The 1COR Quarterly Medical Law Review

Updates and analysis of the latest legal developments

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Welcome to the fourth issue of the Quarterly Medical Law Review, brought to you by the barristers at 1 Crown Office Row:

We start by exploring some recent **judicial reviews** exploring the interaction between the **immigration system** and **healthcare.** In the first, David Manknell discusses a healthcare judicial review concerning the eligibility of a non-UK resident for NHS care – *R (Johnson) v Royal Free London NHS Foundation Trust* – Page 2.

Matthew Flinn considers another decision of the Administrative Court relating to NHS charges - *R (ERA) v Basildon and Thurrock University Hospitals NHS Foundation Trust* – and a decision concerning whether a failure to provide prompt medical treatment to a detained Claimant breached his Article 3 rights - *Watling v Chief Constable of Suffolk* – Page 3.

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Causation comes up next with the first article, by John Whitting QC, providing an insight into his own experience of issues of **statistical association** and causation - *Clements v Imperial College Healthcare NHS Trust* and *AB v East Lancashire Hospitals NHS Trust* – Page 7. This is followed by Dominic Ruck Keene's piece on *Collyer v Mid Essex Hospital Services NHS Trust*, which concerns **extremely rare complications** and establishing causation - Page 8.

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ELIGIBILITY OF NON-UK RESIDENTS FOR NHS CARE

David Manknell

R (Johnson) v Royal Free London NHS Foundation Trust [2019] EWHC 1143 (Admin)

Background

The Claimant was seriously ill with cancer, for which she was receiving medical treatment, most recently a cycle of palliative chemotherapy infusions. The "overseas visitors team" at the Defendant NHS Trust received an anonymous phone call asserting that the Claimant was not in fact eligible for NHS treatment because she resided in Nigeria and only travelled to the United Kingdom for health care. The Defendant then investigated this, by way of telephone calls, letters and interviews with the Claimant and members of her family. She was asked to provide further evidence. The Trust also obtained, from the Home Office, a list of the Claimant's travel movements in and out of the UK for the previous five years.

Based on the information available to it, the Defendant informed the Claimant that it had concluded that the Claimant was not ordinarily resident in the UK, and that she was ineligible for free NHS treatment under the NHS overseas visitors' charging regulations. She was presented with an invoice for £71,000, and informed that after her current cycle of chemotherapy treatment, no more treatment would be provided.

The Claimant brought judicial review proceedings, and the matter came before the court, prior to a decision on permission, as a result of her application for interim relief. Judgment was given in that context.

Judgment

Judgment was given by Mrs Justice Lang. The judge set out the background, and the circumstances of the hearing. It was noted that all the evidence had not been provided, and that the Claimant had not yet been provided with the material from the Home Office, which she indicated she sought to challenge. The application proceeded however, as the Claimant, who was in person, indicated that she wished to do so.

Having set out the evidence, the judge considered the legal framework, which is contained in the National Health Service (Charges to Overseas Visitors) Regulations 2015. Regulation 3 requires that in respect of an overseas visitor, where an NHS body is satisfied that the case is not one where the Regulations provide for no charge to be made, that the NHS body *"must make and recover charges for any relevant services it provides…".* The judge also noted the guidance issued by the Department of Health as to the meaning of *"ordinarily resident"* and the concept of *"settled purpose".*

The judge proceeded to dismiss the application, ruling that the Claimant had not established an even arguable claim. The judge assessed the accounts given by the Claimant had been "*inconsistent*", that her documentary evidence of residence in the United Kingdom was "*patchy and incomplete*", and that the Home Office documents were *"the most damning evidence against her",* and was "*powerful evidence that the Claimant has not been ordinarily resident in the United Kingdom"*, and that *"she has not been truthful with either the Defendant or this Court".*

The judge then proceeded to consider the evidence as to the treatment that that Claimant was receiving. She held that the Claimant *"would be able to return to Nigeria to obtain further chemotherapy if she wished",* and that regardless of her means, if the Claimant remained in the UK she would still be entitled to any immediately necessary and urgent treatment. In the circumstances, she decided that there was no arguable breach of Articles 2, 3 or 8 of the ECHR.

Comment

This case came before the court in unsatisfactory circumstances, including that the judgment was given prior to development of the substantive case and disclosure of relevant evidence, and also in that the Claimant was unrepresented. There will no doubt be further such cases before the courts, given what has been made a mandatory requirement on NHS Trusts that they "*must*" make and recover charges for those who do not qualify for free NHS treatment. The approach of the court is of note: despite judicial review proceedings being ill-suited to disputed questions of fact, and despite the lack of evidence, the judge was prepared to make strong findings of fact against the Claimant, including that she was not in fact ordinarily resident, that she had been dishonest, and that it was open to her to return to Nigeria and receive treatment there. In the circumstances, and no doubt in part as the Claimant was not represented, the court did not explore issues such as the standard of review to be exercised over the Trust's findings, or the quality and detail of the investigation that is required from an NHS Trust before reaching such a decision. The question of the impact of the ECHR on such cases will also no doubt be much more of an issue in subsequent cases.

LIFE-SAVING CANCER TREATMENT NOT A GROUND FOR ASYLUM

Matthew Flinn

R (ERA) v Basildon and Thurrock University Hospitals NHS Foundation Trust [2019] EWHC 1249 (Admin)

The High Court held that a person seeking to avoid removal from the United Kingdom on the basis that she would not have access to life-saving cancer treatment in her home country did not constitute an asylum seeker, and so a Trust's decision to charge her for NHS treatment was lawful.

Under section 1(4) of the National Health Service Act 2006, NHS services are to be provided free of charge unless any enactment provides otherwise. Overseas visitors (persons not ordinarily resident in the United Kingdom) are required to pay for such services unless a particular exemption applies, pursuant to the National Health Service (Charges to Overseas Visitors) Regulations 2015 ("the Charges Regulations").

ERA suffered from advanced breast cancer and travelled to the UK specifically for the purpose of undergoing treatment. Prior to the expiry of her leave to remain, she applied for further leave outside the scope of the Immigration Rules and on human rights grounds. Eventually, her argument crystallised as being reliant on Articles 3 and 8 of the European Convention on Human Rights ("ECHR"). It was asserted that the lack of adequate medical facilities in Ghana, where ERA had been living, exposed her to a deterioration in her condition which would infringe the Article 3 prohibition on torture, inhuman and degrading treatment (an argument based on a line of authority stemming from *D v United Kingdom* (1997) 24 EHRR 423, as considered and applied in *GS (India) v Secretary of State for the Home Department* [2015] 1WLR 3312). The application was refused, although the decision was being appealed to the Immigration and Asylum Chamber of the First-tier Tribunal.

The Defendant Trust sought to charge ERA, as an overseas visitor, for the treatment she had received. She opposed the imposition of charges in her case, relying on an exemption in section 15(b) of the Charges Regulations which provides that no charge may be recovered to an overseas visitor who *"has made an application, which has not yet been determined, to be granted temporary protection, asylum or humanitarian protection under the immigration rules".*

She argued that her application for further leave to remain in reliance on Articles 3 and 8 amounted to an application for asylum (she did not rely on the terms *"temporary protection"* or *"humanitarian protection",* saying that they were otiose). In advancing her case she relied on paragraph 327 of the Immigration Rules, which provides as follows:

> *327. Under the Rules an asylum applicant is a person who either;*

(a) makes a request to be recognised as a refugee under the Refugee Convention on the basis that it would be contrary to the United Kingdom's obligations under the Refugee Convention for them to be removed from or required to leave the United Kingdom, or

(b) otherwise makes a request for international protection. "Application for asylum" shall be construed accordingly.

It was argued that by including the words *"otherwise makes a request for international protection"*, rule 327 broadened the definition of asylum seeker beyond the traditional understanding of those fleeing persecution, to encompass those who sought protection against an infringement of their Article 3 rights, including cases where such infringements arose from lack of access to adequate medical facilities.

Kerr J, in a succinct but clear judgment, rejected the argument. He found that the policy of the Charges Regulations was to require overseas visitors to pay for treatment, and the interpretation being advanced by the Claimant ran contrary to that objective. Accordingly, it ought not to be adopted when an alternative interpretation existed which was consistent with that objective. Contextual support for that approach was to be found in Direction 2004/83/EC ("the Qualification Directive") which dealt with qualifications for refugee status and international protection and the subsequent CJEU case of *M'Bodj v Belgium* [2015] 1WLR 359, which excluded cases based on differential healthcare standards from the scope of that Directive.

Whilst further specific reasoning is set out in the court's judgment, it is clear that this was a case where the court felt that the Claimant's argument simply stretched the words of the relevant legislation an insupportable distance beyond their natural meaning. The Claimant's situation was undoubtedly a sympathetic one, but someone seeking medical treatment would not naturally be considered an asylum seeker.

FAILURE TO RECOGNISE CLAIMANT'S STROKE NOT A BREACH OF HIS HUMAN RIGHTS

Matthew Flinn

Watling v Chief Constable of Suffolk [2019] EWHC 2342 (QB)

The High Court rejected a claim that a failure to recognise the signs of a stroke in a detained person and transport him to hospital entailed breaches of his human rights.

In the early hours of 18 May 2014, the Claimant was driving home from a visit with a friend. He was stopped by the police, who had observed him driving erratically. In fact, he had suffered a sudden stroke.

There was no smell of alcohol and a breath test was negative, but the police suspected that he had been driving under the influence of drugs. He was arrested and transported to a nearby police station. A Forensic Medical Examiner ("FME") was called, but a medical assessment did not take place until around two hours later (outside the one-hour target time). Upon examination, he was conveyed to hospital, but despite treatment was left significantly disabled.

The Claimant brought an action against the police and G4S (the company contracted to provide the FME services) for acting in violation of his Article 3 and 8 rights under the European Convention on Human Rights ("ECHR"). Initially, he had also sought damages for false imprisonment and negligence giving rise to personal injury. Those claims were not pursued to trial, however, in part because the evidence had shown that, on the balance of probabilities, earlier medical attention would not have yielded a better result. Focusing on the human rights claims would lower the causation threshold for the Claimant, who would need to show only that there was a failure to take steps which had had a real chance of altering the outcome or mitigating the harm (see *Daniel v St George's Healthcare NHS Trust* [2016] 4 WLR 32, quoting from Simor & Emmerson, *Human Rights Practice* (2015)).

