, *Correia*, *Shaw*, *Duce*, *Diamond*). The last four of those occasions included consideration (and rejection) of the existence of a free-standing action for breach of patient autonomy, independent of the need to demonstrate causation of injury.
- Of the 29 reports of first instance decisions[1], only 2 are reports of County Court cases, which likely reflects the sporadic inclusion of reports below High Court level on the usual online databases.
- In terms of outcomes, the prospects of establishing breach of duty are finely balanced in that of the 34 distinct actions, breach was established in 18.
- Causation is a significant hurdle with 5 distinct cases (out of the 18 that get that far) failing at this stage.
- 16 of the 34 cases failed on breach. Of those 16, in 10 cases (*A v East Kent*, *Connolly*, *Grimstone*, *MC*, *Holdsworth*, *Correia*, *Duce*, *Keane*, *Richardson* and *Ollosson*[2]) the court went on to find (or upheld a finding) that even if warned/advised in the terms for which the claimant contended, this would not have made any difference i.e. causation would not have been established in any event. Of the remaining 6 cases, in 5 (*Tasmin*, *Bayley*, *Cameron*, *ML* and *Mordel*) causation is not separately considered, having dismissed the case on breach grounds. *Worrall* is the exception in that whilst a judge's finding in favour

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[1] Of the 30 High Court decisions, *Price* is the only example of a decision on an appeal from the County Court.

[2] In fact in *Ollosson* the judge states at [158] "*It is not sensible to consider causation in the alternative since, by definition on my findings, Mr Ollosson did give properly informed consent*" before setting out three reasons why the claim would have failed on causation.

of the claimant on breach was overturned, the Court of Appeal declined to disturb the finding that the claimant would not have proceeded surgery if given what she contended was the appropriate advice.

Conclusions

Trying to discern trends in litigation by reference to reported cases is perhaps like trying to work out what is going on in a crowded room by peering through the keyhole; the vast majority of cases brought (even if they get as far as the issue of proceedings) are settled long before they are exposed to the public gaze through a published judgment. In addition, there are challenges in capturing all relevant decisions, particularly those at County Court level. Nonetheless, the reported cases suggest that this continues to be a well-litigated area with sufficient uncertainty of outcome for it to remain so.

No.	Case name	Citation	Date handed down	Judge	Court	Area of clinical practice	C wins on breach & causation	C wins on breach, loses on causation	C loses on breach
1	FM v Ipswich Hospital NHS Trust	[2015] EWHC 775 (QB)	27/03/2015	HHJ McKenna	HC	Obstetrics	X		
2	A v East Kent Hospitals University NHS Foundation Trust	[2015] EWHC 1038 (QB)	20/04/2015	Dingemans J	HC	Fetal medicine			X
3	Spencer v Hillingdon Hospital NHS Trust	[2015] EWHC 1058 (QB)	21/04/2015	HHJ Collender QC	HC	General Surgery	X		
4	Connolly v Croydon Health Services NHS Trust	[2015] EWHC 1339 (QB)	15/05/2015	HHJ Collender QC	HC	Cardiology			X
5	Barrett v Sandwell and West Birmingham Hospitals NHS Trust	[2015] EWHC 2627 (QB)	18/09/2015	Blair J	HC	Ophthalmic Surgery		X	
6	Shaw v Kovac	[2015] EWHC 3335 (QB)	28/10/2015	HHJ Platts	HC	Cardiac Surgery	X		
7	Tasmin v Barts Health NHS Trust	[2015] EWHC 3135 (QB)	30/10/2015	Jay J	HC	Obstetrics			X
8	Grimstone v Epsom and St Helier University Hospitals NHS Trust	[2015] EWHC 3756 (QB)	23/12/2015	McGowan J	HC	Orthopaedic surgery			X
9	Lunn v Kanagaratnam	[2016] EWHC 93 (QB)	22/01/2016	HHJ McKenna	HC	Cardiology	X		
10	MC v Birmingham Women's NHS Foundation Trust	[2016] EWHC 1334 (QB)	08/06/2016	Turner J	HC	Obstetrics			X
11	Crossman v St George's Healthcare NHS Trust	[2016] EWHC 2878 (QB)	25/11/2016	HHJ Peter Hughes QC	HC	Neurosurgery / Spinal surgery	X		
12	Worrall v Antoniadou	[2016] EWCA Civ 1219	06/12/2016	Tomlinson LJ David Richards LJ	CA	Breast Surgery			X
13	Holdsworth v Luton and Dunstable University Hospital NHS Foundation Trust	[2016] EWHC 3347 (QB)	21/12/2016	HHJ Freedman	HC	Orthopaedic surgery			X
14	Webster v Burton Hospitals NHS Foundation Trust	[2017] EWCA Civ 62	13/02/2017	Jackson LJ Simon LJ Flaux LJ	CA	Obstetrics	X		
15	Thefaut v Johnston	[2017] EWHC 497 (QB)	14/03/2017	Green J	HC	Neurosurgery / Spinal surgery	X		
16	Correia v University Hospital of North Staffordshire NHS Trust	[2017] EWCA Civ 356	12/05/2017	Black LJ Simon LJ	CA	Podiatric Surgery			X
17	Diamond v Royal Devon and Exeter NHS Foundation Trust	[2017] EWHC 1495 (QB)	23/06/2017	HHJ Freedman	HC	General Surgery		X	

