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The 1COR Quarterly Medical Law Review

Updates and analysis of the latest legal developments

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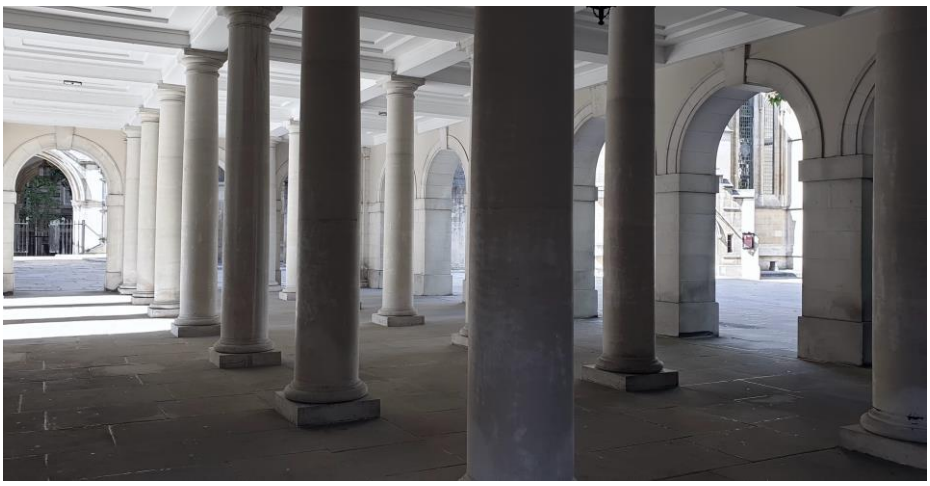

Welcome to the seventh issue of the Quarterly Medical Law Review, brought to you by the barristers at 1 Crown Office Row. This issue was unfortunately somewhat delayed but covers developments in Autumn 2020. In this edition you will find:

Robert Kellar QC explains the Supreme Court decision in *Henderson v Dorset Healthcare* concerning the illegality defence on page 2.

Jeremy Hyam QC analyses two cases on informed consent and the new GMC guidance on page 4 .

Matthew Flinn summarises a High Court decision concerning material contribution and PTSD on page 7.

A webinar by Lizanne Gumbel QC and John Whitting QC on *Swift v Carpenter* has been transcribed for readers by Henry Tufnell on page 8.

Shaheen Rahman QC considers *Maguire,* Article 2 and healthcare inquests in a very in-depth analysis of the domestic and European case-law on page 12.

Matthew Hill also considers Article 2 in the inquest context, covering a significant decision relating to police failures on page 19.

Suzanne Lambert and Dominic Ruck Keene cover decisions relating to fundamental dishonesty. Dominic also considers an interesting judicial review regarding medical records and GDPR on pages 21 to 28.

Charlotte Gilmartin follows up on a case covered in Issue 6 concerning extra-territoriality and the Civil Liability Act on page 28.

Michael Deacon explains a recent decision on vicarious liability in the context of a practical joke gone wrong at work on page 30.

Matthew Flinn provides an update on two Court of Protection cases, the first concerning deputies and the second concerning an individual with alcoholism on page 32.

Sarah Lambert QC, our resident costs expert, continues her helpful updates on page 35.

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

MENTAL HEALTH, CLINICAL NEGLIGENCE AND THE ILLEGALITY DEFENCE

Robert Kellar QC

Ecila Henderson v Dorset Healthcare University NHS Trust Foundation [2020] UKSC 43

In *Ecila Henderson v Dorset Healthcare University NHS Trust Foundation* [2020] UKSC 43 the Supreme Court has revisited the defence of illegality ("ex turpi causa") in the context of a claim for clinical negligence.

The Claimant — a mental health patient — had committed a criminal offence as a result of the Defendant Health Authority's admitted negligence. Can a claimant, who would not have committed an offence but for the defendant's negligence, recover losses arising from their own criminality? Can they seek compensation for the pain, suffering and loss of earnings caused by a custodial sentence? Can they recover general damages for feelings of guilt and remorse? The Supreme Court answered these questions with a resounding "no".

The facts

Ms Henderson suffered from paranoid schizophrenia or schizoaffective disorder. Whilst under the care of the Defendant's community mental health team she stabbed her mother to death. She did so whilst experiencing a serious psychotic episode. She was convicted of manslaughter by reason of diminished responsibility.

In sentencing her, the judge said that: *"… there is no suggestion in your case that you should be seen as bearing a significant degree of responsibility for what you did.*" The judge sentenced Ms Henderson to a hospital order under the Mental Health Act 1983.

Ms Henderson subsequently brought a civil claim against the Defendant Trust. The Trust admitted liability for its negligent failure to return her to hospital when her psychiatric condition deteriorated and accepted that, if it had done this, the tragic killing of Ms Henderson's mother would not have taken place.

However, the Trust argued that Ms Henderson's claim was barred for illegality ("*ex turpi causa*"), because the damages she claimed resulted from: (i) the sentence imposed on her by the criminal court; and/or (ii) her own criminal act of manslaughter.

The Supreme Court's decision

The central legal issue was whether the court was bound by the House of Lords' decision in *Gray v Thames Trains Ltd* [2009] UKHL 33. A claim on very similar facts was dismissed in that case. Alternatively, the court could depart from *Gray* in the light of the more recent decision of the Supreme Court in *Patel v Mirza* [2016] UKSC 42. In that case the majority adopted a flexible policy based approach to the illegality defence which took into account competing public policy and proportionality factors.

The Supreme Court affirmed that the *ex turpi* defence was justified by two public policy considerations:

i. First, the need to ensure consistency between the criminal law and the law of tort. The integrity of the justice system depended on its consistency. It would be inconsistent for the law, on the one hand, to imprison a person for the consequences of their criminality but, on the other, to compensate them for it. Or to put it another way the law should not "*condone when facing right what it condemns when facing left."*

ii. Second, the need to maintain public confidence in the legal system. It was offensive to public notions of the fair distribution of resources that a claimant should be compensated for the consequences their own criminal conduct. This would risk bringing the law into disrepute.

The court held that conviction of manslaughter on the grounds of diminished responsibility meant that responsibility for the criminal act was diminished but not that it was removed. To allow recovery in civil proceeding would lead to inconsistency. It would attribute responsibility for the criminal act not, as determined by the criminal law, to the criminal but to the tortious defendant. The criminal under the criminal law would become the victim under the civil law. Moreover, to allow a civil judge to revisit the question of whether a convicted person bore personal responsibility for their crimes would create a clear risk of inconsistent decisions in the criminal and civil courts.

Applying the flexible policy based approach endorsed in *Patel* did not lead to a different conclusion. There was a strong public interest in the condemnation and punishment of unlawful killing. Moreover the court stated that:

> *"NHS funding is an issue of significant public interest and importance and, if recovery is permitted, funds will be taken from the NHS budget to compensate the appellant for the consequences of her criminal conviction for unlawful killing."*

The Claimant relied upon countervailing policy considerations. The policy of encouraging NHS bodies to care competently for the most vulnerable was one such policy. The policy of ensuring that public bodies paid compensation to those they had injured was another. The court recognised that there was some force in these considerations. But they did not begin to outweigh those that supported the denial of the claim:

> *"… concern for the integrity of the legal system trumps the concern that the Defendant be responsible."*

Accordingly, *Gray v Thames Trains Ltd* remained good law and was consistent with the policy driven approach in *Patel v Mirza.*

Comment

This case provides helpful clarity for clinical negligence practitioners who bring or defend allegations of sub-standard mental health care. Following *Henderson* the general rule is that Claimants can recover for the personal consequences of self-harm as a result of negligent mental health care but not for the personal consequences of causing criminal harm to others.

This general prohibition applies to damages resulting from the imposition of a criminal sentence, such as general damages for the detention and loss of earnings during it. It also applies to damages for feelings of guilt and remorse consequent upon a criminal act. Nor can claimants seek indemnities from defendants against claims brought by the victim or the victim's dependents.

Interestingly the court left open the possibility there may be some very exceptional cases where the defence of illegality would not apply. This may be where the criminal act committed as a result of the defendant's negligence did not constitute 'turpitude'. Examples might include trivial offences or strict liability cases where the claimant is not privy to the facts making his act unlawful (see [55-56] and [112]). The potential existence of this exceptional category follows from the application of the flexible policy based approach endorsed in *Patel*. In practice, the author would expect this exceptional category to apply very rarely indeed. However, it would not be a surprise if the limits of the illegality defence were tested in respect of a much less serious offence in the future.

This article originally appeared on the UK Human Rights Blog.

INFORMED CONSENT

Jeremy Hyam QC

Alan McNab and Others v Greater Glasgow Health Board [2020] CSOH 53

Plant v El-Amir [2020] EWHC 2902 (QB)

Updated GMC Guidance on Consent, effective from 9 November 2020

On 9th November 2020, new guidance from the GMC came into force with respect to informed consent. This guidance was produced after a period of public consultation on the draft guidance between October 2018 and January 2019. The draft guidance was then redrafted to take account of the evidence gathered throughout the consultation period. That draft was approved by Council in November 2019 and is now published in final form.

The updated guidance lists 'seven principles' of decision making and consent, including:

- All patients have the right to be involved in decisions about their treatment and care, and to be supported to make informed decisions.

- Decision making is an ongoing process focused on meaningful dialogue, based on the exchange of relevant information specific to the patient.
- All patients have the right to be listened to, and to be given the information they need to make a decision and the time and support they need to understand it.
- Doctors must try to find out what matters to patients so they can share relevant information about the benefits and harms of proposed options and reasonable alternatives.
- Doctors must start from the presumption that all adult patients have capacity to make decisions about their treatment and care. A patient can only be judged to lack capacity after assessment in line with legal requirements.

Although not one of the "seven principles of informed consent", paragraphs 50-51 contain key guidance as to the recording of decisions which will doubtless be relevant for litigated cases:

> *"Patients' medical records*
>
> *50. Keeping patients' medical records up to date with key information is important for continuity of care. Keeping an accurate record of the exchange of information leading to a decision in a patient's record will inform their future care and help you to explain and justify your decisions and actions.*
>
> *51. You should take a proportionate approach to the level of detail you record. Good medical practice states that you must include the decisions made and actions agreed - and who is making the decisions and agreeing the actions - in the patient's clinical records. This includes decisions to take no action."*

That markedly different outcomes are possible where recording of dialogue and decision making are inadequate may be seen in the two recent informed consent cases of *Alan McNab and Others v Greater Glasgow Health Board* [2020] CSOH 53 and *Plant v El-Amir* [2020] EWHC 2902 (QB).

In *McNab* the Outer House considered the case of a woman who it was claimed did not give informed consent to the risks of ureteroscopy. She underwent the procedure on 23 September 2013 and died from sepsis, one of the known risks. The Outer House (Lady Carmichael) summarized the relevant law from *Montgomery* and applied it to the facts. She explained at [103] (uncontentiously):

> *"A doctor such as* [the Defendant] *must take reasonable care to ensure that the patient is aware of any material risks involved in any recommended treatment and of any reasonable alternative or variant treatments. A risk is material if in the circumstances of the case, a reasonable person in the patient's position would be likely to attach significance to the risk, or the doctor is or should be reasonably aware that the particular patient would be likely to attach significance to it. Montgomery, paragraph 87. Whether a risk is material cannot be reduced to percentages, but will reflect a variety of factors such as those mentioned in Montgomery, paragraph 89. A doctor must engage in a dialogue with the aim of ensuring that the patient understands, amongst other things, the anticipated benefits and risks of the proposed treatment and any reasonable alternatives. That duty is not fulfilled by "bombarding the patient with technical information which she cannot reasonably be expected to grasp: Montgomery, paragraph 90."*

In approaching the informed consent issue the case turned largely on the oral evidence of the Defendant surgeon who had not made any contemporaneous record of the consenting discussion. The impression which her evidence created on the judge was "*of sorrow and regret, rather than defensiveness or self-justification".* The judge concluded the surgeon was generally reliable and answered the key questions as follows:

(a) Was there an increased risk of sepsis because of the previous episode? Answer: no because of earlier sepsis, yes because of the Deceased's age. The increase in risk was small.