It was said to be common ground between the parties that a failure to provide appropriate medical care to a detained person could, in principle, constitute a violation of their Article 3 rights, and the majority of the

judgment focuses on the Article 3 claim. After determining that G4S was a public body for the purposes of the litigation (as a "hybrid" public body carrying out a relevant public function under section 6(3)(b) of the Human Rights Act 1998), the court considered the two ways in which it was alleged that one or other of the Defendants had contravened Article 3 by exposing the Claimant to inhuman or degrading treatment:

1. It was alleged that there had been a breach of the positive "systems duty" under Article 3 i.e. a duty to have in place adequate legislative and administrative systems to provide for the health of detained persons such as the Claimant, and thereby protect them from treatment or circumstances which might constitute inhuman or degrading treatment.

2. It was argued that there had been a breach of the positive "operational duty" under Article 3 i.e. the Defendants had an obligation to take further specific steps to protect the Claimant (e.g. by taking him to hospital) because they knew or ought to have known that he was at "real and immediate" risk of suffering inhuman or degrading treatment.

The Claimant argued that but for these failings, he would have been taken to hospital earlier for treatment, and had a realistic chance of a better recovery.

Both arguments were unsuccessful. The court carried out a detailed analysis of the evidence relating to the Claimant's presentation in the police station and determined that the police officers reasonably concluded either that the Claimant was choosing not to engage with them, or was unable to due to the effects of drugs. The signs of a stroke were subtle and could be missed by someone who was not a doctor. That meant that their conduct did not reach the threshold of severity which Article 3 required, and the Claimant could not show that they knew or ought to have known that he was, actually or potentially, a medical emergency case, or at risk of any form of treatment prohibited by Article 3.

Further, the court found that the system in place (through the arrangements with G4S) was adequate, and so there was no breach of the systems duty. This was based largely on the evidence of experts with experience of out-sourced medical services.

Finally, the court noted that because Article 8 did not have a severity threshold requirements, there could be cases where Article 3 claims would fail but Article 8 cases would succeed. This was not one of those cases, according to the court.

It is a case which does not break significant new ground on matters of principle, but is a useful example of the way claims under Articles 3 and 8 of the ECHR can be advanced and defended in medical cases.

Discrimination and the NHS Charging Regime

Rajkiran Barhey

Shu & Anor, R (ota) v The Secretary of State for Health And Social Care & Anor [2019] EWHC 3569 (Admin)

SHU, a national of Ghana, entered the UK in 2004 without entry clearance. She gave birth to E in 2007. In 2014, E received a life-saving liver transplant on the NHS at Kings College Hospital. E acquired British citizenship in 2018.

Under the National Health Service (Charges to Overseas Visitors) Regulations 2011 and the later 2015 equivalent, charges were raised in respect of treatment received by E and SHU. SHU was liable for E's debt as E was a minor. The debt had been written off as SHU was destitute. The debt was not, however, extinguished.

Discrimination – Articles 8 and 14 ECHR

The essence of SHU's challenge to the Regulations was that the NHS charging regime unjustifiably discriminated between, on the one hand, parents of a child who acquired status as an ordinarily resident British citizen before receiving treatment and on the other hand, a parent (like SHU) with a child who acquired that status after receiving the treatment. The parents in the first group would not incur any debt, as SHU had.

First, SHU had to show her claim fell within the ambit of a Convention right. She relied on Article 8, arguing that the ambit of Article 8 included *"the intrusion into family life of the instability and anxiety caused by a large, unpayable debt to the NHS and fear of its possible repercussions for the long-term status of one of the Claimants."* [112].

Foster J found that, on the facts of the present case, the intrusion in this case did not reach the threshold of seriousness, such that it fell within the ambit of Article 8, particularly given that the debt had been written off.

In any event, Foster J then went on to consider whether the difference in treatment was justified. She found at [124] to [125]:

"In my judgement there is in this case such an obvious, and relevant difference between the Claimant and E on the one hand, and those with whom they seek to compare themselves that the situations just cannot be regarded as relevantly analogous.

It cannot properly be said that a person who received treatment whilst here without the status of ordinary residence (or indeed their mother, whatever her status), is in an analogous position to a person who receives treatment here after the acquisition of ordinary residence. The very reason for the differential treatment is that difference in immigration position."

She went on to say at [129] that: "*The policy objective of deterring those with a less strong connection to the UK from travelling to or remaining in the UK, and receiving free health treatment, is plainly rational and constitutes a legitimate aim. The aim of protecting a finite national service under financial and resource pressure from use by visitors and those who, in general, do not make a permanent contribution to paying for it, is in my judgement clear and proportionate."*

She further found that, in so far as there were exceptions to the charging regime for asylum seekers, refugees, humanitarian protection cases, victims of human trafficking and children in local authority care, the justification for those exceptions was reasonable, and those groups were in a different position from E.

Immigration Rules

A further limb of SHU's challenge was to paragraph 322(12) of the Immigration Rules. This paragraph provides that, where debts are unpaid, the Secretary of State for the Home Department "should normally" refuse any future applications made by SHU regarding her own leave to remain.

The Claimant argued that this paragraph was *ultra vires* as it pursued a non-statutory purpose – it was a *Padfield* challenge. The Claimant argued that this was effectively a debt-collecting provision.

The SSHD argued that it *"part of the policy advanced on behalf of the SSHD was the desirability of encouraging those who "kept their social compact": in other words paid their dues and obeyed the rules."* [151].

Foster J found that this was not an irrational policy aim. She further stated: *"The Rule in question is part and parcel of a general policy safeguarding NHS resources on the basis of rational choice but, necessarily, seeking to deter others from incurring unpaid health debts by making them relevant to future grants of permission to remain."*

Overall, therefore, the Claimant lost on both grounds of challenge.

DAMNED LIES: RISK, STATISTICAL ASSOCIATION AND CAUSATION

John Whitting QC

Clements v Imperial College Healthcare NHS Trust [2018] EWHC 2064; AB v East Lancashire Hospitals NHS Trust [2019] EWHC 3542 (QB)

We are all familiar with the challenge of proving that a given breach of duty was causally relevant to injury and all too often parties, or more specifically their expert witnesses, will revert to statistics to make good their case. After all, save in the most mundane case, it is highly unlikely that the precise factual scenario which forms the subject matter of the litigation will have been replicated elsewhere previously, still less reported. In those circumstances, there is an understandable, if superficial, attraction in relying on a reported statistical association between one event (the breach of duty) and another (the injury). Two recent cases, in which I have acted, have explored, and cast doubt on, the extent to which that approach can, of itself, satisfy the legal test of causation.

In *Clements v Imperial College Healthcare NHS Trust* [2018] EWHC 2064, the Claimant was less than an hour old when she collapsed on her mother's breast and suffered severe hypoxic brain damage. Her parents claimed that she had suffocated on her mother's breast and that they should have been advised by the midwifery staff to keep Cerys' nose clear and continuously to check that she was still breathing. To corroborate her case on causation, the Claimant relied on published studies which had found a statistical association between sudden unexpected postnatal collapse ('SUPC') and the baby being breastfed, or being skin to skin, at the time: the implication of that association being, of course, that the causal mechanism of collapse was suffocation through obstruction of the baby's nose and mouth on the maternal breast. On that basis, the Claimant invited the court to draw the inference that in every case where, as here, the collapse occurred while the baby was on the mother's breast, the probable cause was suffocation.

In truth, and as the Defendant sought to demonstrate, the literature was rather more nuanced. While it was true that, in many cases of SUPC, the baby was on the mother's breast, that was hardly surprising given the high incidence of collapse in the first hour or so following delivery and the nearly universal practice of babies being skin to skin, if not actually breast feeding, at that time. Equally, the literature also reported a significant number of babies collapsing when suffocation could not possibly be the cause.

Having already found for the Defendant on breach of duty, Mrs Justice May went on to reject the Claimant's case on causation. She found that: *"The precise cause or causes of extremely rare events of sudden untoward postnatal collapse in newborns remain unknown. Although in some cases asphyxiation by lying prone, or up against the mother's side or breast in skin to skin contact has been posited as a cause, these are not the only hypotheses which have been put forward in the literature; in a significant minority of cases the circumstances in which the baby has been found are suggestive of no apparent cause at all. I have concluded that Cerys' collapse remains unexplained; the evidence has not demonstrated on the balance of probabilities that she was suffocated by her mother's breast."*

In other words, even where the Claimant could place her case within a cohort of apparently similar cases where the literature suggested a statistical association between the relevant event and the clinical outcome, she still had to prove that, in her particular case, the mechanism which she postulated was the actual cause of her injury.

Similar issues were explored in *AB v East Lancashire Hospitals NHS Trust* [2019] EWHC 3542 (QB). The Claimant suffered a perinatal arterial ischaemic stroke ('PAIS') at about the time of her birth and sustained devastating injuries as a result. She alleged that she should have been delivered some weeks earlier and that, if she had been, the stroke would have been avoided. The Trust denied any negligence in her antenatal care and said that, even if she had been delivered earlier, she would still have suffered the stroke.

As in *Clements*, the Claimant relied on a number of case studies which purported to identify a significant statistical association between abnormal placental pathology and PAIS; the causal mechanism postulated in

those studies was, plausibly, emboli from the placenta moving through the vascular system and causing a cerebral infarct. Here, it was common ground that the placenta was profoundly abnormal by the time of delivery and the experts even agreed that, if the cause of the PAIS were placental emboli, then earlier delivery would have avoided the same.

The Defendant argued that, while the literature had identified an association between placental dysfunction and PAIS, it had also done so in relation to a host of other factors. Equally, the pathogenesis of PAIS was, as the Claimant's experts accepted, poorly understood and all of the possible associations remained only that. Crucially, perhaps, the Defendant was able to point to the fact that neither of the Claimant's experts was able satisfactorily to explain the pathophysiological process by which there could be, as would have been the case here had the cause been placental embolus, a delay of up to nearly two days from the time of the PAIS to its clinical manifestation.