No.	Case name	Citation	Date handed down	Judge	Court	Area of clinical practice	C wins on breach & causation	C wins on breach, loses on causation	C loses on breach
18	Shaw v Kovac	[2017] EWCA Civ 1028	18/07/2017	Davis LJ Underhill LJ Burnett LJ	CA	Cardiac Surgery	X		
19	Gallardo v Imperial College Healthcare NHS Trust	[2017] EWHC 3147 (QB)	08/12/2017	HHJ Peter Hughes QC	HC	General Surgery	X		
20	Bayley v George Eliot Hospital NHS Trust	[2017] EWHC 3398 (QB)	21/12/2017	HHJ Worster	HC	Vascular Surgery			X
21	Cameron v Ipswich Hospital NHS Trust	[2018] EWHC 38 (QB)	18/01/2018	HHJ Forster QC	HC	Neurosurgery / spinal surgery			X
22	Hassell v Hillingdon Hospitals NHS Foundation Trust	[2018] EWHC 164 (QB)	06/02/2018	Dingemans J	HC	Neurosurgery / Spinal surgery	X		
23	Duce v Worcestershire Acute Hospitals NHS Trust	[2018] EWCA Civ 1307	07/06/2018	Hamblen LJ Newey LJ Leggatt LJ	CA	Gynaecological surgery			X
24	ML (A Child) v Guy's and St. Thomas' National Healthcare Foundation Trust	[2018] EWHC 2010 (QB)	31/07/2018	Martin Spencer J	HC	Obstetrics			X
25	Keane v Tollafield	[2018] 8 WLUK 306	12/10/2018	HHJ Williams	CC	Podiatric Surgery			X
26	Richardson v Newcastle upon Tyne Hospitals Foundation Trust	[2018] 12 WLUK 556	19/12/2018	Recorder Cox QC	CC	Neurosurgery and Maxillofacial surgery			X
27	Kennedy v Frankel	[2019] EWHC 106 (QB)	25/01/2019	Yip J	HC	Neurology	X		
28	Keh v Homerton University Hospitals NHS Foundation Trust	[2019] EWHC 548 (QB)	08/03/2019	Stewart J	HC	Obstetrics		X	
29	Ollosson v Lee	[2019] EWHC 784 (QB)	29/03/2019	Stewart J	HC	General Practice (involving vasectomy)			X
30	Diamond v Royal Devon and Exeter NHS Foundation Trust	[2019] EWCA Civ 585	08/04/2019	McCombe LJ Floyd LJ Nicola Davies LJ	CA	General Surgery		X	

No.	Case name	Citation	Date handed down	Judge	Court	Area of clinical practice	C wins on breach & causation	C wins on breach, loses on causation	C loses on breach
31	Mills v Oxford University Hospitals NHS Trust	[2019] EWHC 936 (QB)	12/04/2019	Karen Steyn QC	HC	Neurosurgery	X		
32	Price v Cwm Taf University Health Board	[2019] EWHC 938 (QB)	15/04/2019	Birss J	HC	Orthopaedic surgery			X
33	Mordel v Royal Berkshire NHS Foundation Trust	[2019] EWHC 2591 (QB)	08/10/2019	Jay J	HC	Sonography / Fetal Medicine	X		
34	Metcalf v Royal Devon and Exeter NHS Foundation Trust	[2019] EWHC 3549 (QB)	19/12/2019	David Pittaway QC	HC	Oncology / Thoracic surgery		X	
35	Pepper v Royal Free London NHS Foundation Trust	[2020] EWHC 310 (QB)	25/02/2020	Geoffrey Tattersall QC	HC	HPB Surgery		X	
36	NKX v Barts Health NHS Trust	[2020] EWHC 828 (QB)	08/04/2020	Simeon Maskrey QC	HC	Obstetrics	X		
	Totals						14	6	16

BOLAM, BOLITHO OR BOTH-OF-'EM?

Rajkiran Barhey

Bradfield-Kay v Cope [2020] EWHC 1351 (QB)

This split trial on breach of duty concerned allegations relating to the performance of a total left hip replacement by the Defendant. Of interest is the approach taken by the judge to the distinction between the *Bolam* and *Bolitho* tests.

Facts

In November 2009, following osteoarthritic changes, the Defendant had privately performed a right total hip replacement for the Claimant, who was satisfied with the results. Later that month, following a consultation, the Claimant decided to undergo a left total hip replacement. He did not recover as planned and had to undergo two further revision surgeries.

Allegation

The Claimant alleged that the Defendant had been negligent in three respects [8]. For the purposes of this article, I will only consider the first allegation, namely that, when he performed the left total hip replacement on 18 December 2009, the Defendant permitted the acetabular component of the prosthetic hip to be prominent, in such a position that the iliopsoas tendon caught on it, causing him to develop iliopsoas tendonitis.

The evidence

The judge heard evidence from both parties' experts. The judge acknowledged that the Claimant's expert was primarily a knee specialist although he had performed a number of hip replacements. The Defendant's expert, however, focused on hip arthroplasties and was a former President of the British Hip Society. The judge concluded that: *"Mr Manktelow* [the Defendant's expert] *was better able than Mr Chatterji* [the Claimant's expert] *to speak to the practice of hip specialists in England."*

Having considered the evidence, particularly the evidence from the revision surgeries, the judge concluded that the Defendant had permitted the acetabular component of the prosthetic hip to be prominent and that this was sufficient to cause irritation of the anterior structures, specifically the left iliopsoas tendon. The question was whether this was negligent or not.

The experts agreed that *"surgeons should ensure the acetabular component is not placed in a position that could interfere with the iliopsoas tendon such as beyond the acetabular margin of the native acetabulum."* [29]. The Defendant's expert said that "*typically, once the socket has been positioned, the surgeon will run a finger or surgical instrument over the anterior aspect of the socket to ensure that is seated deep to the natural bony acetabulum."* However this practice would not always prevent the prominence of the anterior aspect of the cup.

The Defendant's expert further gave evidence that, in his experience, many surgeons fail to ensure that the acetabular component is not prominent. He said "*a number of surgeons make this error because surgeons are not as careful as they should be to ensure that the socket is deep to the anterior bone.*"

The Defendant surgeon admitted that he did not check that the acetabular component did not protrude, because he had never been trained to do this in the three training sessions which he had attended on hip replacements.

The Claimant's expert referred to the practice described by the Defendant's expert of running a finger around the rim of the acetabulum to check that the component is not prominent, but accepted that he could not *"refer to any textbook or handout from any presentation to demonstrate that his practice was accepted throughout the profession as standard either in 2009 or at present."*

On the ultimate question of whether the failure to ensure the acetabular component was prominent was a breach of duty, the Claimant's expert insisted it was, whereas the Defendant's expert was adamant that it was not. However, the judge found that the Defendant's expert failed to adequately explain why he did not consider this failure to be a breach of duty: *"I was left with the impression that Mr Manktelow's justification for asserting that there was no breach of duty was because he said so."*

The judge went on to find that *"there is plainly a body of surgeons undertaking hip arthroplasties that holds the opinion that surgeons should ensure that (so far as possible) the acetabular component is not placed in a position that could interfere with the iliopsoas tendon such as beyond the acetabular margin of the native acetabulum… In my view, the evidence justifies a finding that there is a body of surgeons that does not hold that opinion. At the time of the operation in question, Mr Cope was one such. Mr Manktelow's experience of undertaking revision arthroplasties demonstrates that there are other surgeons who appear to adopt the same practice."* [41]-[42].