(b) What matters did the Defendant surgeon have a duty to discuss with the Deceased? The key (or material) matters were: the risk of infection/sepsis, the reasonable alternative of postponing and having a CT scan. Other matters were peripheral or immaterial to the key decision.

(c) What did the Defendant surgeon discuss with the Deceased? The key elements necessary for informed consent namely (i) the risks and benefits of ureteroscopy including an increased risk of urosepsis, and the alternative of delaying and having a CT scan.

(d) Did the Deceased understand any advice tendered? Yes, and chose the ureteroscopy rather than delay.

Contrast the case of *Plant v El-Amir* where informed consent was raised in a case concerning allegedly unnecessary (and delayed) treatment leading to eye damage. As summarized by the judge (Stacey J) the issues fell into two distinct strands:-

(a) a failure properly or adequately to obtain the informed consent of the Claimant for the surgery and to perform the surgery without such consent (allegations at paragraph 25(a)-(g)); and

(b) the failure to diagnose and treat in a timely manner the Claimant's raised intraocular pressure (IOP) and glaucoma between 25 September 2013 (as pleaded) and 13 December 2013 said to have caused significant, permanent and irreversible damage to her right eye.

It was not said that the surgery itself had been performed negligently, but the Claimant's challenge was to the fact that the surgery was performed at all.

In terms of the law, the issue was narrow. The Claimant's case was that she would never have agreed to have had any eye surgery if she had been made aware of both the risks and the very limited prospect of any improvement from the operation. Thus, the potential area of legal uncertainty concerning the precise scope of the *Montgomery* modification of usual principles of causation (see *Duce v Worcestershire Acute Hospitals* [2018] EWCA Civ 1307) was not relevant. It was also common ground that the Claimant must still both plead and prove with evidence that if the correct information had been given (in the event of the Claimant establishing liability), that she would not have had it (*Correia v University Hospital of North Staffordshire* [2017] EWCA Civ 356).

The facts leading up to the surgery do not reflect well on the London Eye Hospital (now in administration) or Dr Qureshi, its director, who since been struck off the GMC register.

On 15 July 2013, after seeing an article in the Daily Mail, the Claimant and her partner travelled from their home in Tydd St Giles, Wisbech, Cambridge, approximately 100 miles to the London Eye Hospital's premises in Harley Street, London, to attend an appointment with Dr Qureshi to discuss laser eye surgery. At that meeting, as recorded in the cursory notes made, the claimant was explicit that the purpose of her interest in the surgery was to improve her eyesight so that she could read magazines again and that she wanted the surgery on her worse left eye. Dr Qureshi assured her that he could help her see better. However, during the course of the appointment, she was persuaded to have both eyes done, because she was worried that her right eye would deteriorate and Dr Qureshi suggested it would be sensible to have both eyes treated. She was insistent and Dr Qureshi agreed that the surgery should be performed on the left eye first with the operation on her right eye to follow a few weeks later. She was clear that she did not want to risk her much better (right) eye, as if anything was to go wrong with that eye, it would be devastating.

From what she was told by Dr Qureshi, she was confident enough to agree to proceed and paid the full cost of surgery to both eyes – £11,000 per eye together with £1,500 extra for use of a femtosecond laser which she was told would reduce the risk of infection totalling £25,000 – before setting off back home to Cambridgeshire with an appointment date. She was enthusiastic to proceed. Mr Qureshi did not explain any risks of surgery beyond the possibility of infection which, he said, would be reduced by the use of the femtosecond laser for which she had paid extra. He did not effectively communicate that it might not work or that she could have any problems. He did not share with her any of what little research data there was about the limited benefits and risks of the proposed surgery for someone with her level of AMD (age-related macular degeneration) in both eyes. He told her that he was confident that he could make her sight better and she believed him. She was not informed of

the inherent risks of any intraocular surgery. She was asked to sign various documents which she did not pay much attention to.

The Claimant then came to see Mr El-Amir, an NHS consultant in Reading who was practising privately at the London Eye Hospital. He reviewed the notes of the earlier appointment, and requested she attend for further tests. As a result of those tests (and despite the results being contrary to the Claimant's experience) he suggested the right eye should be operated on first. He gave no further information about the surgery, its risk or possible benefits or the availability of any alternatives. Mr Amir was determined to operate on her right eye (her only good eye) saying that "*it would help balance the vision*". In fact as a result of the surgery on 23 August 2013 her optic nerve was damaged and she lost total loss of vision in her right eye.

Mr El-Amir in his defence claimed he had gone through the risks and possible outcome of surgery with the Claimant prior to the operation in meticulous detail. This was roundly rejected by the judge based on the Claimant's evidence [33]:

> *"The statement of the Claimant made just 2 years after the surgery and the statement of Mr Gifford [her partner] had the ring of truth and were inherently plausible and were consistent with both her letter of complaint in March 2015 and her response to LEH's reply to her letter of complaint. She had been absolutely clear throughout both that she wanted to read again and did not want to risk jeopardising the sight in her right eye. So if the first defendant* [Mr El-Amir] *had given an accurate assessment of the likely benefit to be obtained from the surgery and warned her of the risks, it is implausible that she would have consented."*

The judge's ultimate conclusion was that Mr El-Amir failed to take all reasonable steps to obtain her informed consent to ensure she was aware of the very limited potential benefits of the surgery which would not have enabled her to read again, which was the reason for her interest in the surgery. Neither did he inform her of the very considerable risks and dis-benefits of operating on her only good eye. He failed properly to consent the Claimant by sufficiently explaining the risks of losing sight in her only good eye and performing the surgery without having provided her with the material information. He also failed in his duty to her by omitting to tell her on 23 August 2013 that surgery could improve the sight in her left eye.

As to causation, if she had been correctly informed that the surgery would not have enabled her to read magazines again and carried a risk of complications she would not have elected to have the operation on her right eye on that, or indeed on any other day. Liability and causation were therefore established against the first defendant, Mr El-Amir, in relation to consent.

Comment

The new guidance from the GMC to replace its former 2008 Guidance is welcome. It is likely to be the 'starting point' for the court in understanding the expected standards both in relation to the expected dialogue, discussion of reasonable alternatives, and the recording of the same as part of the informed consent process. But as the divergent outcomes in the cases above illustrate, ultimately these cases are very fact sensitive. If the judge forms the view that the patient has been 'mis-sold' a treatment of doubtful benefit she otherwise would not have undergone (*Plant v El-Amir*) the lack of appropriate documentation of the consenting process is likely to provide the easiest route for a finding in her favour. But if the overall impression of the evidence (despite the absence of recording of the consenting process) is that the patient probably understood the risks and would have gone ahead with the treatment knowing of those risks, then subtle differences in the nature of the risk, or aspects of the benefits of alternatives which are not included as part of the informed consent discussion, may not be material.

MATERIAL CONTRIBUTION AND PTSD

Matthew Flinn

Leach v North East Ambulance Service NHS Foundation Trust [2020] EWHC 2914 (QB)

The High Court applied material contribution causation principles to a case where distress over a delay in an ambulance arriving led the Claimant to develop Post-Traumatic Stress Disorder ("PTSD").

The facts

The Claimant suffered a sub-arachnoid haemorrhage due to a ruptured aneurysm. Her initial call for an ambulance was timed at 14:22 hrs, but the ambulance did not arrive until 16:11 hrs – 1 hour and 49 minutes later. The judge expressed "surprise" at that time period, although the parties agreed that the claim was to be determined on the basis of a period of negligent delay which had been admitted by the Trust: that period was 31 minutes.

With hospital treatment the Claimant made a good physical recovery. However, she also developed PTSD, which manifested in severe anxiety. The question for the court was whether the PTSD was caused or contributed to by the admitted breach of duty i.e. the 31-minute delay. In that regard, the evidence was clear that the haemorrhage itself was distressing, and any period of waiting for help was frightening. The Claimant was at home alone at the time, and experienced symptoms such as severe pain, vomiting, and repeated loss of consciousness.

The judgment

The judge applied the causation principles articulated by Waller J in the case of *Bailey v Ministry of Defence* [2008] EWCA Civ 883 (see in particular [46] of that judgment) and transposed them into the case before him as follows:

(a) *If it can be shown that the claimant would have developed PTSD, in any event, irrespective of the negligent period of delay, then the claim fails;*

(b) *If it can be shown that but for the period of negligent delay the claimant would not have developed PTSD, then the claim succeeds;*

(c) *If, on the other hand, the evidence is incapable of supporting either of the two propositions set out above, then if it can be shown that the negligent period of delay has made a material contribution to the PTSD, the claim succeeds.*

In assessing the matter, the judge preferred the evidence of Claimant's expert, observing that the Defendant's expert had expressed a number of unfair criticisms of the Claimant, that he had cited statistics without providing the source material, and that he had seemed to change his opinion during his oral evidence as to whether PTSD was triggered by the haemorrhage itself, or some point subsequently but before the period of negligent delay.

Perhaps more importantly, the judge made some more general comments about PTSD, which will assist Claimants in what is likely to be a very common kind of claim.

First, he emphasised that, just because PTSD could have been triggered by a shorter period of trauma, it did not necessarily follow that it could not be said that a longer period made a material contribution to PTSD, and he felt that it would be speculative to attempt to identify a trigger point. At [38] he said:

> *"…Undoubtedly, what occurred prior to the negligent period of delay was traumatic and, in particular, the fact that the claimant felt that she was going to die; and that she was suffering intense physical pain. Nonetheless, it does not follow that it is possible to identify a specific cut-off point when it could*

> *be said that whatever happened thereafter, PTSD was going to evolve. To the contrary, it seems to me that to look at the matter in that way is to adopt an artificial approach. It is, to my mind, in the realms of speculation to attempt to identify a fixed time when the claimant had suffered sufficient trauma such that she was likely to go on to suffer PTSD. Accordingly, I think there is considerable force in the proposition advanced by Dr Smith to the effect that medical science is not capable of dissecting that 31-minute period from the rest of the period of delay, so as to enable the inference to be drawn that PTSD would have occurred irrespective of the 31-minute delay."*

It is of note that he described the exercise of identifying a PTSD trigger-point as an artificial approach, rather than reaching a view solely based on the substantive evidence presented in the particular case – that could cause some consternation for Defendants.

Secondly, he declined to make any apportionment between the negligent and non-negligent periods of waiting for the ambulance, because he considered PTSD to be an indivisible injury. At [43] he said:

> *" …I have already observed in the course of this judgment that I regard PTSD as an indivisible injury. It is far removed from, for example, industrial diseases such as noise induced deafness or asbestosis which are known to be dose related. That is simply not the case with PTSD. If I cannot say when the trigger for the PTSD occurred, it would not be logical to go on to conclude that, nevertheless, there can be an apportionment exercise. In any event, such would not be legitimate if my assessment is correct that this is an indivisible injury."*

Although the point that apportionment would not be possible in circumstances where he was not able to say when the PTSD was triggered is cogent, his identification of PTSD as an indivisible injury implicitly discounts the possibility of arguing, on different facts, that PTSD could be exacerbated by a particular period of delay. It will be interesting to see if that approach continues to find favour.

In any event, in this claim, the Claimant succeeded on the basis that the negligent period of delay materially contributed to her developing PTSD, and the judge was not able to make any apportionment, so she recovered damages in full.