The court dismissed the claim, finding for the Trust on breach of duty and both medical and legal causation. Mrs. Justice Lambert found that: *"…as Mr Whitting submitted, a belief, however strong, of an association or possible causal link between placental pathology and PAIS which has not been scientifically demonstrated is not proof of causation in general and certainly not in the particular case. Likewise, a widely held hypothesis, or presumption, is not proof on the balance of probabilities of cause, or in the legal context, of causation."*

Both cases confirm that a statistical association is not, itself, proof of medical cause or, in a legal context, of causation.

John Whitting QC appeared for the Defendant in both cases.

How Rare is a Rare Complication?

Dominic Ruck Keene

Collyer v Mid Essex Hospital Services NHS Trust [2019] EWHC 3577 (QB)

The Facts

The Claimant underwent a planned surgical removal of his larynx in order to treat recurrent laryngeal cancer. There was no disagreement that this was the only appropriate treatment option. However, as a consequence of the procedure, the Claimant suffered nerve damage and lost all movement in his tongue. The parties' respective experts had been unable to find any evidence in the relevant literature of comparable nerve damage as a complication of laryngectomy: whether following negligence or otherwise. The Claimant sought to rely on the fact of the total absence of reports of such damage occurring to argue that, if the injury suffered is one that does not ordinarily happen if reasonable skill and care is exercised, then since it is not a potential non-negligent complication it must have been caused negligently, and suggested initially that it gave rise to a "*presumption of negligence."*

Causation in law

The Claimant had not sought to plead that this was a case where the 'material contribution' exception to the usual 'but for' causation principle could apply. Accordingly, HHJ Coe siting as a judge of the High Court unsurprisingly emphasised that, as the Claimant had the burden of proving his case, even if a court considers that there are a number of negligent and non-negligent possible causes of an injury, nevertheless a Claimant must still establish that the negligent cause he puts forward was not just the most likely but was more likely than not to have been the cause.

HHJ Coe cited the decision of the House of Lords in *Rhesa Shipping Co S.A. v Edmunds and Fenton Insurance Co Ltd* [1985] 1 WLR 948 ("*the Popi M*") as authority for the principles that a Defendant is not obliged to suggest an alternative cause for injury, or to prove on a balance of probabilities the truth of any particular alternative cause, and that "*when considering the burden of proof on a balance of probabilities, common sense must be applied.*

Before a judge can find that a particular event occurred, he or she must be satisfied on the evidence that it is more likely to have occurred than not. If the judge concludes even on a whole series of cogent grounds that the occurrence of an event is extremely improbable, a finding by him that it is nevertheless more likely to have occurred than not does not accord with common sense." HHJ Coe also referred to *O'Connor v The Pennine Acute Hospitals NHS Trust* [2015] EWCA Civ 1244 for the proposition that where there are a number of alternative causes, disproving all the alternatives does not in itself amount to proof of the remaining possible cause as being the effective cause.

Conclusion

Having analysed the respective expert evidence HHJ Coe concluded that both experts had been forced to identify a possible cause for the Claimant's nerve damage rather than a likely one. HHJ Coe found that the Claimant had a lack of tongue functioning immediately following the operation, and according the 'mechanism of injury' had occurred during surgery. However, when considering which of the four possible mechanisms of injury mooted by the experts had in fact occurred, HHJ Coe concluded in favour of the Defendant as while there were two mechanisms that were remote possibilities/not completely impossible, it was not possible to say on a balance of probabilities that either had in fact been the cause. Accordingly, while unsatisfactory, there was no option for the court but to conclude that the injury remained unexplained.

Comment

This case is a useful reminder that even with all the benefits of medical expert evidence, there may well be cases where it is simply impossible on a balance of probabilities to establish what was the mechanism of injury. It also is another reassertion of the importance of the 'but for' causation test – following not long after the judgment in *Arksey v Cambridge University Hospitals NHS Foundation Trust* [2019] EHWC 1276 (QB) (discussed in the previous edition of the QMLR) represented a similarly robust assertion of the importance of the 'but for' causation test and a further reminder that pleading 'caused and/or made a material contribution' is not a 'get out of gaol free' card.

William Edis QC acted for the Claimant in this case. He did not contribute to this article.

GENDER REASSIGNMENT FOR PRISONERS

Jeremy Hyam QC

R (ota KK) Tavistock & Portman NHS Foundation Trust [2019] EWHC 3565 (Admin)

This judicial review sought to challenge the decision by an NHS Trust to refuse to recommend a transgender prisoner for NHS-funded gender reassignment surgery by reference to an alleged protocol of the Defendant which in its operation de facto barred transgender persons (save those with no possibility of release) from being referred for gender reassignment surgery. The claim was unsuccessful, largely because (i) the Tavistock did not on a proper examination of the facts have any such protocol but rather treated each individual case on its individual facts and (ii) the expert clinical opinion (which was not disputed) was that no such referral should be made on clinical grounds and (iii) there was no unlawful interference with the Claimant's rights under Article 8 or 14 ECHR because insofar as she was treated differently from how she would have been treated if living in the community, that is because the difference in environment is clinically relevant to the question of whether to make a referral.

Comment

Permission had been granted on the basis that it appeared from the Defendant's correspondence, in particular its Chief Executive, Paul Jenkins, that there was a protocol of the kind complained of by Claimant. Following the production of witness evidence by the Defendant it quickly became apparent this was not in fact the case. Once that issue was decided against the Claimant the rest of the grounds (which were really parasitic upon there being

some kind of written or unwritten protocol) collapsed. If the claim has any lasting interest it is from the observation that the environment of a prison is relevant to the clinical assessment of whether gender reassignment surgery is appropriate and will provide lawful justification under Article 8 or 14 for differential treatment.

JUDICIAL REVIEW AND CONTINUING HEALTHCARE – WHEN RELIEF WILL BE DENIED

Jeremy Hyam QC

R (ota Gossip) v NHS Surrey Downs CCG [2019] EWHC 3411 (Admin)

This was a judicial review of a decision that the Claimant was not eligible for NHS Continuing Healthcare. The Claimant had suffered a severe spinal injury while playing rugby in 1984. He suffers from tetraplegia with no active motor or sensory function in the trunk or lower limbs and with very limited function in his upper limbs. Remarkably, despite his very significant disabilities, the Claimant qualified as a solicitor and has worked for the CPS for nearly 30 years. Although not presently responsible for funding his own care his concern was that when he retires he will have to contribute to the cost of his care services from his income as social services may no longer be willing to fund the level of care (around 42 hours a week) that he needs. The Defendant Clinical Commissioning Group ('CCG') undertook an assessment for eligibility of Continuing NHS Healthcare ('CHC') but ultimately its panel concluded that he was not eligible despite an earlier recommendation that there was evidence of a primary health need for skilled individualised care which the MDT felt met the CHC eligibility requirement. That decision was upheld by an Independent Review Panel ('IRP') in a decision of 6 July 2018.

Dismissing the claim and refusing relief, the judge first held that the Claimant had addressed his claim to the wrong target. The judge found that the target should have been the IRP rather than the CCG and that the Claimant had had a proper opportunity to challenge the decision in the appeal to the IRP. All but one of the ten grounds of judicial review failed. In respect of the one ground that succeeded *"the panel which met in March 2017 had no delegated authority to make a decision"*, relief was refused having regard to s.31(2A) of the Senior Courts Act 1981. Even if there had been a joint panel, bearing in mind that the CCG is the ultimate decision-maker, it is, in the words of the statute: *"highly likely that the outcome would not have been substantially different".*

Comment

This case underlines the importance of properly identifying the right target for judicial review, exhausting remedies, and the application of the new test in s.31(2A) of the Senior Courts Act 1981 which provides that the court must refuse relief if the outcome would not have been substantially different. It is important to understand this provision in context and that it will usually be applied with caution. See in particular Lindblom LJ at paragraph 273 of the Heathrow Third Runway case, *R (Plan B Earth) v Secretary of State for Transport* [2020] EWCA Civ 214 :

"It would not be appropriate to give any exhaustive guidance on how these provisions should be applied. Much will depend on the particular facts of the case before the court. Nevertheless, it seems to us that the court should still bear in mind that Parliament has not altered the fundamental relationship between the courts and the executive. In particular, courts should still be cautious about straying, even subconsciously, into the forbidden territory of assessing the merits of a public decision under challenge by way of judicial review. If there has been an error of law, for example in the approach the executive has taken to its decision-making process, it will often be difficult or impossible for a court to conclude that it is "highly likely" that the outcome would not have been "substantially different" if the executive had gone about the decision-making process in accordance with the law. Courts should also not lose sight of their fundamental function, which is to maintain the rule of law. Furthermore, although there is undoubtedly a difference between the old Simplex test and the new statutory test, "the threshold remains a high one" (see the judgment of Sales L.J., as he then was, in R (on the application of Public

and Commercial Services Union) v Minister for the Cabinet Office [2017] EWHC 1787 (Admin); [2018] 1 All ER 142, at paragraph 89)."

JUDICIAL REVIEW AND RECONFIGURATION

Jeremy Hyam QC

R (Nettleship) v (1) NHS South Tyneside Clinical Commissioning Group (2) NHS Sunderland Clinical Commissioning Group [2020] EWCA Civ 46

This was a judicial review of a hospital reconfiguration decision following a consultation by the Clinical Commissioning Group ("CCG"). The appellant contended that the decision breached s.14Z2(2) of the NHS Act 2006 and/or followed an unlawful consultation process contrary to the principles set out in *Gunning v Greater London Council* [1985] 11 WLUK 47; that it was *Wednesbury* unreasonable; and that the CCGs should have considered it in the light of government decisions to remove doctors and nurses from the immigration cap for skilled worker visas and to provide additional NHS funding. The claim failed on all grounds both at first instance and on appeal. The case has some importance because it provides helpful guidance on what a decision maker has to consult upon having regard to the relevant statute and guidance. As Davies LJ held, the wording of s.14Z2(b) of the 2006 does not impose a duty on the decision-maker to consult on options which the decision-maker (here the CCG) deems to be unviable, unrealistic or unsustainable as they do not represent "*proposals for change"* [56] and that the duty of consultation is only on those options which present "*genuine proposals for change*" – [59] per Davies LJ. The case also underlines the difficulty which will often confront those who challenge these kind of decisions, that minor procedural or even substantive failures of process are unlikely to result in relief because the outcome of the decision-making process is not likely to be "*substantially different*" if the impugned conduct had not taken place.