The Defendant argued that this conclusion provided the Defendant with a *Bolam* defence and that the Claimant was required to rely on *Bolitho.* The judge refused to accept this submission, finding that: "*In my view, both Bolam and Bolitho require the court to examine the different schools of thought and to ask itself whether the school of thought relied upon by the defendant can demonstrate that its exponents' opinion has a logical basis."* [43].

He then concluded that: *"I reach the conclusion that there was no logical basis for neglecting to ensure that the acetabular component was not placed in a position that could interfere with the iliopsoas tendon. No good reason has been advanced for not taking this precaution. It has not been shown that the two views show that there is a nice balancing of different risks about which surgeons could reasonably disagree. The risk of impingement on the iliopsoas tendon was a well-recognised risk which could easily have been identified by visualisation and/or by palpation or running an instrument around the acetabular rim. If there was any risk in the placement of the cup, it was a relatively simple matter to remove the cup and replace it. There was no surgical or anatomical reason for running the risk in this case."*

The first allegation of breach of duty was therefore established. The judge went on to say that *"I acknowledge that Mr Cope is being held to a standard of which he was unaware at the time. For the reasons I have sought to explain in this judgment, the evidence establishes that this is the standard that Mr Bradfield-Kay was entitled to expect from a competent hip surgeon in 2009."*

Comment

The judge's approach to the *Bolam* and *Bolitho* tests was somewhat unusual in this case. This appears to be a reasonably straightforward example of a case in which, whilst the Claimant could not show *Bolam* negligence as the Defendant's practice was reasonably widespread at the time of the negligence, the practice was without a logical basis, and therefore the *Bolitho* test operated to establish that the practice was negligent.

The judge rejected the submission, however, that *Bolam* and *Bolitho* required one to consider different things, instead finding that both tests required one to consider whether a practice is logical. This is somewhat contrary to the traditional understanding of the manner in which the respective tests operate and it is not clear why the judge took this approach. In practical terms, it made no difference to the outcome and, in every case, practitioners and experts will need to consider carefully whether a practice is logical, even if it is accepted by a body of medical opinion.

Also of interest is the fact that, although the Defendant's expert was acknowledged as better qualified to opine on the practice of hip arthroplasty in the UK, the judge preferred the Claimant's expert.

MONITORING DURING LABOUR

Dominic Ruck Keene

NKX v Barts Health NHS Trust [2020] EWHC 839 (QB)

The Facts

This was a liability only hearing where the Claimant alleged that his mother was given insufficient warning that she should have continuous fetal monitoring ("CFM") when she was in labour; that if she had been given appropriate warnings she would have accepted CFM rather than, as in fact occurred, monitoring by intermittent auscultation ("IA"); that CFM monitoring would have detected abnormalities of the fetal heart earlier; that as a consequence a uterine rupture would have been detected more quickly, with consequently speedier delivery, thus avoiding some of the acute profound hypoxia that accompanied the uterine rupture and some or all of the permanent brain damage resulting from it. The Claimant's secondary case was that IA should have increased in frequency from the point at which midwifery staff should have known or assumed that his mother was in the second stage of labour, and that such an increase in frequency would, again, have resulted in earlier detection of the uterine rupture.

The Issues

Simon Maskrey QC identified the central issue in respect of breach to be whether the Claimant was given sufficient information that there was a risk of later detection of uterine rupture if the monitoring was by way of IA rather than CFM, with a consequent increased risk of permanent brain damage. The Claimant's case was that his mother did not appreciate these consequences of her decision to opt for delivery in a birthing centre without access to CFM, it not having been made clear to her by midwifery staff either when discussing options for delivery or when she arrived at the hospital in labour. It is the Defendant's case that the mother opted for delivery in the birthing centre monitored only by IA fully aware of the risks and benefits of so doing and exercising her undoubted right to choose how and where she would labour and with what monitoring.

Judgment - Breach

Simon Maskrey QC found that, following her initial midwife consultations, the Claimant's mother understood that she was a candidate for Vaginal Birth After Caesarean (VBAC), that VBAC was high risk and that there would be close monitoring as VBAC had a small (less than 1%) risk of a uterine rupture. The Claimant's parents were adamant that while they understood there was a very small increased risk of uterine rupture, they did not appreciate that there was a consequent risk of permanent brain damage. They maintained they did not appreciate that CTG monitoring was designed to give early warning of uterine rupture. Simon Maskrey QC found that, while the parents had been informed of CTG monitoring, it was not described in any detail, in particular as to any differences between IA and CTG. He further accepted that the Claimant's parents did not appreciate that hypoxia could result in permanent brain damage.

However, when it came to the stark differences in the accounts given by the Claimant's mother and the consultant midwife as to the critical follow up consultation at which the definitive birth plan for a water birth in the birthing centre was formulated, Simon Maskrey QC broadly found against the Claimant.

He held that the consultant midwife informed the Claimant's mother that IA was not recommended by the Royal College of Obstetricians and Gynaecologists; that a uterine rupture was a small possibility but that CFM reduced the risk of a rupture damaging the baby; that CFM was available in one room in the delivery suite but might not be in the birthing centre; and that if the mother wanted to labour in the birthing centre without CFM that would only be possible if staffing levels permitted. He concluded that the Claimant's mother did appreciate the difference between CFM and IA, and that CFM carried a greater chance of detecting a rupture than IA. This was on the basis in particular that: (1) a person of the Claimant's mother's intelligence would have appreciated the IA was different from CFM, and was plainly not the close monitoring as was standard for a VBAC; (2) the Claimant's mother had been told that CFM was the standard close monitoring offered; (3) the absence of specific

reference to the risks and consequences in the record did not cause any doubt that the risks and consequences were discussed.

Accordingly, the consultant midwife had done enough to inform the Claimant's mother of the risks of having IA, and the Claimant's mother had appreciated that CFM was better for the baby than IA. The consultant midwife had appropriately balanced the need to make it clear that IA was not recommended by the hospital or the Royal College with the need to support the Claimant's mother in the choice that she took. Critically he held that:

"whatever the perceived deficiencies of the antenatal counselling I find that the Claimant's mother knew of the increased risks of having a water birth with IA as contrasted with labouring with CFM whether in a pool or otherwise. She may not have appreciated that hypoxic-ischaemic encephalopathy could lead to brain damage but she knew that it was "bad for the baby" and in my judgment that sufficed."