SWIFT V CARPENTER – QUESTIONS AND OBSERVATIONS

Lizanne Gumbel QC and John Whitting QC, transcribed by Henry Tufnell

Swift v Carpenter [2020] EWCA Civ 1467

Days after the judgment in *Swift v Carpenter* was handed down, Lizanne Gumbel QC ("EAG QC") and John Whitting QC ("JW QC") of 1 Crown Office Row gave a webinar in which they talked through some questions arising out of the judgment and provided their observations. Henry Tufnell has diligently transcribed their conversation for the purposes of this article, which is an abridged version of the webinar for those who missed it.

Introductory remarks

EAG QC: *Swift* is a Court of Appeal decision and it is binding; it would need to go to the Supreme Court to be displaced. The way in which all three judges decided on the different criteria from *Roberts v Johnstone* was that the economic conditions have changed to such an extent that it is fair to say that *Roberts v Johnstone* doesn't fit accommodation claims in modern conditions and something needs to be devised that will. The solution that has been found is simple and applies to capital recovery, but it doesn't tell us about betterment or about parental property and there is no suggestion in the judgment that one should take the latter into account. The only property that is taken into account in *Swift v Carpenter* is the adult's own property and there is no discussion about running costs. The only discussion is how you work out the capital amount.

The theory of *Swift* is that if the Defendants are paying the outlay on the property of the disabled person it would be a windfall unless they got back something at the end of the Claimant's life. Whilst you don't actually pay anything back, you make the notional deduction for what the revisionary interest will be at the end of the Claimant's life.

The best recovery for Claimants will be for cases with the longest life expectancy and the most expensive property. Now a lot of people have asked the question, well what if you aren't going to need the property until age 30? I think that the simple answer and the one the Defendant will contend for is, if you are getting the capital outlay subject to the revisionary interest and if you are getting your loss of earnings at the time of the recovery, then probably the position is you take off what the uninjured property is from the outset and do one calculation, but there are no examples in the Court of Appeal decision to confirm that. There are various other calculations that might be appropriate, and which divide the calculation into separate periods. We discuss these further below.

Betterment – there is no mention of betterment. It seems to me that the only possible way of bringing in betterment is working out the Defendant's share of the betterment in the revisionary interest and deduct that as well, it will usually be a small amount. They simply haven't told us what to do on betterment.

JW QC: As with *Roberts v Johnstone* the courts have gone for an artificial construct to compensate the Claimant for what is an anomalous head of loss: the capital purchase cost of alternative accommodation will give the Claimant an asset which, uniquely, will appreciate in value. As with *Roberts v Johnstone*, the methodology prescribed in *Swift* means that the Claimant will never be fully compensated for the cost of purchasing suitable accommodation. That is because *Swift* requires:

1) The value of the property which the Claimant would have purchased in any event to be deducted from the cost of purchase.
2) An additional deduction of the value of the revisionary interest.

The balancing exercise between those disadvantages to the Claimant as against the disadvantage to the Defendant that the Claimant's estate will have a windfall is anomalous to this head of loss, so whichever solution the Court of Appeal was going to come up with, they had to balance those two against one another.

The trouble is that the methodology of *Swift* means that the greater the shortfall to the Claimant by reason of the value of the revisionary interest, the less likely that the Claimant will be able to fund that shortfall from the award of general damages or future loss of earnings.

This is because the shorter the Claimant's life expectancy, the greater the reversionary interest will be and, conversely, the lower the award will be for general damages or future loss of earnings. That in my opinion creates an internal paradox and an inherent unfairness. The only way that the Claimant has to fund the inevitable shortfall in the award which the Court will make to purchase suitable accommodation is by using the awards made for those heads of loss which are not going to have to meet actual, specific, needs in the future, such as care, case management, therapy, deputyship, aids & equipment etc. However, the lower the Claimant's life expectancy, the greater the revisionary interest and the greater the deduction that will have to be made, then, inevitably, the lower the value of the heads of loss that are going to be available to meet that shortfall. A layperson would have some difficulty in understanding the logic of that methodology.

The utility of a methodology whose practical effect is inherently perverse is questionable. I believe that one can test the validity of a legal principle, or the value of it, by how logical it sounds when you explain it to your client. I am visualising the conversation now: telling my client that he won't be awarded the cost of the accommodation that we all agree he needs and that he will have to meet the shortfall with the awards for general damages and loss of earnings, but the greater the shortfall the less likely he will be able to meet it.

It is also disappointing that the Court of Appeal had a once in a generation opportunity to consider one of the most vexed questions in clinical negligence and personal injury law and yet failed, comprehensively, to address all of the issues which that question raises – in relation, for instance, to the relevance of the parental home, wrongful birth, betterment and/or running costs. What is simply inexcusable is not only to offer an artificial and unsatisfactory solution which is inherently paradoxical and unfair, but then to say that it probably doesn't apply to short life expectancy cases without offering either a definition of what a short life expectancy is, or an alternative methodology in such cases, leaving it open therefore for either party to say that Swift doesn't apply.

I tried to test the process by looking at the 5% discount rate tables, as the Court of Appeal requires us to do, to calculate the reversionary interest. I found that if there is a five year life expectancy then there is a 75% reduction for the revisionary interest. For eight years it is a 66% deduction; for fifteen years it is a 50% deduction and then for thirty years life expectancy it is a 25% deduction. I ask rhetorically - what is the fair threshold beyond which it would be inappropriate to apply *Swift*? Is it fifteen years and 50%? Is losing 50% of the value of the property for the revisionary interest fair – meaning *Swift* should apply - but more than that would be unfair – meaning that it should not? I am sure that it will be a hotly contested battleground in the future.

With the one hand the Court of Appeal gave to Claimants by giving the balance between the property he needs and the property that he would have had in any event. With the other hand, it takes away by saying that the new methodology doesn't apply to every case and says we are not going to tell you which cases it will apply to and which it doesn't, and in cases of up to 15 years life expectancy, which isn't uncommon, we will knock off 50%.

In fairness, *Roberts v Johnstone* had a similar effect, in that, as the Claimant only received 2.5% of the value of the property multiplied by the multiplier, it had a detrimental effect for those on a short life expectancy. That said, it was universally applied so at least you knew where you were in relation to it, but here I can see endless arguments about whether *Swift* applies to a particular case. In any event, in those cases where it does apply you will have this paradoxical effect that the less your ability to pay, the greater the shortfall will be, and it raises questions. Unfortunately, the simple solution that we have been looking for since *Roberts v Johnstone* was decided has not happened.

EAG QC: In terms of the short life expectancy, the Court of Appeal haven't actually said that it doesn't apply, they have said that we might have to look at a different way of doing it as it might not be very satisfactory. I think it will be difficult to say if the Claimant wants to apply the *Swift v Carpenter* methodology that it shouldn't be applied, it is just whether the Claimant can find a fairer way to be compensated which in some short life expectancy cases will be the rental value. If the rental is more and is needed, then there will be strong case for having the rental, as otherwise you will be unable to meet the needs, where there is no loss of earnings claim. There is also this distinction between the short life expectancy cases where it is short for a child and short life expectancy for an adult where the adult will have a loss of earnings claim, it is just that they are only going to live to 65, rather than a child who doesn't have a loss of earnings because they are only going to live to age 15. All of that has yet to be argued.

Does Swift apply to wrongful birth? If yes, whose life is it therefore calculated on?

EAG QC: There was one bit in the judgment where it said it won't necessarily always be the life of the Claimant that you are calculating the reversionary interest on. The example that they discussed was a Claimant who has (vanishingly rare) a pre-ordained plan that they want to move to residential care when they are aged 70, and therefore the house can be given up at aged 70 and the Claimant can move into residential care. That is very unlikely, but it is at least some support that it may not be the life of the Claimant that you are calculating the revisionary interest on. Therefore, in a wrongful birth claim with a child who is severely disabled child and who is going to live much less long than the Claimant, it would have to be calculated on the child's life, if shorter.

JW QC: Wrongful birth is the other big issue in terms of quantum, which is ripe for Court of Appeal review generally. There is a perennial argument over its scope and how long it lasts – one extreme is that it lasts only until the child reaches majority, or age 19/20 or some later date or, on the other hand, the entirety of life. Accommodation issues are inextricably tied to that, we don't have an authority on that, making it another issue to take all the way to the Supreme Court.

EAG QC: In wrongful birth claims, the compensation calculation for buying accommodation for a severely disabled child is completely unclear. There was never a Court of Appeal decision on whether *Roberts v Johnstone* applied to wrongful birth claims. There were always arguments about whether, as wrongful birth claims are pure economic loss, the accommodation should be calculated differently from a personal injury claim. Those arguments will continue between Claimants and Defendants. Claimants will argue that the only criteria we have is that of the personal injury claim and we use that for other the heads of loss in wrongful birth claims, why wouldn't we use that for accommodation claims. Defendants will argue its pure economic loss and therefore different.

JW QC: I agree, the trouble is that wrongful birth as a cause of action has mushroomed in last few years, as scanning has improved exponentially and that which you can detect antenatally has improved exponentially. So,

a significant part of my work is wrongful birth and yet the quantification of it remains obscure, because nobody has taken it to the Court of Appeal to find out how one does it. There are therefore so many issues arising out of wrongful birth. This is just one of them.

EAG QC: I don't think there is any quantified wrongful birth quantum decision after the decision that it is economic loss, there are only very old first-instance decisions that quantified it at all.

The other problem with wrongful birth claims, is as Lady Hale said – in wrongful birth claims the Court has departed from the normal rules of tort law by ruling that the Claimant cannot recover the whole cost of upbringing as they previously had. Putting the Claimant back in the position they would have been without the tort would mean the Claimant recovered for all of the cost of upbringing, as the Claimant wouldn't have had the child at all. Once the court departs from the normal rule by saying the Claimant only recovers the additional costs the court has no parameters to assess anything else about the claim.

JW QC: We will be here for the rest of the day if we continue about wrongful birth.

Short life expectancy

EAG QC: My view is that we will use this formula if we can and if it really doesn't provide for accommodating an injured Claimant for a very short life expectancy and rental is what the family are doing at the date of trial or settlement, and is what the family want to continue doing, then there will be a strong argument for recovering rental costs. The outcome for the time being will be on a case-by-case basis.

JW QC: Yes – to contextualise it – if you have a 5 year life expectancy then you would be looking, solely on the basis of the revisionary interest at a 75% reduction; then that goes down, with a 30 year life expectancy, to a 25% reduction. Then, as you go beyond that, towards normal life expectations then the reduction diminishes exponentially below that. In that middle ground (5 – 30 years) then there are going to be some interesting arguments. I agree with EAG QC that for the particularly short ones, people are going to be suggesting renting and other solutions like that.

EAG QC: Even if you are getting 25% recovery then it is 25% more than you were getting on the basis of *Swift v Carpenter* at first instance.

What do you say to clients?

EAG QC: The next question is – how should one explain the new methodology to clients. All that can be said is that the Court of Appeal has found that Claimants should be able to buy the property they need but have to give credit, if they are an adult, for the property that they are in already and credit that the property will have value at the time they die. The amount of credit to be given is worked out on how far ahead the Claimant is predicted to be going to die. The further ahead death is predicted to occur, the less the value now of the revisionary interest and therefore the smaller the reduction. Not much else that you can say.

JW QC: The client understands that property is an asset that appreciates. All that one can say is, look, your estate will have a huge windfall for which you are going to have to pay now and you are going to have to meet the shortfall that creates by utilising other aspects of your own heads of damages. I don't think you can put it any more simply that that.

Claims where house would not have been bought until aged 35 and then might have upgraded once their earnings increase.

EAG QC: One question which I left to last, because it is one a lot of people have asked is what we do with the children claims where they wouldn't have bought a house until aged 35 and then they might have upgraded once their earnings went up when they were 45 or 50. Do we work this out in stages or do we look at it on the basis that the 'but for' house has to be taken into account from the outset because the loss of earnings are recovered at the outset? I don't know what the answer is and they give us no way of working it out in chunks. One of the paradigms they discussed was a house that wasn't needed for 10 years, but oddly, and I don't know whether else has understood example number 2, but the Court of Appeal seem to work out that you are not going to need it for 10 years but then you are going to need the whole cost and you don't need to give credit for anything that you are living in now. Is that how you read number 2?