PRACTICE DIRECTION UPDATES: NEW RULES FOR WITNESS STATEMENTS AND STATEMENTS OF TRUTH

Jo Moore

Amendments to the Practice Directions coming into force on 6 April 2020 will introduce some important changes to witness statements and statements of truth that readers should be aware of in advance. The updates can be found in full on the justice.gov website here.

Statements of Truth – The Contempt Warning

Perhaps the most important update is to **PD 22 – Statements of Truth**. From 6 April 2020, all statements of case, responses, application notices and notices of objections must be verified by the following statement of truth (additions in bold):

"[I believe][the (claimant or as may be) believes] that the facts stated in this [name document being verified] are true. ***I understand that proceedings for contempt of court may be brought against anyone who makes, or causes to be made, a false statement in a document verified by a statement of truth without an honest belief in its truth.****'* (§2.1)

Statements of truth verifying witness statements are amended in the same manner and will henceforth read:

'I believe that the facts stated in this witness statement are true. ***I understand that proceedings for contempt of court may be brought against anyone who makes, or causes to be made, a false statement in a document verified by a statement of truth without an honest belief in its truth.****'* (§2.2)

The update also provides that the statement of truth verifying a witness statement must be in the same language as the witness statement (§2.2). Where a legal representative has signed a statement of truth on their client's behalf, they will be taken to have explained its effects through an interpreter where necessary (§3.8).

Statements of Truth – New Requirements

Two entirely new provisions will be added to **PD22** providing as follows:

> '***2.4 The statement of truth must be in the witness's own language.***
>
> ***2.5 A statement of truth must be dated with the date on which it was signed.***'

Further amendments clarify that the provisions at PD 22 §3A pertaining to those unable to read or sign verified documents do not apply to individuals unable to read the document *'by reason of language'*, who are catered for by the new language requirements set out in the update.

Witness statements – Language and Production Process

Along with incorporating the amendments above, the update to **PD 32 - Evidence** provides for further information to be contained within witness statements, as follows:

- The heading to the witness statement must contain the date of any translation (§17.2(6));
- The body of the witness statement must not only, if practicable, be drafted in the individual's own words, but "***must in any event be drafted in their own language***" (§18.1 and §19.1(8)); and
- The body must also state '***the process by which it has been prepared, for example, face-to-face, over the telephone, and/or through an interpreter***' (§18.1(5))

Finally, PD 23.2 is amended to reflect the now default position of witness statements being filed in the writer's own language:

> "***23.2 Where a witness statement is in a foreign language—***
>
> ***(a) the party wishing to rely on it must—***
>
> ***(i) have it translated; and***
>
> ***(ii) file the foreign language witness statement with the court; and***
>
> ***(b) the translator must sign the original statement and must certify that the translation is accurate.***"

ISSUES IN LITIGATING INFORMED CONSENT CLAIMS

Suzanne Lambert

Johnstone v NHS Grampian [2019] CSOH 90 (13 November 2019)

The Outer House of the Court of Session found that the Pursuer/Claimant ("J") had given informed consent to the transsphenoidal surgery he underwent and dismissed J's claim for damages brought against the health authority.

Background

J suffered from a condition called acromegaly, which occurs when the pituitary gland produces excessive growth hormone and which manifested itself in acute and worsening arthritis. In 1980 he underwent transsphenoidal surgery to remove a benign tumour in his pituitary gland in order to attempt to cure his acromegaly. The surgery was initially considered to be successful and J continued to be monitored annually by the health authority's

endocrinologist ("B"). However, after a few years J's level of growth hormone was found to be consistently in excess of the reference range, even after being prescribed medications to reduce his hormone levels.

In 2004, some 24 years after his initial surgery, an MRI scan showed an enlarged pituitary fossa and by that stage his hormone levels were at times more than twice the maximum level within the normal range. In 2010, a further MRI scan showed that there had been no change from the 2004 scan, indicative of a persistent pituitary adenoma. After discussion at a multidisciplinary team meeting, B wrote to the consultant neurosurgeon ("K") requesting an opinion as to whether repeat transsphenoidal surgery or radiosurgery (an alternative procedure) would be appropriate. K advised that surgery should be explored prior to radiosurgery, which might not be suitable for J. In September 2010, K met with J to discuss the medical problems and available options. Although there is a dispute as to precisely what was discussed and in what detail, following that meeting, it was agreed that J would be put on the waiting list for surgery, which was carried out in January 2011. On the morning of the operation, J signed a consent form but there is a dispute as to what extent any explanation or information was given to J on that occasion, and whether any explanation was given specifically by K (as opposed to the registrar who formally consented J).

During the operation carried out by K no tumour was found. A few days later, J became unwell and was re-admitted to hospital where he was diagnosed with a post-operative CSF leak and meningitis. J's acromegaly has since been managed conservatively without further surgery and he requires medication for the rest of his life.

J brought a claim against the health authority on the basis that the consent given by him in September 2010 and again on the morning of the surgery was not given on the basis of full or sufficient information about the potential risks of the surgery, the alternative treatments available and the risks and benefits of those alternatives, including the option of doing nothing. J alleged that the health authority was vicariously liable for the breaches of duty on the part of B and K to obtain valid informed consent.

Judgment

Lord Glennie held that J had been given sufficient information as to the treatment options by both B and K in compliance with the *Montgomery* duty of care so that the health authority was not vicariously liable for any failure on the part of either B or K to obtain valid informed consent.

Comment

As Lord Glennie explained, although the medicine in this case was complex, the issue in this case was a relatively straightforward one of whether informed consent had been validly obtained [121].

However, the judgment provides some very useful discussion in relation to a number of issues which arise in informed consent claims, which has become more common post-*Montgomery*. The following five issues should be of particular interest to both claimants and defendants dealing with *Montgomery* claims.

1. Importance of contemporaneous documentary evidence

In determining whether there has been valid informed consent, the court has to consider all available written and oral evidence to assess the credibility of the competing accounts as to what information was given for the purpose of obtaining consent. In this case, the court's assessment of credibility and reliability was hindered by the passage of time, with J not having any contemporaneous documentary evidence (such as a diary entry or notes to aid recollection) prior to his formal complaint made some two and a half years after the index events.

B and K were in a better position having the benefit of the contemporaneous medical records and notes which indicated that J had been advised about both options (surgery and radiosurgery). B's contemporaneous notes were of particular importance as he was unable to given oral evidence, due to the state of his health.

Lord Glennie acknowledged that the contemporaneous medical notes had not been made for the purpose of litigation and therefore were devoid of the level of detail necessary to inform a forensic analysis of precisely what took place. The recognition that medical records and contemporaneous notes will not necessarily be as detailed as an account or statement prepared for litigation will be of some comfort to defendants concerned

about having to practice defensive medicine. K was not criticised for not writing to patients to set out in detail the diagnosis and treatment plan, a practice he stopped when a patient complained that the letter was full of incomprehensible medical terminology [48(iv)].

Further, Lord Glennie held that whilst the GMC Guidance on Consent set out good practice and informed the content of *Montgomery* duty of care, it was not prescriptive of the precise steps a doctor should take in his dealings with the patient (such as recording key elements of the discussion between patient and doctor). It was not for the court to police the Guidance and any alleged breach of the Guidance should be taken up with the GMC accordingly [131].

2. Issues-based consideration of credibility

In this case, however, it was not simply a matter of determining that a particular witness was inherently more credible than the other and therefore all of the evidence of that witness was reliable. Lord Glennie cautioned against such an approach and made clear that he was satisfied that all of the witnesses before him were doing their best to tell the truth. Rather, questions of reliability had to be decided on an issue by basis. Indeed, although ultimately finding in favour of the health authority, Lord Glennie favoured the evidence on behalf of J in relation to some issues (e.g. finding at [147] that K himself did not speak to J and his wife on the morning of the surgery).

3. More difficult if it is a stand-alone Montgomery claim

This case demonstrated the difficulties and risks in advancing a stand-alone *Montgomery* claim without any *Bolam* allegations of negligence.

There were no allegations that the diagnosis made (that J had a tumour, which required active treatment) was negligent. Lord Glennie held that the fact that the diagnosis was not challenged meant that it was difficult for J to argue that he should have been advised as to the option to do nothing about a condition that had been diagnosed as requiring active treatment.

The fact that neither the diagnosis or the actual surgery or post-operative care were challenged on a *Bolam* basis also meant that the extensive expert evidence relied on by both parties was of limited relevance to the central issue of consent [101].

4. Vicarious liability only without allegations of direct liability is risky

Somewhat curiously, the claim against the health authority was based on vicarious liability only rather than any allegation that the authority was directly responsible for ensuring or taking reasonable care to ensure that J was made aware of all material risks associated with surgery, and of all reasonable alternatives. This meant that J had to establish that either B or K personally failed to provide sufficient information.

The potential risk to a claimant advancing such a case was illustrated by way of a hypothetical example where both B and K reasonably believed that the other had given J the relevant information then the defendant would escape liability (§132). Although it was not determinative of the instant case, it is a good reminder to claimants not to limit their case to that of vicarious liability.

5. Establishing causation is not straightforward

Even if J had established that there was a failure to provide him with sufficient information to make an informed decision, Lord Glennie explained that he would have found that he probably would have chosen surgery (instead of radiosurgery or doing nothing) in any event, particularly given that he had previously had the same procedure 30 years earlier. Therefore, success at the first hurdle of breach does not guarantee success at the second hurdle of causation in a *Montgomery* claim.