Simon Maskrey QC went on find that once the Claimant's mother was in labour, she did not have a preference for IA, did not need to be persuaded to have CTG, and that the midwifery staff simply considered that the birth plan had previously been agreed to by the consultant midwife and that they should support that plan, whatever they thought about it. Accordingly, they did not warn the Claimant's mother of the risks or potential consequences of IA nor did they recommend she should have CFM in order to reduce the risk to the baby. He found that there was no counselling or re-assessment of the risks once the Claimant's mother came to the hospital and that was a breach of duty given the agreement of the midwifery experts that a birth plan required reconsideration during the course of the pregnancy and in particular when the mother goes into labour. Further, that counselling and re-assessment of risks was necessary because there was a very real possibility that the Claimant's mother would change her mind if provided with a sober re-assessment of the risks and benefits of IA. The Claimant's parents should have been told that there was no one available with experience of caring for a VBAC mother without CFM.

Lastly, Simon Maskrey QC found that there had been a breach to perform IA sufficiently frequently.

Judgment - causation

Simon Maskrey QC held that despite the risk of subsequent events colouring the Claimant's father's recollection, he had given compelling evidence that, if there had been a recitation on the night in question of the risks of IA, they would have desired to accept whatever additional monitoring could be provided. Further, the Claimant's mother, when faced with the reality of labouring in a busy maternity unit, would have re-evaluated her decision with the input of her husband. With that input she would have opted for CFM if it had been emphasised that that was the advice of the midwives on the night.

With regards to causation and the issue of the uterine rupture, Simon Maskrey QC rejected the Claimant's argument that where there was no CFM (as there ought to have been) the evidence should be considered 'benevolently'. However, he found that there had been a delay in commencing resuscitation, and consequently the Claimant would have only suffered mild rather than severe brain damage.

Comment

Any decision involving consent and causation in clinical negligence is bound to be highly fact sensitive. However, what is interesting about this judgment is the degree to which the judge's assessment of what information should have been conveyed to the Claimant's mother, and what degree of understanding she was required subsequently to have of the relevant risks, was formed on a relatively broad brush basis, rather than by particular reference to the magnitude of risk or the specific details of the risks involved.

Further, as an aside, the judge made extensive use of answers to his own questions to both witnesses and experts when reaching his conclusions in respect of both breach and causation – having a very experienced clinical negligence QC as the judge potentially made a significant difference to the outcome.

Application for Permission to Amend a Statement of Case

Matthew Flinn

Pearce v East and North Hertfordshire NHS Trust [2020] EWHC 1504 (QB)

In a succinct judgment from Lambert J, the High Court has provided a useful summary of the court's approach to applications for permission to amend a statement of case.

The claim related to a delay in carrying out an ultrasound examination of the Claimant's hips following his birth in the breech position. As a result of the delay, a diagnosis of hip dysplasia was made belatedly, with a worse outcome and prognosis for the Claimant. The Defendant had a protocol indicating that such scans should take place within six weeks. However, the Defendant offered the Claimant's mother an appointment at nine weeks, which she then re-arranged as she was not aware of any urgency.

The Claimant alleged that the appointment should have been arranged within six weeks in accordance with the protocol, and further that the Defendant failed to explain to the mother that timing was critical. As a result, she did not press for an appointment to be arranged within six weeks, and felt able to rearrange the appointment that was offered at nine weeks.

As the litigation progressed, the Defendant admitted breach of duty by failing to carry out an ultrasound scan at six weeks (in breach of its protocol). Other allegations of breach were denied – including the allegation of a failure to communicate to the Claimant's mother that a scan was time-critical.

It was agreed between the parties that they would proceed to a liability trial only, on the sole basis of the particular breach of duty that had been admitted. In other words, the only liability question for the court was the causative effect of failing to arrange an appointment within six weeks (the Defendant argued that had an appointment occurred within the protocol timeframe, the outcome would have been the same).

The trial was listed for mid-July 2020, and the Defendant made an application to amend its Defence in early May 2020. The effect of the amendment was, in essence, to argue that the proximate legal cause of the Claimant's injury was his mother's failure to take up the appointment that had been offered at nine weeks (the Claimant having argued that treatment at any point up to 12 weeks would have avoided injury).

The judgment

At paragraph 10 of her judgment, Lambert J gives an extremely helpful summary of principles to be applied by the court when entertaining applications such as the Defendant's (under rule 17.3 CPR based on *CIP Properties (AIPT) Ltd v Galliford Try Infrastructure Ltd* [2015] EWHC 1345 (TCC) and *Quah Su-Ling v Goldman Sachs International* [2015] EWHC 759 (Comm)).

The key principles she extracted from the case law were that:

- In exercising the discretion under CPR 17.3 , the overriding objective is of central importance. Applications always involve the court striking a balance between injustice to the applicant if the amendment is refused, and injustice to the opposing party and other litigants in general, if the amendment is permitted.
- A strict view must be taken to non-compliance with the CPR and directions of the Court. The Court must take into account the fair and efficient distribution of resources, not just between the parties but amongst litigants as a group.
- The timing of the application should be considered and weighed in the balance. An amendment can be regarded as 'very late' if permission to amend threatens the trial date, even if the application is made some months before the trial is due to start.

- Where a very late application to amend is made the correct approach is not that the amendments ought, in general, to be allowed. Rather, there is a heavy burden on the amending party to show the strength of the new case and why justice requires the amendment to be allowed.
- There needs to be a good reason for the delay in seeking to make the amendment.
- The risk to a trial date may mean that the lateness of the application to amend will of itself cause the balance to be loaded heavily against the grant of permission.
- Prejudice to the amending party if the amendments are not allowed will, obviously, include its inability to advance its amended case, but that is just one factor to be considered. Moreover, if that prejudice has come about by the amending party's own conduct, then it is a much less important element of the balancing exercise.

Lambert J concluded that allowing the amendment in this case would necessitate vacating the trial, because it would necessarily have the effect of reviving the Claimant's allegations of breach which it had previously decided not to pursue (for good reason). That was so because whether or not the failure of the Claimant's mother to take up the appointment at nine weeks could be said to be the proximate legal cause of the injury would depend to some extent on whether she ought to have been told that the appointment had some urgency. In turn, exploring that argument would require expert evidence on breach which had not been obtained in light of the admissions made and the agreed basis of the trial.

Because the trial date would be lost, the application was to be treated as "very late", and in order to be granted permission the Defendant would need to show a good reason for the delay and the amended case had some genuine strength. On the facts, Lambert J found that the amendment had been in the mind of the Defendant for some considerable period (indeed, the argument had been deployed in the Letter of Response), and the explanation for delay was unsatisfactory. Further, she had doubts about the merit of the proposed amendment. The application was therefore refused.