JW QC: I didn't find the paradigms easy. The way I would approach this is to value the 'in any event' house on the basis of a weighted average. So, I would calculate the weighted average house cost based on the usual way

that you would calculate a weighted average. If you take the property you get when you are 25 or 30 then the property you get when you are 35 and then the one you get at 45, it is a straightforward calculation to work out the weighted average cost of that property over the course of the lifetime. Then I would use that single average value as the one that I would deduct from the cost of the accommodation which the Claimant actually needs now. I think this is the simplest way, as there is only one cost to deduct from the cost of the accommodation that you actually need. Otherwise, the calculations become absurdly complex.

EAG QC: So, if you have a life expectancy of 40 years and you would have bought a property in 20 years, the first 20 years you wouldn't have a property at all, as you are not taking into account parental property, do you only take off half of the total amount of discount?

JW QC: No, I would do it on the assumption that what *Swift* says is that you take off the total value in the 'any event' property now, so that is the figure that you need. You don't then calculate this sort of blank period in the meantime. For the period that the Claimant would have been a homeowner, that's your total period of homeownership over which you calculate your weighted average.

EAG QC: So, your weighted average is the difference between the first property being £350K and the second property being £700k but spread over the whole lifetime, not saying that you deduct something for the first 30 years. Whereas *Robert v Johnstone* we used to wait until 35 before giving credit.

JW QC: Now you are having to give credit now.

EAG QC: With reversionary interest because you are only giving credit at the end, it doesn't seem that the same logic applies.

JW QC: Given that they require us to make a deduction for the full value that only arises in 30 years, but have to give full credit for it right now, then I don't see why logically you wouldn't calculate on the same basis now.

EAG QC: There might be an argument that if you weren't giving credit for 30 years then you would be doing that on a -0.25% basis rather than on a 5% basis, so actually would be deducting more if you are waiting for the 30 years for the reduction.

JW QC: You could do that; I suspect you won't.

EAG QC: I am suggesting the Defendant argument that if you are going wait for 30 years before you give credit then you have to give credit for more because you apply a -0.25% to the period for which you give credit.

JW QC: They don't do that in the examples. I thought about that, ordinarily you would and therefore you uprate the value of it, as long as negative discount rate. They don't appear to do that in their paradigms.

EAG QC: Some people will deduct it now, but individuals may want to raise arguments about that.

ARTICLE 2 AND THE PROVISION OF HEALTHCARE

Shaheen Rahman QC

R (Maguire) v HM Senior Coroner for Blackpool [2020] EWCA Civ 738

Where Article 2 of the Convention is invoked to allege inadequate provision of healthcare by the state, recent Strasbourg and domestic authorities suggest an increasingly restrictive approach.

An expansive approach

The 2015 Chamber decision of the Fourth Section of the court in *Lopes de Sousa Fernandes v Portugal* [App No 56080/13] signalled the possibility of a more expansive application of Article 2 in the healthcare context than hitherto adopted.

The case concerned the death of the applicant's husband following nasal polyp surgery performed in November 1997, when he was around 40 years old. He developed bacterial meningitis and investigations revealed two

duodenal ulcers, but he was discharged when his condition appeared to stabilise. He deteriorated, developed infectious ulcerative colitis and was later readmitted. He died of peritonitis and a perforated viscus in March 1998.

It was held, by five votes to two, that there had been a substantive violation of the right to life protected by Article 2. The court took the view that the lack of coordination between the ear, nose and throat department and the emergency unit revealed a deficiency in the public hospital service that deprived the patient of the possibility of accessing appropriate emergency care. It also held, unanimously, that there had been a violation of Article 2 under its procedural limb. Three sets of internal proceedings did not meet the requirement of promptness nor had they addressed satisfactorily the question of the possible causal link between the various illnesses suffered by the patient following his operation and his death. The court also found that the domestic courts had failed to establish with sufficient clarity whether the patient had been appropriately warned of the risks of surgery which included meningitis.

The joint dissenting opinion noted that the court's position in previous authorities had been that, where a Contracting State had made adequate provision to ensure high professional standards among health professionals and the protection of lives, matters such as an error of judgment on the part of a health professional or negligent coordination amongst health professionals in the treatment of a particular patient would not be sufficient to call a Contracting State to account from the standpoint of its positive obligations under the Convention to protect life – see *Powell v UK* [App no 45305/99 (2000) 30 EHRR CD 152, ECHR 703.]

Clarification of the scope of the substantive positive obligation

The dissenting view prevailed when the case proceeded to the Grand Chamber in 2017. The court noted that it had frequently been called upon to rule on complaints alleging a violation of Article 2 of the Convention in a hospital setting and that the case presented *"an opportunity to reaffirm and clarify the scope of the substantive positive obligations of States in such cases"*. It emphasised at the outset, however, that "different considerations arise in certain other contexts, in particular with regard to the medical treatment of persons deprived of their liberty or of particularly vulnerable persons under the care of the State, where the State has direct responsibility for the welfare of these individuals" [162-3]. We will return to such contexts below.

In this context, the court considered that the position that it had consistently emphasised in medical negligence cases was as per *Powell* above, and that the court had only rarely found deficiencies in the regulatory framework of Member States. It noted the case of *Arskaya v Ukraine* [App 45076/05/05], where the applicant alleged that her son, who had been hospitalised for pneumonia and tuberculosis, had died as a result of medical negligence on account of inadequate healthcare regulations concerning patients refusing to consent to treatment. The court, when finding a substantive violation of Article 2, noted that the local regulations governing patients' admission to intensive care were inadequate. It further found that there was a lack of appropriate rules for establishing patients' decision-making capacity, including their informed consent to treatment. It considered therefore that the authorities had not taken sufficient steps to put in place a regulatory framework ensuring that the life of the applicant's son was properly protected by law as required by Article 2 of the Convention [170].

The court usually reviewed the substance of medical negligence allegations in the context of the procedural limb of Article 2, determining whether the mechanisms in place for shedding light on events were adequate. [172]

It also reiterated that it was not for the court to take a stand on issues such as the allocation of public funds and that it was a matter for Contracting States to consider and decide how their limited resources should be allocated [175].

Violations of the positive obligation under Article 2 had also been found in a number of cases where there had been a denial of life saving emergency treatment, for example in *Mehmet Şentürk and Bekir Şentürk v Turkey* [App no 13423/09] where a pregnant woman died after being refused life-saving treatment because she could not pay a deposit for the operation. [178]

Likewise, a violation was found in *Asiye Genç v. Turkey* [App no. 24109/07] where a newborn baby died after being denied admission to hospital due to a lack of space and equipment. The court held that the state had not sufficiently ensured the proper organisation and functioning of the public hospital system. This was not a case of negligence or an error of judgment – no care had been offered at all [179].

In *Elena Cojocaru v Romania* [App no. 74114/12] a pregnant woman died after being refused an emergency C-section and being transferred to a hospital 150 km away, the baby dying two days later. The circumstances were said to attest to a dysfunction in public hospital services [180].

The final case considered by the court was *Aydoğdu v Turkey* [App no. 40448/06], where a baby died as a result of a combination of circumstances, including dysfunction of the health system in a particular region of the country. The court considered that the authorities must have been aware at the time of events that there was a real risk to the lives of multiple patients due to a *"chronic state of affairs that was common knowledge"* yet had failed to take any of the steps that could reasonably have been expected to avert the risk, without any explanation as to why this would have placed a disproportionate burden upon them. There was a causal link between the baby's death and these structural problems, as well as individual negligence on the part of doctors [181].

The court considered that, apart from the *Elena Cojacaru* case, which followed the line taken in the Chamber judgment, these cases distinguished between cases of *"mere negligence"* and "*exceptional*" cases where there had been a denial of immediate emergency care. In the latter context, they noted the observations of the Government of the United Kingdom, who had been permitted to intervene in the proceedings, that the approach was akin to that in *Osman v the United Kingdom,* i.e. that the positive obligation arises when the state is required to undertake preventative operational measures to protect the life of an individual whose life is imminently at real risk. The court did not consider that the dysfunction of the hospital services in these cases was to be characterised as ones of negligent coordination between hospital services or hospitals, but as a structural issue linked to deficiencies in the regulatory framework [184].

Having considered the case law, the court reaffirmed the approach in *Powell* that in the context of alleged medical negligence, the substantive positive obligations on the state are limited to a duty to regulate, i.e. to put together an effective framework compelling all hospitals to adopt appropriate measures to protect patients' lives, including supervision and enforcement.

It also set out the *"very exceptional"* circumstances in which the responsibility of the state under the substantive limb of Article 2 may be engaged in the following way in cases of denial of treatment:

1. First, where a patient's life is knowingly put at risk by denial of access to life-saving emergency treatment. It does not extend to circumstances of deficient, incorrect or delayed treatment.

2. Second, where systemic or structural dysfunction in hospital services results in a patient being deprived of access to life-saving emergency treatment, which the authorities knew or ought to have known about and failed to take adequate steps to address, putting lives at risk.

It was acknowledged that it will not always be easy to draw the line between cases of *"mere negligence"* and *"denial of access to life saving treatment"*. However, to fall into the latter category, a number of factors are *"cumulatively"* required:

1. First, the acts or omissions in such cases must go beyond mere error or negligence and constitute a denial of care in the full knowledge that the patient is at risk, in breach of professional obligations.

2. Second, the dysfunction must be systemic or structural as opposed to comprising of individual incidents when things have gone wrong.

3. Third, there must be a link between the dysfunction complained of and the harm the patient sustained.

Finally, the dysfunction must have resulted from the failure of the state to meet its obligation to provide a regulatory framework in the broader sense of ensuring effective functioning of the regulatory framework [185-196].

The circumstances of the instant case did not fall within any of the exceptional categories, notwithstanding the comments of some medical experts reviewing the care who alluded to serious systemic inadequacies. A lack of coordination between hospital departments was not sufficient to engage the state's responsibility under Article 2 and there was accordingly no substantive breach. The allegations were of medical negligence and in such cases the state's substantive obligations were limited to the setting up of an adequate regulatory framework compelling hospitals to adopt appropriate measures for the protection of patient's lives [197-205].

The court did, however, uphold the finding of a violation under the procedural limb of Article 2 as there had been a failure to provide an adequate and timely response to the applicant by the domestic authorities [206-238].

Criticism of the approach

It will be apparent that the requirements for a breach of the substantive obligation under Article 2 set by the Grand Chamber overlap to some extent, and it is difficult to understand how all the factors identified in denial of treatment cases can be cumulatively required, as opposed to being alternative bases for a violation in some instances. On any view, however, the overall effect is extremely restrictive and has been criticised as such, not least in a powerfully worded dissenting judgment from Judge Pinto de Albuquerque:

> *"For a State to avoid international-law responsibility under the Convention, it is not sufficient for health-care activities to be circumscribed by a proper legislative, administrative and regulatory framework and for a supervisory mechanism to oversee the implementation of this framework, as the Court held in Powell […]By evading the question of the specific protection of the individual right of each patient and instead protecting health professionals in an untouchable legal bubble, Powell renders the Convention protection illusory for patients. Powell seeks a Convention that is for the few, the health professionals and their insurance companies, not for the many, the patients. This must be rejected outright"* [64].
>
> *[…]*
>
> *This case could have been a tipping point. The Grand Chamber did not want it to be that way. I regret that, by rejecting a purposive and principled reading of the Convention, the Court did not deliver full justice"* [94].

Judge Serghides, also dissenting, but in less trenchant terms, regretted the Grand Chamber had "*missed a good opportunity to follow Elena Cojocaru and to abandon the Powell principle for good or distinguish the present case from that old decision*" [15].