Relationship between criminal and civil liability under the Occupiers' Liability Act and when a Claimant's risky conduct breaks the chain of causation?

Cara Guthrie

Mrs James v The White Lion Hotel [2020] 1 WLUK 39

The facts

The Deceased fell out of the sash window of a second-floor hotel room in the middle of the night and died. The sill of the window was much lower than normal. The sash was also defective as the window would close under its own weight unless held open. There were no witnesses to the fall and the Defendant contended that the Deceased had been smoking a cigarette at the time. The Deceased must have appreciated that there was the risk, if he sat on the sill or leant out of the window, that he might fall.

The criminal proceedings

The Defendant was charged with an offence under section 3 of the Health and Safety at Work Act 1974.

The health and safety failings alleged by the prosecution could be summarised as:

(a) failing to carry out a suitable and sufficient risk assessment;

(b) failing to identify the risks associated with low-silled windows;

(c) failing to use window restrictors.

The Defendant pleaded guilty after a submission of no case to answer had failed. The basis of the plea was that the Defendant accepted that the window posed a (low) risk to an adult occupying the room.

The relevant provisions of section 2 of the Occupiers' Liability Act

s. 2(2) The common duty of care is a duty to take such care as in all the circumstances of the case is reasonable to see that the visitor will be reasonably safe in using the premises for the purposes for which he is invited or permitted by the occupier to be there.

s. 2(3) The circumstances relevant for the present purpose include the degree of care, and of want of care, which would ordinarily be looked for in such a visitor, so that (for example) in proper cases—

(a) an occupier must be prepared for children to be less careful than adults; and

(b) an occupier may expect that a person, in the exercise of his calling, will appreciate and guard against any special risks ordinarily incident to it, so far as the occupier leaves him free to do so.

…

s. 2(5) The common duty of care does not impose on an occupier any obligation to a visitor in respect of risks willingly accepted as his by the visitor (the question whether a risk was so accepted to be decided on the same principles as in other cases in which one person owes a duty of care to another).

What was the effect of the criminal conviction?

HHJ Cotter QC acknowledged that sections 2-8 of the Health and Safety at Work Act are unenforceable in civil law and that the functions of civil and criminal law are quite different. However he rejected the Defendant's argument that the criminal conviction was irrelevant, finding that by the guilty plea (1) the Defendant accepted that there was a reasonably foreseeable risk of harm to adults if falling from the sash window and (2) the Defendant admitted that a risk assessment would have resulted in the use of measures to address the risk (i.e. window restrictors). Accordingly, the effect of the guilty plea was to prove some of the ingredients necessary to establish civil liability.

Liability under the Occupiers' Liability Act

The court found that:

i. the Defendant owed the Deceased a duty;

ii. there was a foreseeable risk of injury;

iii. any injury would inevitably be very serious;

iv. there was no social value to failing to restrict the window opening;

v. the cost of a restrictor was minimal,

The court then had to consider whether, given the Deceased had been willing to run the risk from an obvious danger, the Defendant was not liable.

The judge found that the common law defence of '*volenti non fit injuria*' differed from the section 2(5) defence. The *volenti* defence operates where a Claimant voluntarily accepts a risk negligently created by the Defendant's negligence whereas the s.2(5) defence only bites if there is no obligation to act under s.2 and thus no negligence.

When deciding whether there was a breach of statutory duty, the judge noted that sections 2(2) and 2(3) required occupiers to conduct a risk assessment taking into account that visitors may not be careful. He decided that the criminal conviction resolved the question of whether or not a risk assessment was required and that such a risk assessment would have required steps to be taken to reduce the risk. Given that there was an obligation to act and that the steps taken in response would have avoided the Deceased's death, he held that the obligation to take such steps could not be avoided on the basis that the risk was obvious and a person would have to voluntarily run the risk before injury could occur. He concluded that "*the civil law surely cannot regard a step required under the criminal law as unduly paternalistic. Rather the expectation should be that primary liability should follow a failure to take a step required by the criminal law*."

Intervening event

The Defendant also argued that the Deceased's decision to lean out of the window was an intervening event which broke the chain of causation. The Claimant argued that the Deceased's actions and decision making in this case could not be equated to the conscious risk taking involved in climbing from one hotel balcony to another or jumping headfirst into a small inflatable pool.

The judge, in deciding where to draw the line, considered the three considerations identified by Aikens LJ in *Spencer v Wincanton* [2009] EWCA 1404. He found that the Deceased's conduct was reasonably foreseeable, entirely voluntary and that "*there was a high but not a very high degree of unreasonableness".* By a narrow margin, he found that the Deceased's act in sitting on the windowsill did not break the chain of causation; the accident was still the result of the Defendant's failure to apply window restrictors to a very low window.

Comment

This is an example of the court having to decide where to draw the line between a defendant being held primarily liable and there being no such liability. The basis of the Defendant's guilty plea to the section 3 HSAW offence assisted in establishing many of the ingredients required for a breach of statutory duty in civil law. It is plain that the un-onerous nature of the step required to avoid the risk, i.e. fitting window restrictors, was a material factor in the judge's conclusion that liability was established.

The judge found that the Deceased's risk-taking did not break the chain of causation, but only by a narrow margin. One can well see that in many cases a claimant's risk-taking might be sufficient to break the chain of causation.

Sexual abuse: A Third Party's Fault?

Charlotte Gilmartin

BXB v Watch Tower and Bible Tract Society of Pennsylvania [2020] EWHC 156 (QB)

On 30 January 2020, Mr Justice Chamberlain gave judgment in *BXB v (1) Watch Tower and Bible Tract Society of Pennsylvania (2) Trustees of the Barry Congregation of Jehovah's Witnesses* [2020] EWHC 156 (QB), making an important contribution to the law of vicarious liability.

Background

The factual background is complex, but the essential facts relied upon by BXB or "Mrs B" were as follows. She was baptised in to and began attending the Barry Congregation of Jehovah's Witnesses in about 1986. With her husband, ("Mr B"), she befriended another couple in the congregation, the Sewells. Mark Sewell was a 'Ministerial Servant', and as such had special responsibilities within the congregation. He later became an 'Elder', a spiritual leader.

The friendship became strained as Mark's behaviour became increasingly volatile and inappropriate; however, Mrs B was encouraged by another Elder, Tony Sewell, to provide Mark with extra support. In 1990, the two couples went "pioneering" (door-to-door evangelizing) together. They then returned to the Sewells' home where, in a back room, Mark raped Mrs B.

Mrs B later reported the rape to the Elders, who appointed investigators, and Mrs B was asked intimate questions about her version of events. She was invited to attend a 'Judicial Committee' hearing, where, in the presence of the Sewells, she was questioned as to the veracity of her claim. Mark Sewell denied the allegations and was found not guilty. The offences were then investigated by the police decades later, culminating in a criminal trial in 2014. Mark Sewell was convicted of raping Mrs B and of 7 counts of indecent assault against other individuals.

The Defendants accepted that Mark Sewell had raped Mrs B, but denied that they were vicariously liable. Mrs B also claimed that the Defendants were liable for the failure of the Elders to adequately investigate and act upon the allegations of rape. The Defendants denied that they owed any such duty or that it was breached (though this issue was ultimately not determined by the court, see [186]-[187]).

Limitation

First, the court considered whether it would be equitable to allow the substantive claims to proceed under s. 33 of the Limitation Act 1980, given that the primary limitation period for the rape expired on 30 April 1993. The application of s.33 discretion is notoriously difficult to predict, but the approach here is noteworthy. Referring to the seminal case of *A v Hoare* [2008] UKHL 6 (and to Lord Hoffman's approach there at [49]), it was stressed that:

"there is nothing in the statute, or the case law interpreting it, to suggest that the only valid reason for delay… is a diagnosed psychiatric disability covering the entire period of the delay. Section 33(3)(a) is framed in deliberately general terms. It invites focus on the 'reasons' for delay." [124].

Mrs B's evidence was accepted as true, namely that:

"following the Elders' investigation Mrs B felt humiliated, upset and ashamed; and, as a result, she felt that she would not be believed if she raised the matter formally again." [124].

This was consistent with the medical evidence [123]. The "*key factor*" was the effect of the delay on the cogency of the evidence [125]. Noting that this was not a case *"where it can be said that Mrs B's evidence, in its essentials,*

was so inconsistent as to be obviously unreliable" [128], the Defendants' case on this issue was dismissed: the evidential difficulties highlighted would not cause them significant prejudice [125] – [129].

Vicarious Liability

The basic inquiry is that articulated in *Various Claimants v Catholic Child Welfare Society* [2013] 2 AC 1 at [21] by Lord Phillips, namely: (i) whether the relationship between the tortfeasor and the party said to be vicariously liable is capable of giving rise to vicarious liability, and (ii) whether there is a sufficient connection between that relationship and the act or omission of the tortfeasor [134].

At the first stage, Mr Justice Chamberlain held that the key questions, following *Cox v Ministry of Justice* [2016] UKSC 10 are: (i) whether Mark Sewell carried on activities as an integral part of the 'business' activities carried on by the Defendants and for their benefit, and (ii) whether the commission of the rape was a risk created by the Defendants by assigning those activities to Mark Sewell. The answer to both questions was 'yes' [157].

The first question was easily satisfied by the evidence before the court of the position of Elders within the congregation, supported by the findings in *A v Trustees of the Watchtower Bible and Tract Society* [2015] EWHC 1722 (QB) ("*A v Watchtower*") regarding the position of Ministerial Servants [159].

As to creation of risk, the court held that:

"any organisation that confers on its leaders power and authority over others creates a risk that those leaders will abuse that power and authority… where an organisation makes rules for all aspects of its adherents' lives, and sets its leaders up as moral and spiritual exemplars, it imbues those leaders with power and authority even outside the confines of their religious activities… Often, the perpetrator abuses his own power, or that of others, to engineer the situation in which the abuse can occur… any organisation that confers on its leaders power over others creates the risk that they will abuse it in that way." [161] – [163].