This is a very digestible case, and there are some key points of which practitioners should take note. In particular, the reminder that for very late amendments the court will not start from the assumption that amendments ought to be allowed, and in particular, the principle that an application to amend will be treated as "very late" if it threatens the trial date, even if made some months before trial. Practitioners are therefore well advised, when considering a potential amendment, to review the directions timetable and ensure that any consequential directions and changes to the timetable can be arranged whilst retaining the trial fixture.

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10 of 20 – Useful Costs Cases to be Aware of From the First Half of 2020

Sarah Lambert QC

Costs is not always the first thought on a clinical negligence practitioner's mind, but the first 6 months of this year have been busy with relevant costs decisions. Here are the author's top 10 useful costs decisions to keep in mind as you plan, practice, and seek to recover / oppose the maximum costs recovery in your claims.

Reductions to Successful Claimant Costs

A win will not necessarily equate to full costs recovery, as the following cases demonstrate.

Exaggerated claim = reduction of costs recovery

This is an interesting case where the Claimant was successful at trial, beat the Defendant's Part 36 offer, was specifically found not to have been fundamentally dishonest, but nonetheless was penalized for exaggeration short of dishonesty. In *Morrow v Shrewsbury Rugby Union Football Club* [2020] EWHC 999 (QB) the successful personal injury Claimant, who had beaten the defendant's Part 36 offer, nonetheless had his costs reduced by 15% across the board, for "*engrained*" exaggeration. We might anticipate that this case will be much produced

in an attempt to obtain similar reductions in many cases where a recovery noticeably below the pleaded value has been achieved.

Disbursement funding / interest not recovered

On the same date, In *Nosworthy v Royal Bournemouth & Christchurch Hospitals NHS Foundation Trust* 2020 EWHC B19 (Costs) Master Brown in the Senior Court Costs Office decided that awards of interest on costs for the pre judgment period (in order to compensate for interest paid by a party on disbursement funding) should not as a general rule be recovered: *"costs recovery is not intended to be a complete indemnity. Under the pre-LASPO costs regime the element of the success fees which was attributable to the delay in payment of fees was not recoverable inter partes: see rule 44.3B of the then applicable Civil Procedure Rules. Indeed, it seems to me that it might reasonably be thought that if Parliament had now intended there to be a recovery of the costs of funding or borrowing in litigation of this sort in the manner in which it is now claimed it would have provided an appropriate mechanism for its ascertainment."*

And the latest in the long running list of cases re change of funding is also a win for the Defendant

The vexed issue of a pre LASPO change from public funding to CFA continues to produce litigation. Despite 1 recent case finding such change to have been reasonable, the tide is very much the other way, with yet another example *XDE v North Middlesex University Hospital NHS Trust* [2020] EWCA Civ 543 holding once again that additional liabilities are irrecoverable. The Court of Appeal upheld on the particular facts of this case the decisions of the courts below that the reasons for the change from public funding to CFA were unreasonable, disallowing recovery of the success fee and the ATE premium.

Reductions to Successful Defendant Costs

It is not only successful Claimants who have seen their costs entitlement cut in principle.

Successful Defendant penalised in costs as a result of failure to engage in ADR

In *Wales (t/a Selective Investment Services) v CBRE Managed Services Ltd & Anor* [2020] EWHC 1050 (Comm), His Honour Judge Halliwell sitting as a Judge of the High Court held that such failure meant that the parties were denied the opportunity to fully canvass and engage with the underlying issues. Costs were denied to the tune of 50% from the date upon which the Defendant's solicitors confirmed that their client would not take part in ADR, and disallowed to the tune of 20% for the final period prior to trial, once a further refusal to mediate was communicated.

The above case is in fact just 1 of a whole raft in the past 6 months where costs penalties against both Claimants and Defendants have been made, whether parties were ultimately successful or not, where there have been failures actively to engage in mediation / ADR/ negotiations. Attendance at JSM but making no offers is also penalized.

Refusal actively to engage in settlement negotiations = indemnity costs

Indemnity costs against unsuccessful Defendant from the date of unreasoned refusal to engage attend a JSM

In *BXB v Watch Tower and Bible Tract Society of Pennsylvannia & Ors* [2020] EWHC 656 (Admin) Chamberlain J considered an application by the successful Claimant, who had 'beaten' her first Part 36 offer (made on 9 July 2019) in respect of claim arising out of serious sexual abuse, that the Second Defendants should pay all of her costs on the indemnity basis, in view of the Defendants' unreasonable conduct, in particular their refusal to engage in alternative dispute resolution ('ADR'). Whilst not going that far, the learned judge did consider *"that an order that the Claimant's costs be assessed on the indemnity basis is, in my judgment, appropriate. But it should not apply to the whole of the Claimant's costs – only those incurred after 25 February 2019, the date of the Defendants' unreasoned refusal to engage with the invitation to attend a joint settlement meeting."*

Even a reasoned refusal to attend a settlement meeting however may not assist, as was held a week later.

Indemnity costs against unsuccessful Defendant from the date when negotiations ought to have been considered

In *DSN v Blackpool Football Club Ltd (Rev 1)* [2020] EWHC 670 (QB) the reasons given for refusing to engage in mediation were found inadequate. They were, simply, and repeatedly, that the Defendant *"continues to believe that it has a strong defence".* This was not considered reasonable by Griffiths J, "*No defence, however strong, by itself justifies a failure to engage in any kind of alternative dispute resolution. Experience has shown that disputes may often be resolved in a way satisfactory to all parties, including parties who find themselves able to resolve claims against them which they consider not to be well founded. Settlement allows solutions which are potentially limitless in their ingenuity and flexibility, and they do not necessarily require any admission of liability, or even a payment of money. Even if they do involve payment of money, the amount may compare favourably (if the settlement is timely) with the irrecoverable costs, in money terms alone, of an action that has been successfully fought. The costs of an action will not always be limited to financial costs, however. A trial is likely to require a significant expenditure of time, including management time, and may take a heavy toll on witnesses even for successful parties which a settlement could spare them".*

Moreover, attendance at JSM must be meaningful and not just designed to tick the box of being able to say in respect of costs that a meeting was attended.

Indemnity costs against unsuccessful Defendant who attended JSM but makes no offers

EAXB v University Hospitals of Leicester NHS Trust will be of particular interest to all of us who have attended RTMs only to be told that the opposing side will be making no offers. The Claimant having succeeded on liability in a wrongful birth claim, was awarded indemnity costs largely as a result of the Defendant, which had itself requested a JSM, attending but making no offers.