Domestic interpretation and impact on the procedural limb of Article 2

The restrictive approach affirmed in *Lopes de Sousa Fernandes* was swiftly deployed in proceedings before the Divisional Court in *R (Parkinson) v HM Coroner for Kent and Others* [2018] EWHC 1501 (Admin). This was a judicial review of a Coroner's decision that an inquest concerning the death of a patient at an Accident and Emergency department did not engage the investigative duty under the procedural limb of Article 2. The Coroner considered that the patient was already in the advanced stages of dying by the time she arrived and no additional treatment could have been given to her to avoid her dying. He recorded a conclusion of natural causes.

The Divisional Court noted that the duty of enhanced investigation is parasitic upon an arguable breach of the substantive obligations in Article 2. The *Lopes de Sousa* case was noted to be of great importance and a submission made by the claimant that it should not be followed was rejected.

Distilling the principles it considered now applied to medical cases, the court held that the *"crucial distinction"* was between *"ordinary"* cases of medical negligence, and cases of *"systemic failure"*. That distinction was also evident from the domestic caselaw. It was noted, for instance that in *R (Humberstone) v Legal Services*

Commission [2010] EWCA Civ 1479 Smith LJ had cautioned that it would be necessary in determining whether an inquest engages Article 2 for *"care to be taken that allegations of individual negligence are not dressed up as systemic failures"* [71].

The court rejected the submission that because the patient lacked capacity, her situation was analogous to one of compulsory detention, in respect of which it was acknowledged that different considerations would apply. It was noted that there will frequently be patients who have capacity issues in the A&E department and Article 2 inquests are not required in all such cases.

The court ultimately rejected the submission that defective triage and resuscitation policies at the hospital amounted to arguable breaches of the substantive obligations in Article 2. It followed that there was no enhanced duty of investigation under its procedural limb either [120].

Vulnerable patients under the care of the state

It was noted in *Fernandes* and *Parkinson* that the position for those detained or otherwise under the care of the state is different. It gives rise to greater substantive obligations under Article 2. The position in has developed in the following way.

In *Keenan v The United Kingdom* [App No 27229/95], a 2001 case concerning the suicide of a 28 year old prisoner, the court noted that it had already emphasised that persons in custody are in a vulnerable position. It is incumbent on the state to account for any injuries suffered in custody, particularly where a person dies. A state's positive obligation to protect life could include taking reasonable steps to prevent self-harm in cases where the authorities knew or ought to have known that a person in detention posed a real and immediate risk of suicide.

In *Savage v South Essex Partnership NHS Foundation* [2009] 1AC 681 the House of Lords considered the case of a woman who committed suicide whilst compulsorily detained under section 3 of the Mental Health Act 1983. It was held that her position was analogous to that of a prisoner and the operational obligation must extend to such patients when they were at a real and immediate risk of suicide. The Supreme Court subsequently held in *Rabone v Pennine Care NHS Trust [2012] UKSC 2* that the operational duty to prevent an informal psychiatric patient at a real and immediate risk of committing suicide from doing so when wrongly permitted home leave had been violated. Whilst not compulsorily detained under the MHA she was effectively in the same position and the authorities could and should have exercised its powers under the Act had she sought to leave hospital.

Accordingly, voluntarily and compulsorily detained patients have been viewed in the domestic caselaw as being essentially in the same position for the purposes of the substantive obligations under Article 2, with the operational duty to take preventative steps arising in cases where a real and immediate risk to life should be appreciated.

However, the position is rather more nuanced in the Strasbourg caselaw and has developed at a different rate. Whether the operational duty extended to a voluntary patients was not finally determined until the case of *Fernandes de Oliveira v Portugal* [2019 ECHT 106].

As in the *Lopes de Sousa Fernandes* case, the matter was first considered by a Chamber of the Fourth Section of the court, which unanimously found a violation of the substantive and procedural aspects of Article 2. It considered that the emerging trend of providing treatment on the basis of the principle of least restriction under an open-door regime did not exempt a state from its obligation to protect mentally ill inpatients from the risk they posed to themselves. In this case staff should have adopted greater safeguards to prevent the patient, who had previously attempted suicide, from leaving the hospital grounds.

Again, the Grand Chamber reversed the decision as regards the substantive violation. Whilst confirming that the operational duty does extend to voluntary psychiatric patients, it emphasised that the specific measures required to protect a patient from a real and immediate risk of suicide will often differ depending on whether the patient is voluntarily or involuntarily hospitalised. It considered that the court could apply a stricter standard of scrutiny in the case of an involuntary patient. Moreover, it would bear in mind the choices that needed to be made in terms of priorities and resources in providing public healthcare [124-5].

In the instant case, it concluded that whilst the risk of suicide could not be excluded in inpatients suffering from multiple conditions, the immediacy of the risk would vary. The monitoring regime was increased or decreased depending on the patient's changing mental state. The patient had not demonstrated suicidal behaviour in the immediate period before his death. The court also took into account expert evidence from experts that complete prevention of suicide in such patients was *"an impossible task"* and stated that it *"approached the question of risk with a view to assessing whether it is both real and immediate and notes that the positive obligation incumbent on the State must be interpreted in a way which does not impose and impossible or disproportionate burden on the authorities"*. It concluded that it had not been established that there was a real and immediate risk to life in this case [131].

Once again, there was furious dissent from Judge Pinto, joined by Judge Harutyunyan, asserting that the majority had made findings on the basis of a series of errors of fact. As to the law:

> *"the majority's opinion pursues the Lopes de Sousa Fernandes ideologically charged minimalist approach to the State's positive obligations in the sphere of health care to its limits, this time regarding the particularly vulnerable category of psychiatric inpatients under State control. The effect is that of downgrading the level of the Convention protection to an inadmissible level of State inertia"* [2].

The most strongly worded criticism was reserved for the "hands-off" approach and differentiation between voluntary and involuntary patients:

> *"The right to life prevails over the right to liberty, especially when the psychopathological condition of the individual limits his or her capacity for self-determination. It is nothing but pure hypocrisy to argue that the State should leave vulnerable suicidal inpatients in State-run psychiatric hospitals free to put an end to their lives merely in order to respect their right to freedom. At the end of the day, what really drives the majority is not the concern for more or less freedom of psychiatric inpatients interned in public hospitals, but the strict financial interest in safeguarding the hospital authorities from legal challenges to "excessively restrictive measures" while "bearing in mind the operational choices which must be made in terms of priorities and resources in providing public healthcare and certain other public services". Ultimately, this reflects a hidden social-welfare disengagement policy, which aims at the maximum commodification of health-care services and above all at the protection of health professionals..."* [21].

R (Maguire) v HM Senior Coroner for Blackpool [2020] EWCA Civ 738

The two lines of Strasbourg authority considered in the two *Fernandes* cases are extensively cited by the Court of Appeal in *Maguire*. This concerned the death of a patient with Down's syndrome, learning difficulties and limited mobility who had lived in a residential care home and was subject to deprivation of liberty safeguards. In the days prior to her death she had been ill but had not cooperated with attempts to take her to hospital and the decision was taken to care for her at the home overnight. She deteriorated and was admitted to hospital where she later died. The cause was a perforated gastric ulcer, peritonitis and pneumonia.

The claimant argued that the circumstances of the death engaged the procedural obligation to hold an enhanced inquest under Article 2. Whilst agreeing initially, and holding a jury inquest, the Coroner subsequently revisited his decision in light of the Divisional Court's judgment in *Parkinson*. Having heard the evidence, he did not consider there was any arguable breach of the substantive operational duty under Article 2 and hence the procedural duty was not triggered. A conclusion of natural causes was recorded with a short narrative description of events.

As the Coroner did not consider that the procedural obligation under Article 2 was triggered, the jury were not asked to express a view on the wider circumstances in which the deceased came by her death or whether her life-threatening condition should have been appreciated by those caring for her and measures taken to reduce the risk to her life.

The Claimant sought judicial review of the Coroner's decision which was dismissed by the Divisional Court, who noted that:

> *"the touchstone for state responsibility has remained constant: it is whether the circumstances of the case are such as to call a state to account: Rabone, para 19 citing Powell. In the absence of either systemic dysfunction arising from a regulatory failure or a relevant assumption of responsibility the state will not be held accountable under Article 2"* [44].

On appeal, the Court of Appeal was referred to a Chamber decision of the Fifth section of the Strasbourg Court, *Dumpe v Latvia* [App No 71506/13]. This concerned the factually similar death of a man who suffered from Down's Syndrome and epilepsy and was in long term care. He was found to have been suffering from malnourishment, hepatitis B, organ dystrophy and extensive psoriasis. The applicant alleged a violation of Article 2 due to inadequate healthcare provision, but it was held that the applicant had not exhausted her domestic remedies as civil proceedings remained open to her.

The Court of Appeal also considered the case of *R (Tyrell) v HM Coroner for County Durham and Darlington* [2016] EWHC 1892 in which the claimant argued that the death of a long term prisoner from cancer was sufficient to trigger the procedural duty under Article 2 to hold an enhanced inquest. That submission was rejected – there was no doubt that the death was from natural causes and thus there was no arguable breach of the state's substantive obligations under Article 2, or need for an Article 2 inquest despite the fact that the deceased was a serving prisoner.

The court noted that the Strasbourg authorities on care homes in which substantive violations of Article 2 had been found were in circumstances where the authorities were aware of appalling conditions and an increased mortality rate and did not act. Further that, as per *Tyrell,* the procedural obligation did not arise in cases of deaths in custody from natural causes. Accordingly, it posited that *"the Article 2 substantive obligation is tailored to harms from which the authorities have a responsibility to protect those under its care"*. An inadequate response to isolated medical emergencies in a care home did not support the imposition of the duty in the same way as the abuse cases. *Dumpe* was a care home case in which no violation of Article 2 had been found, despite the alleged deficient provision of healthcare. Had the death resulted from neglect or abuse, it would have been different. But it was a *"medical case"* and the procedural requirement under Article 2 was satisfied by the existence of an effective judicial system to determine liability [73-5].

Ultimately the court concluded that the operational duty was not owed to all those in a vulnerable position in care homes, placing strong reliance upon its view that the circumstances were closely analogous to those in *Dumpe*, despite the fact that this was not a Grand Chamber judgment. There was no consistent contrary jurisprudence suggesting that those in an analogous position were owed the operational duty when seeking medical care. Thus the procedural obligation was not triggered [96-99].

Neither was the court satisfied that the circumstances were analogous to those of a psychiatric patient who is in hospital to guard against the risk of suicide. The deceased was in a residential care home because she could not live alone or with her family. She was not there for medical treatment, which was provided by the NHS in the usual way. Had she been able to live at home with support, her position would have been no different in this respect [101].

The court did not determine whether there had been a real and immediate risk of death that medical professionals knew or ought to have known about, but noted that the *Fernandes de Oliveira* case suggested a *"relatively light touch"* would be required and it was doubtful that the two GPs and paramedics ought to have been aware of a high risk of mortality.

The Court of Appeal also rejected the claimant's submission that if this was a *"medical case"* as defined by *Lopes de Sousa*, it fell within one of the *"very exceptional circumstances"* that gave rise to an arguable breach of the operational duty due to denial of treatment. The deceased's life was not knowingly put in danger by a denial of life-saving treatment as those who assessed her did not believe her to be at risk. There was no systemic or structural dysfunction which resulted in the denial of life-saving treatment. The evidence did not suggest any

widespread difficulty in taking individuals with learning disabilities or elderly dementia patients to hospital when required. The alleged absence of a plan to get the deceased to hospital and inadequacy of guidance on how to do so did not come close to what was required in this respect.