The next limb, namely whether there was a "sufficient connection" between that relationship and the occurrence of the rape, was less straightforward here than in *Maga v Archbishop of Birmingham* [2010] 1 WLR 1441 and *A v Watchtower*. Mrs B was an adult married woman who had chosen to associate with Mark Sewell, and the rape did not take place while a religious duty was being performed. Notwithstanding, the court stressed that:

"the test is more open-textured and requires an analysis of all aspects of the relationship between the tort and the abuser's status" [167].

Several features of the relationship demonstrated a sufficient connection. The couples had met in the context of religious gatherings, and though they initially got on well, later tension was tolerated because of Mark's position as an Elder, and because Mrs B had been instructed to act as a confidant to Mark by Tony Sewell. This essentially took the form of a religious obligation in the context. This provided a strong causative link: but for their positions as Elders, Mrs B probably would not have remained friends with Mark by the time of the rape. By these features, the Defendants had created or significantly enhanced the risk that Mark would sexually abuse Mrs B, in creating the conditions that they might be alone together. Further, the rape had occurred after the couple had been pioneering, and finally, there was evidence, accepted by the court, that the rape had been engineered to generate scriptural grounds for Mark Sewell's divorce from his wife [168]-[172].

The decision provides a tightly reasoned and thorough analysis of the features said to demonstrate a sufficient connection between the relationship and the tort committed, illustrating that the imposition of vicarious liability in any given case will be intensely fact-specific. Vicarious liability is an area which is often said to be *"on the move",* (and note, the decision of the Supreme Court in *Barclays Bank Plc (Appellant) v Various Claimants (Respondents)*, heard in November 2019: the appeal is awaited). However, this decision shows the capacity of the doctrine to accommodate what may appear to be a tort which is attenuated from the core relationship, yet doing so in a robust manner by reference to very specific facts.

This article also appeared on the UK Human Rights Blog here.

WHEN MEDICAL TECHNOLOGY GOES WRONG

Alasdair Henderson

Hastings v Finsbury Orthopaedics Ltd and Stryker UK Ltd [2019] CSOH 96

Modern medicine increasingly makes use of sophisticated technology, from algorithms for assisting in diagnosis to robots for surgical procedures. But what happens when the technology goes wrong; who is liable and what standard are patients entitled to expect from medical devices? The Outer House of the Scottish Court of Session grappled with these questions in a significant judgment handed down on 26 November 2019.

The facts

A former forestry worker brought a claim against the manufacturers of a metal-on-metal total hip replacement ("MoM THR") prosthesis. The device consisted of a Mitch/Stryker Howmedica uncemented acetabular cup, manufactured by the First Defendant (actually 'defender', as this was a Scottish case), and an Accolade V40 uncemented femoral stem, manufactured by the Second Defendant. As of April 2012, when a 'field safety notice' (effectively a recall notice) was issued regarding this particular prosthesis, it has no longer been used.

The Claimant (or 'pursuer') had a history of arthritis and on 4 March 2009, aged 54, underwent a left hip replacement using the MoM THR device. He then underwent the same procedure on his right hip a few months later, on 16 November 2009.

There was no suggestion that the hip replacement surgery was carried out negligently, nor that the particular prostheses themselves were made in a negligent or faulty manner. However, the MoM THR shed metal debris which meant the Claimant suffered an adverse reaction and had to have revision surgery on his left hip some three years later.

The claim was brought under the provisions of the Consumer Protection Act 1987, section 2 of which imposes no-fault liability on a manufacturer for damage caused wholly or partly by a defect in a product. Section 3 defines a product as defective if its safety is not such as persons generally are entitled to expect. The claim therefore proceeded to a preliminary issue hearing to resolve the question of whether certain propensities and risks inherent in the MoM THR prostheses meant that they were defective within the meaning of s.3 of the 1987 Act.

Very detailed evidence was provided by six factual witnesses from the Defendants about the development and manufacturing process of the MoM THR prostheses, and then from eight experts (four apiece for the Claimant and Defendants) in orthopaedic surgery, biomechanics, immunology/toxicology and histopathology. This is set out at length in the judgment, which also borrows heavily from the earlier case of *Gee and others v Depuy International Ltd* [2018] EWHC 1208, in which Andrews J found in favour of the Defendant manufacturer in a similar challenge to a different type of hip prosthesis system.

Conclusions

It was accepted by the manufacturers that there was an inherent propensity of MoM THR devices of this type to shed metal debris and a risk that some patients may suffer an adverse reaction. The question for the court was whether this was significant enough to make the devices defective as at the date of supply, taking into account the knowledge of orthopaedic surgeons at the time, the information available, and any advice and warnings issued by the manufacturers, suppliers and regulatory authorities.

Lord Tyre held that they were not defective, applying a two-stage approach.

First, he considered what the *"entitled expectation of safety was"*. He emphasised that the level of safety which patients were entitled to expect, for the purposes of s.3 of the 1987 Act, is a legal concept not a medical term of art [113]. Surgeons are more familiar with discussing 'clinical efficacy' or 'known side-effects and risks' rather than 'safety', but those are not the same. What the entitled expectation of safety meant was that (subject to *de*

minimis considerations) the level of safety of MoM THR devices in 2009 was not worse than existing non-metal-on-metal products that could otherwise have been used.

Second, he considered whether the product failed to meet the entitled expectation of safety. The answer to this was 'no'. Despite the fact that the Claimant's experts were preferred on several matters, such that the Claimant had proved there might be a causal link between the shedding of metal debris and injury, this was only in a small number of cases and not necessarily for reasons specific to MoM THRs. The judge noted that the combination of a metal stem and metal cup had been used in other implants and prostheses without any significant damage. The particular combination of cup and stem which the Claimant received was only on the market for a short time, but the data did not suggest it had a materially lower survival rate than other available products. Overall, when he considered the revision rate for MoM THRs and the prospects of success of revision surgery compared with other prostheses, which were the two most important 'safety' criteria, he was not persuaded that these were worse for MoM THRs at the relevant time.

However, Lord Tyre did expressly leave the possibility open that another Claimant might be able to present evidence in relation to a different product or product combination which demonstrated a defect, so this judgment is not the end of the story for MoM THRs as an entire class of device.

Comment

This judgment contains a clear summary of the law on Consumer Protection Act claims as they relate to medical products. It also illustrates how detailed and complex the evidence in such a claim can be, particularly the expert evidence. Finally, it provides a stark example of how critical the state of knowledge and information about a product at the relevant time is for product liability cases. It is not enough to show that there are now concerns about a device or product; the key question is what the state of knowledge was (or should have been) at the time it is used, and this can be a difficult question to answer.

(NOT SO) NICE GUIDELINES?

Rajkiran Barhey

Sanderson v Guy's and Thomas' NHS Foundation [2020] EWHC 20 (QB)

This judgment, delivered by Lambert J on 10 January 2020, is of particular interest for her consideration of the NICE Guidelines and their utility in establishing breach of duty. This specific aspect of the judgment is considered in this article.

The claim arose out of events surrounding the Claimant's delivery at 01:05 on 26 February 2002. She suffered a period of acute brain hypoxia which led to cerebral palsy. The issues before the court related to the management of the Claimant's mother's labour; both breach of duty and causation were in issue.

The timeline of events was substantially agreed between the parties and was set out in table form at [69], reproduced below. Ms Bewley was the Consultant Obstetrician.

00:40	Ms Bewley is called and arrives in Room 4
00:48/49	Ms Bewley leaves Room 4 to obtain equipment for fetal blood sample and make inquiries concerning theatre availability and Room 18
00:53/54	Ms Bewley returns to Room 4 and notes bradycardia
00:54/55	Ms Bewley makes decision that delivery should be undertaken urgently, the Syntocinon is switched off and Dr Bewley leaves Room 4 for the second time, to get the equipment for an instrumental delivery and to make inquiries concerning Room 18.

00:57/58	Ms Bewley returns to Room 4
00:58/59	Ms Bewley makes decision to deliver in Room 4 and prepares for instrumental delivery
00:59	Ms Bewley starts instrumental delivery
01:05	Claimant delivered

First alleged breach of duty – decision to perform a fetal blood sample

The first alleged breach of duty was Ms Bewley's decision to perform a fetal blood sample at 00:48 and not to proceed straight to instrumental delivery at 00:43.

The opinion of the Claimant's expert, Mr Duthie, was that between 00:38 and 00:43 the CTG showed a single prolonged deceleration, that a single prolonged deceleration for over 3 minutes was clear evidence of acute fetal compromise, and the only response was urgent delivery (not fetal blood sampling).

Mr Duthie relied heavily on the 2001 NICE Guidelines concerning the use of electrical fetal monitoring. He relied on the Guideline definition to support his assertion that the CTG showed a single prolonged deceleration between 00:38 and 00:43. He also relied on the Guidelines to establish that a single prolonged deceleration of over three minutes was evidence of acute fetal compromise. Finally, he relied on the Guidelines to show that the response to acute fetal compromise was urgent delivery. As stated by Lambert J at [76]*: "There are, in effect, therefore three links in his chain of reasoning (all derived from his interpretation of the Guidelines) which lead him to the conclusion that the only reasonable management following the initial assessment was urgent delivery."*

Mr Tufnell, the Defendant's expert, attacked each of the Claimant's *"three links".*

Looking at the first, Mr Tufnell's view at [56] was that the CTG did not show a single prolonged deceleration. His view was that a prolonged deceleration was characterised by the heart going down and staying down for a period of time and then recovering back up to the baseline. He agreed that, on a strict view, the NICE Guidelines' definition of a prolonged deceleration simply required the fetal heart rate to fall below the baseline, but it need not necessarily be consistently low.

In the present case he stated that there was an abrupt drop in the fetal heart rate but that it did not remain consistently low – rather there was a partial recovery (albeit not to the baseline as the recovery was interrupted by a further contraction). He appeared to accept that this would have been defined as a prolonged deceleration if one took a strict interpretation of the NICE Guideline definition. However Mr Tufnell took the view that the Guidelines were not necessarily precise enough in every definition. He described the heart complex as an atypical variable deceleration.

His view was that, regardless of how the heart complex was characterised, the important question was how to manage the labour. His view was that, overall, the trace, combined with other features, did not suggest the fetus was acutely compromised [58]. Amongst other factors, the fetal heart rate never dropped below 120bpm.