And it is not only unsuccessful Defendants who are penalized in indemnity costs.

Indemnity Costs against unsuccessful Claimant who ought to have accepted an offer

In *De Sena v Notaro* [2020] EWHC 1366 the Claimant's claims were dismissed in their entirety. In a spectacularly damning conclusion on costs, HHJ Matthews, sitting as a judge of the High Court, had this to say, *"Overall, taking all these points together, I am entirely satisfied that this is an appropriate case to award indemnity costs in favour of the first and second defendants. The case was weak and thin to start with, it was met with reasonable – indeed, generous – offers that should have been accepted, and the litigation was poorly prepared, including the botched expert evidence. In my judgment, if her lawyers did not do this, this is a case where they should have stood up to the client and said "You have no case; it is a waste of time and money to go on." Although I have no doubt that she would have been very unhappy, it would have been, objectively speaking, a kindness to her to do so."*

Any offer to settle would appear to be better than none. Part 36 provides, as usual, ongoing satellite litigation in this respect.

Part 36 Cases

Genuine offer to settle vs. tactical attempt at obtaining the enhancements

In *Rawbank SA v Travelex Banknotes Ltd* [2020] EWHC 1619 (Ch) Mr Justice Zacaroli considered whether the enhancements of Part 36 should apply when a successful claimant made an offer to settle a debt for a slightly reduced figure. The Part 36 offer was made at a discount of only 0.3% of the total amount claimed. The unsuccessful party, unsurprisingly, submitted that this was clearly not a genuine offer to settle, but was a tactical move, designed solely to engage the enhanced payments set out in Rule 36.17(4). The learned judge, whilst seeing the force of that submission, did not accept it, "*The critical question is not a mathematical one – the proportion of the discount – but whether it is possible to infer from the size of the discount that there is no genuine attempt to settle the proceedings."* (From a mathematical perspective however avid followers of these reported offers will note that it seems that a no court is likely to strike down any such offer, see *Huck v Robson* [2002] EWCA Civ 398 where 95% was held to be a genuine offer to settle, and even with an offer to settle for

99.9% of the full value of the claim, at its highest the judge would still only "*have a discretion to refuse indemnity costs*".)

A Defendant beating its own Part 36 offer has less entitlement to costs than a Claimant in the same situation

In *Lejonvarn v Burgess & Anor* [2020] Civ 114 the court considers the anomaly for successful Defendants where a Part 36 offer succeeds;- there is no presumed indemnity costs against the Claimant. This was a claim concerning complaints of negligence in respect of garden design. At trial the Claimant lost, hence failing to beat the Defendant's part 36 offer of £25,000. This appeal concerned the discrete issue of whether or not the Defendant ought to have been awarded costs on the indemnity basis. Part 36 has always been designed to provide that a claimant who beats his or her offer has an automatic entitlement to indemnity costs (unless that can be shown to be unjust) whilst a defendant has no such automatic right. The court affirmed this anomaly and it remains that there is no automatic entitlement on the part of a defendant to indemnity costs if that defendant beats its own Part 36 offer.

Remember also, in principle, the assessment of costs on an indemnity basis is not constrained by the approved cost budget, and to the extent that Coulson LJ's obiter comments in *Elvanite* or *Bank of Ireland v Watts* suggested the contrary, they should be disregarded. This means that indemnity costs can provide a useful means to get around the inability to depart (upwards) from budgeted costs on assessment without good reason.

(A very thorough consideration of caselaw on the issue of indemnity costs in general is given by the court in this decision (Lord Justice Coulson giving the leading judgment) and this decision merits a look for that reason alone.)

PRIVATE INTERNATIONAL LAW AND CLINICAL NEGLIGENCE

Charlotte Gilmartin

Roberts v Soldiers, Sailors, Airmen and Families Association [2020] EWHC 994

The High Court decided two preliminary issues of private international law in a claim alleging negligence of a midwife resulting in acute profound hypoxic brain injury at a hospital in Germany.

Background

Harry Roberts was born on 14 June 2000 in the AKV Hospital in Germany, which provided medical services to members of the UK Armed Forces in which his father was serving. Harry sustained a level 5 Cerebral Palsy. His mother and litigation friend claimed that his injuries were caused by the failure of the midwife to seek the assistance of a doctor much earlier, which would have hastened his delivery and avoided his injuries.

The provision of medical care to servicemen and their families in Germany was governed by a complex series of contractual arrangements. The Ministry of Defence ("MoD") entered into two key contracts: (1) with the Soldiers and Sailors, Airmen and Families Association – Forces Help ("SSAFA"), which provided community and nursing services, including midwifery services; and (2) with Guy's and St Thomas' Hospital NHS Trust ("GSST") which procured non-emergency healthcare to be provided by certain German providers, including the AKV Hospital.

The contract between SSAFA and the MoD required that service to be consistent with British health standards and cultural expectations and delivered in English. Notwithstanding, whilst working in a German hospital, English midwives had to work under the direction of the German system and to German standards and disciplines. In particular, there was a significant cultural distinction between English midwives and the German system in that in the latter, midwives were required to work more closely under the direction of an obstetrician than in the UK ([32]-[33]).

Proceedings were issued in the High Court in London on 31 December 2004. The claim was brought against two Defendants, alleging vicarious liability for the alleged negligence of the midwife. D1, SSAFA, was her employer. D1 was indemnified by the D2, the MoD. The Defendants commenced part 20 proceedings against the third

party, Allegemeines Krankenhaus Viersen GmbH, the body responsible for the AKV Hospital. SSAFA and MoD, in essence, denied any negligent action or omission on the part of the midwife, alleging that any negligence was wholly on the part of the German obstetricians employed by or working at the AKV Hospital.

Preliminary Issues

The High Court was tasked with determining:

1. The applicable law of the Claimant's claim; and

2. Whether the claim is time-barred and/or whether the Defendants are prohibited from reliance on a limitation defence.

If English law applied, the Claimant, being under a disability from birth, would not be statute-barred. However, in the event that German law was applicable, a number of sub-issues arose, notably:

1. Under the Foreign Limitation Periods Act 1984 ("FLPA") would the German law of limitation also apply? The Claimant argued that it fell to be disapplied because it was contrary to public policy or because of undue hardship.