Conclusion

Of course, the Convention is a living instrument and the expansive approach to Article 2 in the healthcare context advocated by Judge Pinto de Albuquerque may one day prevail. Moreover, systemic dysfunction and regulatory failures may still result in a violation of Article 2 in cases of medical negligence, for instance in cases that are analogous to care home cases where risks to life are known about but not acted upon, in addition to the more extreme scenarios of knowing denial of life saving treatment and *Rabone* type cases. However, whilst authorities such as *Parkinson* suggest it will not always be easy to draw the line between medical cases of *"mere negligence"* and those where the operational duty under Article 2 and parasitical procedural duty will apply, the courts have made relatively short work of that task in recent cases. Following *Maguire*, it is difficult to avoid the conclusion that *Rabone* may have been the high water mark in that particular context, or that subsequent Strasbourg authority has placed the operation of Article 2 in the healthcare context more generally under severe constraints.

This article also appeared on the UK Human Rights Blog.

ARTICLE 2 AND POLICE FAILINGS

Matthew Hill

R (Peter Skelton and anr) v Senior Coroner for West Sussex [2020] EWHC 2813 (Admin)

Susan Nicholson and Caroline Devlin were killed by the same man during the course of abusive relationships. They died in 2011 and 2006, but the man was not convicted – of murder and manslaughter respectively – until 2017. The inquest into Susan's death in 2011 resulted in a verdict of accidental death. Following the murder conviction, the Coroner applied to the High Court for this to be quashed, with the intention of holding a short inquest at which a fresh conclusion of "unlawful killing" would be recorded. However, the Claimants in this case – Susan's parents – sought to expand the scope of the inquest to consider what they thought, understandably, were police failings. They were successful; this article explains why, and examines the wider implications of the ruling.

Breaches of Article 2

The Claimants argued that the inquest should be expanded as there were two arguable breaches of Article 2 ECHR (the right to life) in the case.

The first was a failure by the police to conduct an effective investigation into the death of Caroline; had this been done, they argued, Susan's murderer would have been convicted at an earlier stage, thereby protecting her life. Under Article 2, the state has a duty to investigate all deaths in order to protect the lives of its citizens. The degree of investigation will vary, from basic death certification by a doctor to a full criminal investigation. In the recent case of *DSD v Commissioner of Police of the Metropolis* [2019] AC 196 the Supreme Court held that in investigations of crime involving the loss of life, operational failings within an investigation could amount to a breach of Article 3 (and, by extension, Article 2). However, for a breach to be identified a certain threshold of seriousness has to be met. Unhelpfully, that threshold was expressed in a number of different ways. In the present case, Popplewell LJ and Jay J held that the best formulation was that of Lord Neuberger: a "*seriously defective*" investigation would breach Articles 2 or 3. Such a breach could be cumulative or a single failing [57].

The second argument advanced by the Claimants was that the police had failed to protect Susan's life in the face of the threat posed by her murderer. Here, they relied on the well-established *Osman* duty imposed by Article 2. Such a duty arises where (1) the authorities know or ought reasonably to know of (2) a real and immediate

risk to life, which (3) requires them to take measures which could reasonably be expected of them to avoid such a risk. The court noted that this was a "*stringent*" test, and set out the matters that courts have considered to be relevant to it over the years [53].

Having identified these two duties under Article 2, the Claimants had to establish that they were relevant to Susan's death (which does not seem to have been disputed), and that it was arguable that Article 2 had been breached. This test is a low one, meaning that there was a "*more than fanciful*" or "*credible*" suggestion of a breach: see *R (AP) v HM Coroner for the County of Worcestershire* [2-11] EWHC 1453 (Admin), [60]) and *R (Muriel Maguire) v HM Senior Coroner for Blackpool and Fylde* [2020] EWCA Civ 738 [75]. This is to ensure that Article 2 is effective, as any arguable breach requires examination. In England and Wales, an inquest is the usual place for such scrutiny [62].

In respect of Susan's inquest, the Coroner had been unpersuaded that there were arguable breaches of Article 2, and it was this decision that the High Court had to consider.

The first question it had to address was the scope of its jurisdiction. Was it (as the Claimants argued) taking the decision afresh, on the basis that the question of whether or not there was an arguable breach of Article 2 was a matter of law that would only allow for one correct answer? Or was it applying traditional judicial review principles, where the court refrains from considering the merits of the decision and focusses on whether the process by which it was reached was rational, fair and lawful, resulting in a decision that was reasonably available to the person or body that made it?

The court provided a helpful and succinct summary of the competing authorities [69] to [86], before concluding that it did not really matter in the present case. It did not accept the "high watermark" of the Claimants' submissions that – whatever the context – the question of whether or not there was a breach of a convention right would always be a hard-edged question of law [87]. In the present case, the theoretically correct approach would be that of "anxious scrutiny" (judicial review on steroids), but given the circumstances, the result would be the same as if it were a straight legal question: the High Court must ask itself the same question as the Coroner (whether there was an arguable breach of Article 2), using the same evidence (there being no dispute of fact), and while it would take into account the Coroner's reasoning this was not an area in which particular deference had to be shown to her expertise. In short, the Coroner was either right or wrong, and the High Court had to decide which [87 – 93].

Having considered its approach, the court then evaluated the evidence. It found that it was arguable that there had been a breach both of the duty to investigate Caroline's death, and of the Osman duty to protect Susan. The court stressed this was not a finding that there had been a violation of Article 2, just an acceptance that there was enough evidence to show that it was arguable, and hence that these matters should be considered at the fresh inquest [94 – 106].

The court then had to consider a cross-application from the murderer. He submitted that the fresh inquest should examine whether Susan was in fact unlawfully killed. The effect would have been to allow him to argue his innocence and invite a finding from the inquest that would call into doubt his criminal conviction. This was dismissed on both procedural and substantive grounds.

The court found there was no statutory provision that forbade this, as there would have been had the inquests merely been suspended, rather than quashed: see s. 11 and sch.1, para. 8 of the Coroners and Justice Act 2009. However, common law principles were sufficient to prevent it from happening. The Coroner had a discretion as to the scope of her inquest and she had been entitled to rule that it would not consider the murderer's purported innocence. Indeed, it would have been unlawful for her to have decided otherwise, both on *Wednesbury* and *Padfield* grounds – i.e. it would have been so unreasonable as to have been unlawful, and would have violated the principle that a public body can only use it statutory powers to promote the purpose and policy of the statute from which they derive (in this case the 2009 Act). It would not be appropriate for a coroner to allow her inquest to be used as a forum for a convicted murderer to have a "second go" at establishing his innocence. Nor, it

should be added, is it a forum for the police to have a "second go" at proving criminal guilt: see *R v HM Coroner for Derby and South Derbyshire, ex parte Hart Junior* (2000) 164 JP 429.

Conclusions

The judgment helps to provide a checklist for use when claimants seek to use Article 2 to expand the scope of inquests. First, identify clearly what the alleged breaches are, by reference to the applicable thresholds (such as a "serious" failure to investigate, or the Osman test). Second, consider whether they require the attention of an inquest, including by asking whether they are causally relevant to the death, and whether they have been fully investigated before. Third, examine the evidence of why it is arguable that Article 2 has been breached. Fourth, invite the court to consider the matter with "anxious scrutiny", keeping in mind that (as in this case) this may be akin to taking the decision afresh as there may be only one rational answer.

Such an approach should assist courts and coroners in ensuring that inquests fulfil their important role in meeting the state's duty under Article 2 to investigate – and hence protect – life. It is to be hoped that in this case the inquest that will now follow may contribute to the prevention of further deaths in circumstances similar to those of Susan Nicholson and Caroline Devlin.

This article originally appeared on the UK Human Rights Blog.

FUNDAMENTAL DISHONESTY REMOVES COSTS PROTECTION

Suzanne Lambert

David Pegg v (1) David Webb (2) Allianz Insurance PLC [2020] EWHC 2095 (QB)

Introduction

Martin Spencer J held that a judge had erred in dismissing a personal injury claim but not finding that the Claimant had been fundamentally dishonest and, given the finding of fundamental dishonesty, CPR Rule 44.16 applied so that the Claimant lost the Qualified One Way Costs Shifting ("QOCS") costs protection.

Background

This appeal arose from a low-value claim for damages arising from a road traffic accident, where the Claimant was a front-seat passenger in a car that was rear-ended by another vehicle driven by the First Defendant. At trial, the Second Defendant argued that there was fundamental dishonesty on the part of the Claimant in two respects: first in relation to the collision itself (it either did not happen or was staged), and secondly (if the collision was found to be genuine) in relation to the injuries and damages said to have resulted from the collision.

At trial, the judge found that the collision was genuine but went on to find that the Claimant had not made out his case in relation to the nature and extent of the injuries suffered in part because he had pre-existing injuries and in part because he had suffered a quad bike accident after the index collision, which meant that his claim fell to be dismissed as he had failed to prove any injury or loss at all. The trial judge made clear that, in respect of the injuries, he had not found that the Claimant had been dishonest. He then went on to order the Defendant to pay 60% of the Claimant's costs, even though the claim had been dismissed, on the basis that the allegations of fundamental dishonesty made by the Defendant had turned what would otherwise have been a one-day fast-track claim into a two-day multi-track claim.

The Defendant insurer appealed the decision at first instance on two grounds. First that the trial judge was wrong in failing to make a finding of fundamental dishonesty pursuant to CPR Rule 44.16 against the Claimant. Secondly that the costs order was wrong in principle. The Defendant accepted the trial judge's finding that the collision was genuine.

Judgment

Martin Spencer J explained the meaning of the concept of fundamental dishonesty at [19] to [21] of his judgment by reference to the now well-known cases of *Gosling v Hailo*, 29 April 2014 (unreported), which was endorsed by the Court of Appeal in *Howlett v Davies* [2017] EWCA Civ 1696. He held at [20] that, in the present case, *"where the damages claimed are confined to pain, suffering and loss of amenity in relation to the injuries and the cost of physiotherapy, dishonesty as to the extent of the injuries would … be fundamental because the extent of the claimant's injuries is not merely incidental or collateral but forms the very basis of the claim. This is shown by, if nothing else, the fact that the learned judge, having been unable to find the injuries claimed proved, dismissed the claim."*

As to the meaning of "dishonesty", Spencer J referred to the test set out by the Supreme Court in *Ivey v Genting Casinos Limited (t/a Crockfords Club)* [2017] UKSC 67, which explains that the court must first ascertain (subjectively) the actual state of the individual's knowledge or belief as to the facts and then determine whether his conduct was honest by applying the (objective) standards of ordinary decent people.

He also referred to his own remarks (in the context of whiplash cases) in *Molodi v Cambridge Vibration Maintenance Service* [2018] EWHC 1288 (QB) that the problem of fraudulent and exaggerated whiplash claims is well recognised and judges in the county court should approach such claims "*with a degree of caution, if not suspicion",* before going on at [25] to consider carefully the evidence that had been before the trial judge in relation to the nature and extent of the injuries. That evidence, he held, "*pointed strongly, if not inexorably, to the conclusion that the Claimant had been dishonest in his presentation of his injuries*" and that the trial judge had failed to deal with that evidence adequately or at all. In summary, those factors included:

- The fact that the Claimant had not sought any medical assistance at all after the index accident. Rather he instructed solicitors, who then arranged for physiotherapy. That should have *"immediately have raised at least a suspicion in the mind of the judge".*
- In contrast, the Claimant attended A&E and the walk-in centre after his quad bike accident but failed to mention the index accident to the clinicians there nor did he refer to the injuries and symptoms arising from that accident. Spencer J referred to this as *"the first deafening silence".*
- The Claimant had failed to inform his medico-legal expert about the quad bike accident and the only inference was that he had deliberately done so in order to mislead the expert about the effects of the index accident. This was the second incidence of deafening silence.
- The position was "*significantly aggravated*" by the fact that the Claimant told his own expert "*positive lies*" about the longevity of his injuries (the injuries were resolved by the time he saw his expert), and about his physiotherapy being ongoing when he had been discharged after only four sessions.
- The Claimant "*compounded the dishonesty*" by lying about the longevity of his injuries in his witness statement and by adopting his expert's description of the injuries and prognosis for recovery when he signed the Statement of Truth in the Particulars of Claim and signed his witness statement. This formed the basis of his claim for damages.