He therefore disagreed with Mr Duthie that urgent delivery was required. His view was that decelerations lasting 3-5 minutes were normal in labour and he would likely have reviewed the trace to see if it returned to normal, which it did. If so, urgent delivery would not be not required.

Lambert J found in the Defendant's favour on this issue. Looking at Mr Duthie's 'three links' she found that, even if she accepted the first link (that the CTG between 00:38 and 00:43 showed one prolonged deceleration) the next two links were unsustainable. She was unconvinced by Mr Duthie's reliance on the NICE Guidelines to support his reasoning because, as set out at [78]:

"Putting it shortly therefore, the Guidelines on their face appear to advocate two contradictory management options in response to a single prolonged deceleration lasting longer than 3 minutes: conservative measures where possible or feasible (expressly including fetal blood sampling) and a few short paragraphs later urgent delivery (fetal blood sampling being contraindicated)."

She preferred Mr Tufnell's approach to the Guidelines, at [79]: "*He told me that the Guidelines do not provide a complete compendium of either definitions or clinical management options. The Guidelines are useful so far as they go, but they are limited. The Guidelines do not provide a substitute for clinical judgement but must be interpreted by the clinician and then applied in the light of that judgement."*

Having come to this conclusion, Lambert J found Mr Duthie's theory could not stand as it was predicated on a "*formulaic"* and "*highly selective"* application of the NICE Guidelines [80].

The Claimant also failed on her second allegation of breach of duty which related to an alleged delay between the decision to delivery urgently at 00:54/55 and the decision to deliver the Claimant in Room 4 at 00:58/59.

Comment

Lambert J's judgment is a useful reminder of the weight which ought to be placed on NICE Guidelines. The judgment cautions against treating guidelines as providing hard and fast rules for, in this case, management of labour. This is particularly important in a case such as the present where the guidelines themselves did not mandate one course of action but were interpreted by the expert as if they did. Rather, the lesson from this judgment is that guidelines are, at the risk of stating the obvious, simply guides. They are no substitute for clinical judgement. Furthermore, they must be read as a whole, and one cannot pick and choose.

Evidence From Behind Screens in Inquests

Rajkiran Barhey

R (on the application of Dyer) v Assistant Coroner for West Yorkshire (Western) [2019] EWHC 2897 (Admin)

Mr Hall, a black man, died shortly after being in police custody and being restrained. The police officers called to give evidence at the inquest into his death applied for anonymity and to give their evidence from behind screens. The anonymity orders were not contested but the applications to give evidence from behind screens were opposed by Mr Hall's family.

The basis for the application to give evidence from behind screens was to prevent the officers from being identified, particularly by a Mr Qassim Hall. Qassim Hall is a brother of the Deceased and has a lengthy criminal record. There was evidence before the coroner that the police officers were genuinely fearful of what Qassim Hall might do to them or their families, if they were identified. The coroner therefore allowed the officers to give their evidence behind a screen, such that they were not be seen by the public, including Mr Hall's family.

Mr Hall's family alleged that the use of screens was a significant incursion into the principle of open justice which should be no more than was necessary. They argued that observing witnesses was an important part of the investigative process, that preventing the witnesses from being see undermined public confidence in the process, and not being able to see the witnesses reduced the prospect of catharsis for the deceased's family.

Jefford J found that the coroner had undertaken too limited a balancing exercise in considering whether to grant the application. She found that the coroner only balanced two considerations – whether the quality of the evidence is likely to be improved by the use of screens against whether the effectiveness of questioning will be impeded by the presence of a screen. She went on to say at [37] that:

"That, in my judgment, is too limited a balancing exercise. If those were the only factors to be taken into account, it would have the almost invariable consequence that if a witness genuinely expressed fear but the family of the deceased were able to cross examine, screens would be directed. That would not, and in the present case does not, take into account the interest that the public and the family has in seeing those who may be implicated in the death give evidence - an interest the coroner had already recognised – and it takes no account of the fundamental importance of public confidence in the process of the inquest particularly where the death involved raises issues of more general public concern."

Jefford J went on to conclude that the coroner's decision was also irrational. She found that the coroner had failed to consider whether the police officers' fear of Qassim Hall was valid. She found that the coroner had not considered the nature and context of Qassim Hall's offences and events since the Deceased's death. The coroner also failed to consider the risk of anonymity orders being breached by those who may be able to identify the officers. The coroner also did not consider the position if the family (but not the public) were able to see the officers and the attendant risks. Thus the decision to permit screens was quashed but only to the extent that the screens prevented the identified family members from seeing the officers give evidence.

QOCS and Mixed Claims

Jeremy Hyam QC

Brown v Commissioner of Police for the Metropolis [2019] EWCA 1724

The Court of Appeal has clarified that if proceedings involve a claim for damages for personal injury together with a non-personal injury claim, the costs protection under the qualified one-way costs shifting regime in CPR r. 44.13 to r.44.16 does not automatically apply. The Court also gave general guidance on the applicability of the regime in 'ordinary' personal injury cases which might involve consequential and mixed claims.

This was an appeal from Whipple J in respect of a 'mixed claim' i.e. one where the claim included a claim for damages for personal injury, but also included claims for non-personal injury damages and other relief. Claims for general damages for misuse of the appellant's personal data were upheld by the trial judge but she rejected the claim for damages for personal injury. The Claimant had failed to beat the Respondent's Part 36 offer resulting in adverse costs orders against her. The issue was whether the Claimant could automatically avoid the enforcement of those orders by relying on QOCS on the ground that one of her failed claims was a claim for damages for personal injury.

The Court of Appeal set out the relevant rules and the leading cases on the topic, in particular, *Wagenaar v Weekend Travel Limited and Anor* [2015] 1 WLR 1968; *Siddiqui v The Chancellor, Masters and Scholars of the University of Oxford* [2018] EWHC 536 (QB) and *Jeffreys v Commissioner of the Metropolis* [2017] EWHC 1505 (QB). The Court then clarified that: "*The QOCS regime only applies to claims for damages for personal injury. It does not apply to other types of claim. There is therefore no justification for allowing claims which are not claims for damages for personal injury (such as, for example, the data protection or police misconduct claims which were successful) to attract automatic QOCS protection*".

As to the tricky point of interpretation to reach this conclusion, Coulson LJ explained that the exception at r.44.16(2)(b) does not refer to "*proceedings*" but simply refers to *"a claim …other than a claim to which this section applies"*. The narrower words of the exception demonstrate that what the CPR intended was to exempt from the QOCS regime, within the widest possible umbrella of the proceedings as a whole, claims which were *not* claims for damages for personal injury. He also clarified that the word "*claim*" was not to be read as "*cause of action"* and approved Morris J's decision in *Jeffreys* that it was an unwelcome complication to interpret the rules by reference to whether claims were "*divisible*" or "*inextricably linked*" to the claim for personal injuries, whether by reference to claim having the same cause of action, or being linked on the facts.

It was nonetheless necessary for the Court to give guidance on how personal injury claims were to be understood and how the QOCS regime would apply to, for example, ordinary PI or clinical negligence claims where there are claims for loss of earnings, care, accommodation etc. and for mixed claims such as RTA claims where what is claimed is both damages for personal injuries, e.g. whiplash, and damage to property, e.g. repairs, credit hire etc.

What the Court said was that "*if proceedings can fairly be described in the round as a personal injury case then, unless there are exceptional features of the non-personal injury claims (such as gross exaggeration of the alternative care hire claim or something similar) I would expect the judge deciding costs to endeavour to achieve a 'cost neutral' result through the exercise of discretion*." The judgment concludes by saying: "*I consider it likely that in most mixed claims of the type that I have described, QOCS protection will – one way or another – continue to apply. It therefore follows that, to the extent that paragraph 12.6 of PD 44 suggests a different approach, I consider it to be wrong. It needs to be amended as soon as possible*."

That is a reference to the exceptions in CPR 44.16(1) and CPR 44.16(2)(b). That latter exception "*Orders for costs made against the claimant may be enforced up to the full extent of such orders with the permission of the court and to the extent that it considers just, where… (b) a claim is made for the benefit for the claimant other than a claim to which this section applies.*"

Comment

This clarification of a poorly drafted rule on the operation of the QOCS regime to 'mixed cases' is undoubtedly welcome although it still remains the case that a claimant who, for example, puts forward a mixed human rights or data protection and a personal injury claim arising out of treatment in hospital will be uncertain of the extent to which QOCS protection applies to the whole of the claim. On the 'blended' approach there is still a risk that the claim will not be seen as "*a personal injury claim in the round*" and that at least some adverse costs may be payable by the Claimant to the Defendant in respect of the 'add-on' HR/DPA claim if it fails. Certainty of QOCS protection is plainly important to Claimants who otherwise need to rely on BTE insurance or ATE insurance to guard against the risk of adverse costs. As is mentioned in passing by the Court, there is force in the argument that misuse of information and breaches of the DPA (one could also include breach of the HRA) are cases that ought to benefit from QOCS protection, but such extension of the QOCS regime can only be made by amendments to the CPR not be judicial intervention. This last point has been re-emphasised by the recent unsuccessful judicial review of the decision not to extend QOCS protection to discrimination claims following the latest LASPO review- *R(ota Leighton) v Lord Chancellor* [2020] EWHC 336.

STRIKE OUT FOR FAILURE TO COMPLY WITH DIRECTIONS

Dominic Ruck Keene

Bot v Barnick and Others [2019] EWHC 3704 (QB)

The facts

The claim arose out of allegedly negligent care given to the Claimant at the Portland Hospital following the birth of her child in 2011, during the course of which she developed post-partum psychosis.

Procedural History

The claim was issued in December 2016, and directions were first given in January 2018. A full set of case management directions included directions for the service of expert evidence. The case was due to be tried in a window from 24 February to 4 March 2020. The directions had subsequently been varied on a number of occasions by consent, with the time for service of the expert evidence being extended. Both parties were given permission to rely on liability evidence in the fields of obstetrics and psychiatry, and each party was given permission to rely on condition and prognosis evidence from a psychiatrist. The Claimant had failed to serve any

obstetric liability evidence. The Defendant had been unable to serve condition and prognosis evidence due to difficulties in getting the Claimant's attendance at an examination.