2. If the German law of limitation applied, had the cause of action accrued and limitation expired by December 2004?

The Decision

Mrs Justice Foster held that German law was applicable under s.12 of the Private International Law (Miscellaneous Provisions) Act 1995 ("PILA"). The Claimant was only fixed with sufficient knowledge according to German law in June 2003, when a clinician's letter implicating the midwife's standard of care became available. The claim was in time. In the event that this was not the case, the application of the German limitation period would be disapplied for imposing undue hardship upon, pursuant to s.12(2) FLPA.

Applicable Law: PILA

It was common ground that the applicable law must be determined under PILA. The relevant law is set out in sections 11 and 12. S.11 states the "general rule" that: *"(1) … the applicable law is the law of the country in which the events constituting the tort or delict in question occur."* S.12 states a secondary rule that may displace this where "*it is substantially more appropriate*" for the applicable law to be that of another country. The statute dictates a comparison of the significance of the factors connecting the tort or delict with the country in which it occurred and with that of the other country, including *"factors relating to the parties, to any of the events which constitute the tort or delict in question or to any of the circumstances or consequences of those events"* (s.12(2)).

The Court noted that the correct approach to this question was as set out in Dicey, Morris & Collins on the Conflict of Laws 15th Ed at 35-148, namely that *"the provisions of s.12 have been applied to displace the law applicable under s.11 on very few occasions."* The Court also noted that "*the party seeking to displace the law which applies under s.11 must show a clear preponderance of factors declared relevant by s.12(2) which point towards the law of the other country. Whether that is the case will depend on the facts of the case and on the particular issue or issues which arise for decision."* ([115]).

The Claimant argued that although prima facie the case fell within the provisions of s.11, s.12 applied to take the case out of the general rule. The Claimant emphasised that Harry's parents were in Germany because his father was serving the British Crown, their sole connection to the country; the effects of the tort would be experienced in England; the nurses were trained in England according to English standards; and in carrying out their role they sought to abide by duties and obligations imposed by their English training and regulation.

On the other hand, the Court identified numerous factors connecting the tort to Germany, notably: care was under a German obstetric team led by a German obstetrician, in a country where perinatal care was obstetrician-led; the tort took place entirely in a German hospital; and the alleged negligence was "*wholly bound up with the procedures and expectations of the German obstetric system, and with this her interrelationship with the German*

doctors and the hospital which elements would necessarily be governed by German law." In circumstances where there were a number of factors going 'both ways', the Court could not conclude that there was a "*clear preponderance*" of factors connected to the tort itself tying the case to England. The significance of the whole obstetric team, being German obstetrician-led, was a highly persuasive factor ([133]): the British midwifes were *"grafted on*" to the German obstetric system and "*naturally subordinate to the direction of German obstetricians*" ([134]).

The Foreign Limitation Periods Act ("FLPA")

S.1 of FLPA provides that where in any action the law of any other country falls to be taken in to account, the law of that other country relating to limitation shall apply in respect of that matter except where an exception under s.2 applies, namely where its application would to any extent conflict with public policy or where its application would cause undue hardship. The Claimant relied upon the fact that having a disability has no resonance for the German law of limitation.

The Court noted that a foreign limitation period is only very seldom disapplied on grounds of public policy ([155]). The absence of protection for a person with a disability in the law of German limitation was not a ground for holding that the German limitation period was contrary to public policy: different policy choices may be made under foreign law and whereas some aspects of one jurisdiction may be less generous, others may be more beneficial ([162]-[163]).

Regarding undue hardship, the court held that this must be "*over and above the hardship that is inevitably caused by the application of the foreign limitation period itself*". Hardship was interpreted as meaning "*significant detriment*" ([181]). The hardship exception would apply in the event that German law compelled an earlier date of knowledge than the court's finding ([184]). The Court emphasised that if German law were to fix knowledge based on conversations in the immediate after birth, or upon receiving the devastating news of permanent impairment, there would be disproportionate hardship in the particular context of this case which included very serious injuries and a first time mother giving birth in a foreign country. The court further emphasised the complexity of the legal context and the uncertain disposition of potential liability ([185]).

Limitation

In any event, the German law of limitation required time to run from the point where the facts known to the Claimant are sufficient to *"arrive at the conclusion of culpable misconduct by the defendant and of the cause of this misconduct appear obvious for the damage or the necessary subsequent operation*" (sic.,[222]). The quality of knowledge would be of a relatively detailed nature and patients were protected from being required to "*join the dots*" from pieces of information ([230]). The court accepted that knowledge held on behalf of Harry was insufficient to commence an action until the doctor's statement implicating the midwife in the birth became available in about June 2003 ([85]-[86], [239] – [255]).

Conclusion

The judgment provides a detailed exposition of the principles relevant to litigating claims complicated by an international element and the factors which a court will take in to account in exercising its discretion to disapply a foreign limitation period. A very close analysis of the factual circumstances will be required, with the very particular factual and legal context in this case driving the Court's conclusion in respect of the application of the "*undue hardship"* exception under FLPA.

In Brief

Clinical Negligence

Chaplin v Pistol [2020] EWHC 1543 (QB) – Defendant applied for permission for expert evidence in the field of statistics/life expectancy. Application refused.

SC v University Hospital Southampton NHS Foundation Trust [2020] EWHC 1610 (QB) – concerned a failure to diagnose meningitis. C successful.

Taleb v Imperial College Healthcare NHS Trust [2020] EWHC 1147 (QB) – The Defendant's expert had raised the issue of whether the Claimant's injuries might be genetic and therefore not related to the brain injury in question. The Defendant applied for permission to obtain a single joint expert in genetics. Application refused. Judge considered trial date would have to be vacated. He was also sceptical as to the relevance of the evidence sought. Application was also late. Matthew Barnes from 1COR appeared for the Defendant.

McCulloch v Forth Valley Health Boards [2020] CSOH 40 – Claimant died from cardiac tamponade, number of allegations including failure to order repeat ECG, to prescribe colchicine and to prescribe NSAIDs. Claimant partially successful.

Inquests

Maguire, R (On the Application Of) v United Response & Ors [2020] EWCA Civ 738 – Significant decision on Article 2 and inquests. Will likely be covered in a future issue. Court of Appeal considered the operational duty in the context of medical failures in the Deceased's care.

Iroko, R (On the Application Of) v HM Senior Coroner for Inner London South & Anor [2020] EWHC 1753 (Admin) – Concerns procedural aspect of Article 2, failure to make a finding of neglect and failure to make a PFD report. Claimant not successful.