Given those factors, Spencer J held that no judge could reasonably have failed to have come to the conclusion that the claim for damages as presented by the Claimant was dishonest. The appeal would therefore be allowed and the order dismissing the claim would be endorsed with a finding of fundamental dishonesty on the part of the Claimant in relation to the claim for damages [25].

As to costs, the parties agreed that in the event that the first ground succeeded, the costs order could not stand. The Defendant submitted that CPR 44.16 would be satisfied so that the Claimant would lose his QOCS costs protection. However, the Defendant also conceded that it would be appropriate to reflect the fact that it had failed to prove fundamental dishonesty in relation to the accident itself so that the Claimant would only be liable to pay 70% of the Defendant's costs. Spencer J agreed that this was the correct order given that a significant

part of the evidence and court time was directed towards the question whether the accident was bogus and the parties had colluded. Spencer J had no hesitation in rejecting the submission made on behalf of the Claimant ("*perhaps somewhat boldly*") that the Defendant should pay 60% of the Claimant's costs.

Comment

This is yet another decision in an increasing number of cases where fundamental dishonesty has been advanced successfully by defendants, thus depriving a claimant of the costs protection usually afforded by QOCS following the 2013 Jackson reforms.

There are in fact two separate and distinct regimes relating to fundamental dishonesty which can result in a claimant being required to pay the defendant's costs where there has been a finding of fundamental dishonesty. The first relates to unsuccessful claimants pursuant to CPR Rule 44.16. The second relates to successful claimants unders.57 of the Criminal Justice and Courts Act 2015.

As the trial judge dismissed the claim, the allegations of fundamental dishonesty raised by the Defendant fell to be considered in accordance with CPR Rule 44.16, which creates an exception to the QOCS regime by imposing liability on unsuccessful claimants to pay costs where they are found to be fundamentally dishonest on the balance of probabilities.

The Defendant had failed in relation to its allegations that the collision had not occurred or was staged but the trial judge found that the Claimant had not made out his case in relation to the nature and extent of the injuries so that his claim was dismissed. In other words, the trial judge found that the Claimant was unsuccessful. However, rather unusually, the trial judge awarded the unsuccessful Claimant 60% of its costs.

Given the finding of fundamental dishonesty on appeal, it followed that the Claimant would lose his costs protection pursuant to CPR 44.16. However, because the Defendant had lost on the issue of whether the collision was genuine, an issue which had taken up significant court time, it would only be able to recover 70% of its costs from the Claimant.

It is arguable that it would have been open to the trial judge to find that the Claimant had succeeded in his claim (having found that the collision was genuine) but then to go on to find that no award of damages should be made as he had not proven that he had suffered any loss or injury (or alternatively that the Claimant was entitled to nominal damages only if any loss or damage was found to be attributable). This would clearly not have changed the trial judge's failure to make a finding of fundamental dishonesty but, on appeal, it would have meant that the issue of fundamental dishonesty would fall to be considered under the second separate regime unders.57 of the 2015 Act, as has in fact been the approach in cases such as *Pinkus v Direct Line* [2018] EWHC 1671 (QB) where the claimant sought substantial damages for injuries suffered following a car accident. The defendant admitted causing the collision but disputed the nature and severity of the damage and consequential injuries. Although fundamental dishonesty had not been pleaded expressly, the claim was dismissed at trial in accordance withs.57 on the basis that the claimant was found to have deliberately and consciously exaggerated the facts around the accident, his consequential symptoms, and his pre-index situation so that his dishonesty was found to be *"close to the heart"* of the claim. The claimant would have been awarded damages but fors.57, but his claim was dismissed and he was ordered to pay the defendant's costs on an indemnity basis. Similarly, in *Sudhirkumar Patel v Arriva Midlands Limited* [2019] EWHC 1216 (QB), the defendant insurer relied on surveillance evidence to challenge the claimant's expert evidence that the claimant lacked capacity. His expert's previous assessment was found to have been made on the basis of incorrect information gleaned from the claimant's dishonest presentation and from false information from the claimant's son. It was held that the lifetime care needs claimed to be consequential upon the untenable psychiatric diagnosis were fundamentally dishonest and there would be no substantial injustice in dismissing the claim. (See also *Razumas v MOJ* [2018] EWHC 215 (QB)).

Where fundamental dishonesty is found in relation to successful claimants, the court is required to dismiss the entire claim, and the otherwise successful claimant is required to pay the defendant's costs subject to a deduction of damages as assessed by the court that would have been awarded but for the finding of

fundamental dishonesty (s57(5)). Where the notional damages are lower than the assessed costs, the claimant will have to pay the difference to the defendant.

There is room for argument that some judges would have awarded the Claimant some albeit very minimal damages for PSLA that resolved within weeks but the assessment of the Claimant's damages by the trial judge in the instant case was of course nil and therefore unders.57 there would be nothing to deduct from the Defendant's costs. It is also questionable whether the costs order in favour of the Defendant would be reduced to reflect the fact that it had failed in relation to the question of whether the collision was real. Under CPR44.16 there is express provision that the court may determine the costs attributable to the claim having been found fundamentally dishonest as it thinks "*fair and just*". Such equivalent provision is not present ins.57 and therefore the costs outcome for the Defendant arguably may have been even more favourable if the matter was decided unders.57.

SURVEILLANCE EVIDENCE AND FUNDAMENTAL DISHONESTY

Dominic Ruck Keene

Wilcox v King's College Hospital NHS Foundation Trust [2020] EWHC 2555 (QB)

Garraway v Holland & Barrett Limited [2020] 3 WLUK 582 (accessible on Lawtel and Westlaw only)

Two recent decisions consider the use of surveillance evidence in the context of fundamental dishonesty.

Wilcox v King's College Hospital NHS Foundation Trust [2020] EWHC 2555 (QB)

Lambert J upheld the order of Deputy Master Bard refusing the Defendant NHS Trust's application to rely on surveillance evidence of the Claimant at a trial listed for January 2021.

The facts

The claim arose out of an admitted delay in the diagnosis and treatment of the Claimant's cauda equina compression in August 2016. However, the Defendant argues that the Claimant would not have avoided the totality of his injuries.

The Claimant alleged that he suffered from a permanent disability with incomplete paraplegia at L3 with reduced lower limb strength and sensation, as well as neuropathic pain affecting both lower limbs. The pain was claimed to be exacerbated by walking and sitting for extended periods, and led the Claimant to require walking sticks, with his mobility being reduced to around 250 metres.

The Claimant served a supportive condition and prognosis report documenting right knee weakness, right foot drop, distal weakness in the left lower limb and chronic neuropathic pain. The report also supported the requirement for a commercial care regime. The outline Schedule of Loss also referred to potential claims for loss of earnings and adapted accommodation, as well as potentially a claim for 'buddy care' to assist for 2/3 days a week.

The Deputy Master's Decision

The Claimant was filmed over several days between July and December 2019. The Deputy Master accepted the submission made on behalf of the Claimant that there was nothing in the footage that particularly contradicted the Claimant's witness evidence. Sections of the footage in particular (which the Deputy Master viewed) were relied upon by the Defendant. One section showed the Claimant driving on a motorway in heavy traffic and poor weather conditions with poor visibility, suggesting that he remained a confident and competent driver; the

second showed the Claimant shopping in a crowded supermarket just before Christmas and mobilising up and down stairs, and the third showed him negotiating (with some difficulty) steps on a bus.

The Deputy Master concluded that the Claimant's ability to do these things was not inconsistent with the Claimant's case as put forward in the witness statement, not least because the Claimant had described himself in his statement as someone who tried to the extent possible to remain independent, who preferred to do things for himself if he could and who preferred not to use a wheelchair. The Deputy Master noted that the Claimant did not dispute the accuracy of the footage and observed that: "*the material sought to be relied on does not seem to me to be of particular substance; much of it could probably be dealt with by Part 18 questions or notices to admit – for example that the Claimant had driven 140 or 200 miles on the days in question; that he had walked in a crowded Waitrose supermarket before Christmas and so forth and there can be cross examination on those issues of him at trial.*"

The Deputy Master refused permission to rely on the footage on the basis that it was of marginal relevance. He also considered that, if the footage were to be admitted, it would impact upon the duration of the trial, adding perhaps a day to the listing and that additional litigation costs were bound to be incurred by the parties.

The sole ground of appeal was that the Deputy Master's ruling was wrong because there was no evidence concerning the potential value of the claim. There was no challenge to the finding that video footage was evidence without "*much substance to it*" nor to his conclusion that it was improbable that the footage would impact materially upon a substantial care claim, nor to his conclusion that the video footage did not justify the additional court time or the additional litigation expense.

Judgment

Lambert J held at [13] that it was difficult to see how the Deputy Master could have done anything other than refuse permission in light of his findings as to the marginal relevance of the footage, and the lack of any significant inconsistencies between the footage and what was claimed about the disabilities and their impact, as well as the increased trial length and costs. She held that:

> *"Whether the care claim was in due course to be valued at £1,000 or over £500,000 would make no difference to the outcome of the application if, having reviewed the footage and cross-referenced it with the Claimant's own evidence there was no significant inconsistency. That is not to say that there may not be other valid grounds upon which the Defendant may yet, at trial, challenge a very high care claim (or housing or travel claim). But deploying evidence which has not " much substance " would be no more than an expensive distraction and wholly inconsistent with the overriding objective… There may be other lines of attack to be deployed by the Defendant at trial if it is faced with an exaggerated Schedule, but a video which does not significantly undermine the Claimant's own account of what he can or cannot do by reason of his injury is unlikely to assist either the Defendant or the court at trial in resolving the true position of the Claimant's current and future level of amenity."*

Further, the Defendant had failed to take any steps to give any broad indication to the Deputy Master as to the potential value of a buddy care regime.

Lastly, even if the care claim could amount to £500,000 – "*given the unchallenged finding of the Deputy Master concerning the marginal relevance of the evidence, in conjunction with the need to allocate resources fairly across the cohort of all court users, together with the increase of litigation costs, I would have no difficulty in refusing permission. The video evidence is not admissible simply because it is not relevant.*"

Garraway v Holland & Barrett Limited [2020] 3 WLUK 582 (accessible on Lawtel and Westlaw only)

The facts

The Claimant was a 63-year-old singer and music teacher who was involved in an accident at the Defendant's shop in the Arndale Centre, Eastbourne on 30th December 2013. She struck her head on a metal shutter in the

doorway of the shop, which had been partly lowered just ahead of closing time. Liability was admitted and the trial was on the issues of causation and quantum only.

HHJ Simpkiss stated that there was a very considerable discrepancy between what the Claimant claimed were her injuries resulting from the accident, and the documentary evidence of her injuries and the medical experts' view of them. Further, the Defendant had obtained surveillance evidence that contradicted the Claimant's evidence as to her ability to do things, and her account to each of her experts about her abilities.

Judgment

HHJ Simpkiss reiterated the principles concerning a trial judge's determination of witness credibility from *R (Bancoult) v Secretary of State for Foreign and Commonwealth Affairs* [2018] UKSC 3, namely: the importance of (contemporary) documentary evidence in assessing the credibility of oral witnesses; the relevance of the witness's motives and the overall probabilities where there is a conflict of evidence; and the value of the opportunity afforded by cross examination being to gauge the personality, motivations and working practices of a witness, rather than to elicit recollection of particular conversations and events.

He began by considering the Claimant's claim that she had suffered a very serious concussion and been knocked out, and she developed pain in her lower back from trying to get up from lying down. He noted that the medical records stated that the Claimant had not been knocked out, and made no reference to any concussion. He concluded that at best the concussion was minor and was overstated.