Conclusion

Yip J held that the Claimant had failed to prosecute her claim expeditiously – in particular by failing to serve any supportive expert evidence against the First Defendant (an obstetrician). It was in the interest of the Defendants who had the allegations of professional negligence 'hanging over them' that the matter was dealt with promptly, and it was also in the Claimant's best interest to bring the case to a final conclusion. Finally, it was in the interests of other litigants that the court time is used effectively.

Yip J commented favourably on the reasonable and unaggressive approach taken by the Defendants' legal representatives as indicating that they had done everything they could to progress the case to an end point. She held that "*The court should not penalise parties who act in that way and who do their very best to resolve things without making robust applications. But the time has come where the defendants can legitimately say that they would be prejudiced by being required to proceed in February.*"

Yip J granted the First Defendant's application to have the claim against him struck out, holding that *"the first defendant is entitled to say that this claim has been going on long enough and that, in the absence of an expert report from the claimant, he should not be expected to wait indefinitely to see the substance of the case against him and the evidence that is relied upon in support of that case. As is well known, claims against professional people should not be maintained in the absence of supportive expert evidence. It is inappropriate, in my judgment, for the claimant to maintain this action against the first defendant if she does not have an expert opinion to support that claim. If she did have supportive evidence, it would be expected that it would have been served by now, and, in the absence of anything to suggest that within a reasonable time such evidence is likely to be forthcoming, it seems to me that the court must act now and consider whether this matter can properly proceed any further."* There was no suggestion that there was *"some particular problem that has prevented the claimant complying or any indication that the position is likely to be remedied within a short space of time."*

The claim was accordingly struck out under CPR 3.4(2)(c) for a failure to comply with the directions given, in particular with the 'final' extension of time by consent on 11 September 2019 to 18 September – even though that extension had not been couched as an 'unless' order.

Comment

For both claimants and defendants, this case is of course a reminder of the importance of complying with directions. However, more interestingly, it also demonstrates that judges do on occasion take note of the tone and manner in which parties attempt to resolve issues of delay and requests for extension, and may be potentially more receptive to an application that is clearly necessary rather than one that could be seen as more tactical or opportunistic.

LEGITIMATE EXPECTATION OF AN OMBUDSMAN'S INQUIRY

Dominic Ruck Keene

R (Morris) v Parliamentary and Health Service Ombudsman [2019] EWHC 1603 (Admin)

The Claimant unsuccessfully sought to judicially review the Ombudsman's report responding to her complaint against a hospital Trust for misplacing records relating to the death of her daughter in 2011. The Ombudsman had inquired into the Trust's 2014 investigation into its record-keeping, however, the Claimant argued that she had a legitimate expectation that the scope of the Ombudsman's inquiry would include the Trust's initial failure in 2011 to locate the records. The court held that the Ombudsman had a broad discretion to decide what to investigate and had lawfully limited his inquiry to 2014, with any earlier events only being considered as part of

the background and context. Further, there had been no clear, unambiguous, or unqualified representations made by the Ombudsman to the Claimant (applying the *Bancoult* test) as to how his inquiry would be performed.

IN BRIEF

Selected cases which have been covered 'in brief' will be covered in full in the next issue.

Clinical Negligence

Attorney General of St Helena v AB and others (St Helena) [2020] UKPC 1 – Privy Council decision considering whether the Judicial College Guidelines published in England and Wales could be used to quantify PSLA in St Helena. Issue was whether an adjustment should be made to the PSLA amounts to reflect the fact that average earnings were lower in St Helena than England and Wales. Decision – not to make any adjustment.

ABC v St George's Healthcare NHS Trust & Ors [2020] EWHC 455 (QB) – whether the Defendants' had a duty to tell the Claimant of her father's diagnosis of Huntingdon's Disease. The court found that duty contended for by the Claimant did exist, namely "*a duty to balance the Claimant's interest in being informed of her risk of a genetic disorder against her father's interest in having the confidentiality of that diagnosis preserved*" but it was not breached in this case, and in any event she was not successful on causation.

Brady v Southend University Hospital NHS Foundation Trust [2020] EWHC 158 (QB) – concerned a failure to diagnosis the Claimant's actinomycosis infection. At the heart of the Claimant's case were a number of CT scans. Judge commented that, what the scans in fact show is a matter of fact for the judge to determine with the assistance of the experts and witnesses, on the balance of probabilities. Whether the radiologists' assessments of the scans, at the time, was negligent is a separate matter, to which the Bolam/Bolitho tests applied.

Thimmaya v Lancashire NHS Foundation Trust [2020] 1 WLUK 437 – the Defendant NHS Trust applied for a wasted costs order against the Claimant's consultant spinal surgeon, on the basis that he had comprehensively failed in his duties to the court. For example, he had been unable, at trial, to articulate the test for breach of duty. The Claimant had to discontinue, and the Defendant sought, against the expert, the costs of defending the claim. The Defendant was successful in this unusual case involving 1COR's own Giles Colin.

Morrow v Shrewsbury Rugby Union Football Club Ltd [2020] EWHC 379 (QB) – quantum only proceedings, C had allegedly suffered a brain injury. Raises the novel point of the use of intermediaries in civil proceedings. C argued that he suffered from anxiety and depression and an intermediary would assist him with proceedings. The application was considered and granted by the judge, but she noted that she did not consider the intermediary to be helpful [49].

Morrison v Liverpool Women's NHS Foundation Trust [2020] EWHC 91 (QB) – Defendant's appeal against a decision of a Recorder to find in the Claimant's favour. The appeal was unsuccessful. In particular, Turner J noted that the Recorder's judgment failed to refer to the Bolam/Bolitho tests but this was not a ground of appeal in so far as he had, in fact, applied the right test.

King v South Tees NHS Hospital Foundation Trust [2020] EWHC 416 (QB) – The only issue was causation. Specifically, had the deceased been diagnosed when, admittedly he should have been, he would have survived. Extensive consideration of the literature on cancer survival, particularly statistical evidence. Conclusion that: "a *person with a 3cm primary tumour has a 68-75% probability of being N0."*

Ramdhean v Agedo 2020 WL 00620352 – the Claimant claimed damages for personal injury arising out of allegedly negligently dental treatment provided by the First Defendant dentist. His whereabouts were unknown. The dental care provided by the First Defendant was in fulfilment of obligations of the Second Defendant, The Forum Dental Practice Limited, under an Intermediate Minor Oral Surgery contract with Doncaster Primary Care Trust. A key issue was whether the Second Defendant owed any liability to the Claimant. HHJ Belcher found that

the Second Defendant owed a non-delegable duty to the Claimant and/or was vicariously liable for the First Defendant's acts.

Personal Injury

FZO v Haringey LBC [2020] EWCA Civ 180 – a case arising out of sexual abuse perpetrated by a teacher against a student. Raised a number of issues, particularly around limitation and vicarious liability, and whether the school could be vicariously liable for assaults committed by the teacher against the student after the student had left the school. The conclusion of the court was that the school was vicariously liable in that situation. 1COR's own Robert Seabrook QC and Justin Levinson were instructed by the Claimant.

Inquests

R (on the application of Lee) v HM Assistant Coroner for the City of Sunderland [2019] EWHC 3227 (Admin) – inquests - Concerned the Article 2 operational duty and the application of *Rabone* to the facts of the death of the Claimant's daughter.

Regulatory

Arowojolu v General Medical Council [2019] EWHC 3155 (Admin) – appeal by a doctor against an erasure decision by the MPT – followed accusations of sexual misconduct – appeal allowed on the basis that the tribunal chair's advice as to evidence of previous allegations made by the victim against her grandfather had resulted unfairness in a way which invalidated its findings of fact.

Healthcare judicial review

M (Declaration of Death of Child) [2020] EWCA Civ 164 – The Court of Appeal reaffirmed that brainstem death was the applicable test to determine when an individual has died. In any event, regardless of whether brainstem death or whole brain death was adopted as the test, sadly, given his condition, M was dead on either analysis. Once the court was satisfied that M was dead, there was no basis to carry out a best interests analysis. There was no issue as to whether it was in M's best interests to die, as he was already dead.

Rotherham Metropolitan Borough Council v ZZ & Ors [2020] EWHC 185 (Fam) – decision as to whether it was in ZZ's (a baby) best interests to receive life-saving treatment and/or be resuscitated. ZZ was born with a rare congenital malformation where some of the brain hemispheres are not fully formed but are replaced by brain fluid. He could not see or hear, it was likely he could only feel pain. Conclusion – it was not in ZZ's best interests.

Court of Protection

Practice Guidance (CP: Applications Relating to Medical Treatment: Guidance Authorised by Justice Hayden, Vice President of the Court of Protection) Court of Protection [2020] EWCOP 2 – new practice guidance issued by Hayden J on applications relating to medical treatment.

Sherwood Forest Hospitals NHS Foundation Trust [2020] EWCOP 5 – hospital application to provide cancer treatment to Mrs H. Application granted. Particular concern raised as to delay in making the application. Also provides a good example of the application of Hayden J's new practice guidance (above).

Guys And St Thomas NHS Foundation Trust & Anor v R [2020] EWCOP 4 – Hayden J's fully reasoned and important decision on anticipatory/contingent orders.

AG v AM [2020] EWCOP 59 - It was not in the best interests of a patient who had been deprived of his liberty at a specialist nursing home to return to his home. Although there would be benefits to the patient if he were allowed to return home, he would receive reduced medical input at home which would leave him at a significant increased risk of suffering a deterioration in his health, further hospital admissions and/or premature death.

Costs

Swift v Carpenter [2020] EWCA Civ 165 – another stage in the test case concerning accommodation claims. C applied for a Protective Costs Order. It was refused on the basis that C had a private interest in the litigation, it was therefore inappropriate to make such an order.

EVENTS & NEWS

Podcast

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.

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EDITORIAL TEAM

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

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

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