Events & News

News

Podcast

In Episode 109, Editor-in-Chief Rajkiran Barhey discusses highlights from QMLR Issue 4.

Readers may also be interested in Episode 121 in which Gideon Barth discusses secondary victim claims, Episode 110 in which William Edis QC talks about Whittingdon v XX, and Episode 106 in which Robert Kellar QC and Isabel McArdle discuss vicarious liability.

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. Follow us on Twitter @1corQMLR.

CONTRIBUTORS & EDITORIAL TEAM

Rajkiran Barhey (Call: 2017) – Editor-in-Chief

Rajkiran (Kiran) accepts instructions in all areas of Chambers' work and is developing a broad practice, particularly in clinical negligence, personal injury, inquests, tax, environmental and planning law, immigration, public law and human rights. Kiran joined Chambers as a tenant in September 2018 following successful completion of a 12-month pupillage. She has a wide range of advocacy experience, both led and unled.

Jeremy Hyam QC (Call: 1995, QC: 2016) – Editorial Team

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) – Editorial Team

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) – Editorial Team

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) – Editorial Team

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) – Editorial Team

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.

William Edis QC (Call: 1985, QC: 2008) - Contributor

Recognised as a leading Silk in his field, William Edis QC has a wide practice covering healthcare law, clinical negligence, disciplinary and regulatory inquiries, inquests, employment, healthcare-related public law and personal injury. He regularly acts in cases of the highest value, importance and complexity. He has appeared before the Supreme Court, the House of Lords, the Court of Appeal and all courts and tribunals relevant to his practice areas.

He has acted as a mediator.

Marina Wheeler QC (Call: 1987, QC: 2016) - Contributor

Marina Wheeler QC specialises in Administrative and Public Law and family law cases with a cross-border or national security angle. As a junior, she undertook large volumes of work for Central Government Departments and Agencies, predominantly involving prisons, mental health, armed conflict, and radicalisation, as well as employment work. Her local government work has involved child protection and adult social care, usually with a privacy or human rights element. She has also frequently worked for the NHS in employment disputes and the reconfiguration of hospital services.

In 2011 Marina qualified as a mediator and is a part-time teacher of the mediation and alternative dispute resolution course at Regents University, London.

Sarah Lambert QC (Call: 1994, QC: 2018) – Contributor

Sarah Lambert QC is a highly experienced specialist in complex clinical negligence, inquests, personal injury and costs cases. Sarah's empathetic but firm, and decisive but diplomatic approach makes her an astute advisor as well as a skilful and persuasive advocate. With a strong track record of trial and settlement success, recent recovery on behalf of clients is in the tens of millions. She is also often brought in to give unpalatable advice in difficult circumstances.

Sarah has in addition wide ranging judicial experience, sitting as a Recorder on the South Eastern Circuit (both in crime and in civil) and as a Deputy Costs Judge of the Senior Courts Costs Office.

Robert Kellar QC (Call: 1999, QC: 2019) - Contributor

Robert Kellar QC has a broad practice which encompasses clinical negligence, professional discipline, judicial review and human rights, healthcare, personal injury and inquests. In clinical negligence both claimants and defendants instruct him in all types of case. He acts for both individuals and healthcare institutions. He has particular experience in complex, multi-party and high value litigation e.g. the Ian Paterson Group Litigation. Robert acts for healthcare and other professionals in cases before regulatory and disciplinary tribunals.

Richard Mumford (Call: 2004) – Contributor

Richard Mumford's healthcare work is focused on claims relating to medical accidents of all descriptions (including product liability claims arising from medical devices) but also encompasses regulatory proceedings and contractual claims relating to the provision of healthcare and related services.

In addition, Richard regularly deals with personal injury claims ranging from serious road traffic injury and industrial injuries to physical and sexual abuse. Richard also advises and represents clients in relation to costs arising from litigation.

Amelia Walker (Call: 2007) – Contributor

Amelia Walker has a broad Public law practice including public inquiries, education, local government, Court of Protection and human rights law.

She was junior counsel for one of the core participants in the Mid-Staffordshire NHS Foundation Trust Public Inquiry and is currently instructed by one of the core participants in the Independent Inquiry into Child Sexual Abuse.

Amelia is ranked by Chambers and Partners as a leading junior in Education law.

Amelia has been appointed to the Attorney General's C Panel.

Emma-Louise Fenelon (Call: 2015) – Contributor

Emma-Louise Fenelon is developing a broad practice, in particular in Clinical Negligence, Child Abuse Compensation, Inquests, Public Inquiries, Personal Injury and Human Rights.

Emma joined Chambers as a tenant in September 2016 following successful completion of her pupillage. She has a First Class Honours degree from Trinity College Dublin and a Masters in Law from Harvard Law School. She is the Vice-Chair of the Human Rights Lawyers Association.

Emma is also co-presenter of Law Pod UK.

Emma has recently been appointed to the Attorney General's C Panel.

Gideon Barth (Call: 2015) - Contributor

Gideon has a busy practice spanning all areas of Chambers' work. In terms of clinical negligence, he has experience in high-value claims, complex causation arguments, secondary victim claims, issues of informed consent and Fatal Accidents Act claims. Gideon appears in inquests relating to topics ranging from medical negligence, mental health issues, nursing care to road traffic accidents. He was instructed as junior counsel to the Coroner in the Inquests into the Birmingham Pub Bombings (1974).

Gideon has recently been appointed to the Attorney General's C Panel.

Jonathan Metzer (Call: 2016) – Contributor

Jonathan Metzer is developing a broad practice across all areas of chambers' work, with particular expertise in public and human rights law, asylum and immigration, clinical negligence and inquests. He appears regularly in the County Court, the Coroner's Court and the Immigration Tribunals, and has also undertaken hearings in the High Court.

Jonathan joined chambers as a tenant in September 2017 after completion of 12 months of pupillage. Jonathan is also Commissioning Editor for the UK Human Rights Blog.

Jon has recently been appointed to the Attorney General's C Panel.

Charlotte Gilmartin (Call: 2015) – Contributor

Charlotte Gilmartin accepts instructions in all areas of Chambers' work and is developing a broad practice, in particular in Clinical Negligence, Personal Injury, Inquests, and Public Law and Human Rights. Charlotte joined Chambers as a tenant in March 2018 following successful completion of pupillage.

She regularly acts for both claimants and defendants in complex clinical negligence matters, advising on liability and quantum, settling a variety of pleadings and advising in conference. She has appeared in court in a variety of civil hearings on behalf of both claimants and defendants.