HHJ Simpkiss then considered the alleged back pain and emphasised how contradictory her evidence in cross examination was in respect of this injury, and further that, despite been seen by 13 different medical professionals on 6 occasions over the first 2 weeks following the incident, there was no mention of back pain or related symptoms in her notes. He held that it was not credible that she would not have told them, or that if she had, they would not have recorded it.

He then went on to consider the surveillance evidence, which was taken on the same day that she was assessed by the Defendant's orthopaedic expert. She had completed a Disability Index questionnaire to the effect that she was e.g. unable to walk for more than 100 yards, or lift anything, or stand for more than 10 minutes. In cross examination prior to watching the surveillance evidence she was asked if any of her answers to the questionnaire had been true – *"Her reply was equivocal: 'With explanations …there are times when I push myself more. I can do better on some days than on other days.' This was transparently said in anticipation of watching the footage, which she knew might cause her problems."*

HHJ Simpkiss summarised the surveillance evidence as showing the Claimant demonstrating no difficulty bending, walking, or standing. He further noted that her own expert had concluded that the video showed no abnormal features. He concluded that:

> *"There is a stark discrepancy between the way the Claimant has described her medical condition in her witness statements and to the medical experts and the video surveillance evidence, and between the medical notes and her own account now of how the back pain developed.*
>
> *Finally, the Claimant failed to disclose to either medical expert an incident of back pain 13 months before the accident…*
>
> *I am therefore unable to accept as credible any evidence from the Claimant unless it is clearly supported by cogent documentary or other reliable evidence…*
>
> *…the Claimant's back injuries were not caused by the accident.*
>
> *The Claimant has convinced herself that it did, but that belief is not consistent with the chronological development of the symptoms and the medical evidence. As a result, the Claimant has missed no opportunity to justify her belief and to persuade the court that she has proved her case. This has led her to exaggerate her condition to the experts and to attribute symptoms to the accident which there is no rational reason to do. She has misled the experts. In particular, she is recorded by Mr. Ross on 2nd March*

2017 as stating that " she had not experienced lumbar spinal symptoms or sciatica prior to the material incident…"

As a result, he held that the Claimant had been fundamentally dishonest for the purposes of s.57 of the Criminal Justice and Courts Act 2015 in how she had presented her case, and in her presentation of her condition to both the court and to the experts. What she had done was "*objectively dishonest and in doing so, she has misled the experts. Nothing could be more fundamental in a personal injury claim of this nature than to give the experts a false impression of her condition."* Accordingly, he dismissed the claim and awarded the Defendant its costs.

Comment

These two cases are reminders of:

(a) The importance, when seeking permission to deploy covert surveillance to counter a potentially exaggerated claim, of ensuring that the footage is a sufficiently compelling 'smoking gun'.

(b) That while there is a general reluctance on the part of Defendants to incur the expense and complication of seeking surveillance evidence, nevertheless, the right footage, in the right case, can still be compelling evidence, in particular if it supports a potential claim for fundamental dishonesty on the part of a Claimant.

GDPR AND INACCURATE CLINICAL RECORDS

Dominic Ruck Keene

R (Mrs AB) v Northumbria Healthcare NHS Foundation Trust, Cumbria Northumberland Tyne and Wear Foundation Trust [2020] EWHC 2287 (Admin)

HHJ Davis-White sitting as a judge of the High Court refused the Claimant's renewed application for permission to bring a judicial review proceedings challenging the refusal to delete inaccurate information concerning her 17-year-old son's sexual behaviour from his medical records.

The facts

The Claimant's son ("V") suffered from Autism Spectrum Disorder and Attention Deficit Hyperactivity Disorder. From about 2008, he had been under the care of the first defendant, the Northumbria Healthcare NHS Foundation Trust ("Northumbria Trust"), primarily through the Child and Adolescent Mental Health Services.

The claim was that the refusal to delete various records amounted to a breach of the GDPR and the Data Protection Act 2018, as well a breach of the Equality Act 2010. Those dispute centred around a referral from Northumbria Trust to the Forensic Child and Adolescent Mental Health Service ("F-CAMHS") within the Second Defendant ("CNTW Trust"). The referral was inaccurate in suggesting that V had been observed looking at images of naked babies, when in fact the babies had been clothed or wearing nappies. Secondly, regarding the frequency with which V had masturbated - rather than twice a day the incidents were at most two in all.

Following a complaint made by the Claimant, the Northumbria Trust wrote to the CNTW Trust providing updated information about the First Referral and correcting the two points concerning the babies not being naked and the incidence of masturbation. The writer asked, "*At the request of Mrs AB, I would be grateful if the initial referral to the forensics team could now be deleted from your systems..."*

Records from the CNTW Trust showed that their progress notes were updated to refer to the letter from Northumbria Trust setting out the inaccuracies in the information that had been provided, stating the correct position, and that the letter was to be uploaded. However, the CNTW refused to delete the records.

The Claimant also complained to the ICO.

Judgment

HHJ Davis-White emphasised at [39] that judicial review is a remedy of last resort, and where there is or was an adequate alternative remedy, that remedy should be, or should have been, pursued and that route exhausted before deploying judicial review proceedings.

He held that a complaint to the ICO under s.165 Data Protection Act 2018 was on the facts of the case an adequate alternative remedy that should have been pursued first.

He went to hold that in any event, provided there were adequate notes of any inaccuracies, the retention of the records was lawful under the public health exemption in Article 9(1)(h) of the GDPR, for which consent was not required. Accordingly, the exemption from erasure under Article 17(3) applied.

Comment

Heath providers are increasingly being requested to delete allegedly inaccurate medical records. This case is a useful reminder to consider (1) whether a complaint to the ICO should have been pursued first (if the claim is brought by way of judicial review), and (2) generally, whether any inaccuracy can be addressed by way of an explanatory note. The deletion of clinical records should not be undertaken lightly.

PRIVATE INTERNATIONAL LAW AND CLINICAL NEGLIGENCE (PART 2)

Charlotte Gilmartin

Roberts v Soldiers, Sailors, Airmen and Families Association – Forces Help [2020] EWCA Civ 926

The Court of Appeal has confirmed that the Civil Liability (Contribution) Act 1978 ("the 1978 Act") has extra-territorial effect and applied its limitation period to a contribution claim brought by the MOD and Soldiers, Sailors, Airmen and Families Association – Forces Help ("SSAFA") against a German Hospital in the context of clinical negligence litigation.

The facts

The underlying clinical negligence proceedings were covered in detail in Issue 6. In summary, the Claimant was born in a German Hospital, "AKV", in 2000 and suffered brain damage at birth. It was alleged that this was caused by the negligence of an English midwife working at AKV. The midwife was employed by SSAFA. Proceedings were brought in the High Court against SSAFA and the MOD. SSAFA and the MOD in turn brought contribution proceedings against AKV.

The Court of Appeal was tasked with determining whether, as a matter of statutory construction, the 1978 Act had extra-territorial effect. The parties agreed that if German law applied to the contribution claim, it would be out of time. However, if the 1978 Act had extraterritorial effect and liability arose under it, the contribution claim would be in time.

The key provisions of the 1978 Act under analysis were as follows:

> ***"1 Entitlement to Contribution***
>
> *(1) Subject to the following provisions of this section, any person liable in respect of any damage suffered by another person may recover contribution from any other person liable in respect of the same damage (whether jointly with him or otherwise).*
>
> *…*
>
> *(6) References in this section to a person's liability in respect of any damage are references to any such liability which has been or could be established in an action brought against him in England and Wales by or on behalf of the person who suffered the damage; but it is immaterial whether any issue arising*

in any such action was or would be determined (in accordance with the rules of private international law) by reference to the law of a country outside England and Wales.

…

7 Savings

…

(3) The right to recover contribution in accordance with section 1 above supersedes any right, other than an express contractual right, to recover contribution (as distinct from indemnity) otherwise than under this Act in corresponding circumstances; but nothing in this Act shall affect –

(a) any express or implied contractual or other right to indemnity; or

(b) any express contractual provision regulating or excluding contribution;

which would be enforceable apart from this Act (or render enforceable any agreement for indemnity or contribution which would not be enforceable apart from this Act).”

At first instance, Soole J found that the Act did have extra-territorial effect.

Reasoning of the Court of Appeal

The natural meaning of the statute

Irwin LJ began by noting that entitlement to bring a contribution claim under the Act depended on threshold conditions in section 1, including the condition under s.1(6), whereby the liability of each tortfeasor to the claimant is confined to “*the liability which has been or could be established in an action brought against him in England and Wales by or on behalf of the person who suffered the damage*”. The subsequent qualification in s.1(6), namely that “*it is immaterial whether any issue arising in any such action was or would be determined (in accordance with the rules of private international law) by reference to the law of a country outside England and Wales*”, showed that the liability had to be able to be established in an English court, but not necessarily by application of English law [54]. On the face of it, the threshold condition could therefore be established where an English court would give judgment against both tortfeasors, even when applying foreign law to all the issues in the case. Irwin LJ noted: “*If by its own terms the Act applies in relation to the principal liability of the tortfeasors, even where the proper law of the tort is foreign law, then why should a consequential contribution claim where the proper law of the claim is foreign law, fall outside the ambit of the Act*?” [55].

Irwin LJ went on to accept the Respondent’s interpretation of the Respondent of s.7(3), finding that it was difficult to see why the right to recover contribution under the 1978 Act, which by virtue of s.7(3) “*superseded any right, other than an express contractual right, to recover contribution*”, would not include provisions of foreign law [59-61]. The German law which would otherwise have applied to the contribution claim could therefore be displaced.

The purpose of the statute

Irwin LJ held that it was *“tolerably clear”* that Parliament’s purpose in enacting the 1978 Act had been to “*simplify and standardise*” contribution claims [64]. Further, s.1(6), stipulating that liability must be capable of being established in England, also stipulated that it might be established on the basis of foreign law. Irwin LJ considered that if that was established in a given action, there was an obvious question as to what law would govern the contribution claims in such cases. It was notable that “*it would have been simplicity itself to provide that where the proper law of the contribution claim was a foreign law, then the statutory right did not arise. Parliament set no such limit or exclusion*” [64]. The natural interpretation of the language of the Act therefore sat well alongside the standardisation and simplification purpose.

Principles of extra-territorial effect

Finally, Irwin LJ held that this interpretation was consistent with principles of extra-territorial effect articulated in *Cox v Ergo Versicherung AG* [2014] UKSC 22 by Lord Sumption. These were that unless the contrary was expressly enacted or so plainly implied that the courts had to give effect to it, UK legislation was not extraterritorial in effect. The relevant question in the instant case was therefore whether anything in the language of the Act suggested that its provisions were intended to apply irrespective of the choice of law derived from ordinary principles of private international law. Irwin LJ held that the language of s.7(3) had that effect [67].

Phillips LJ agreed with Irwin LJ's analysis; however, although David Richards LJ agreed that the 1978 Act had extra-territorial effect, he based his conclusion on s.1(6), finding that the language of s.7(3) was consistent with either outcome [95].

Comment

This is an important decision with significant practical effect for clinical negligence litigation involving contribution claims in an international context. It suggests that in claims for contribution or indemnity which are heard in the courts of England and Wales, the 1978 Act will apply, including its provisions on limitation. However, take note that this is not a certitude in all cases: the applicable law in this case was not governed by the Rome II Regulation which would apply to contribution claims relating to damage after 11 January 2009. The position as regards extra-territoriality in such cases is yet to be resolved by the courts.

PRACTICAL JOKES AND PERSONAL INJURY

Michael Deacon

Chell v Tarmac Cement and Lime Limited [2020] EWHC 2613 (QB)

If, for reasons best known to themselves, anyone were tempted to engage Spencer J in a practical joke, they may wish to take heed of the opening words of his recent personal injury appeal judgment in *Chell v Tarmac Cement and Lime Limited* [2020] EWHC 2613 (QB):

> *"The practical joke must be the lowest form of humour. It is seldom funny, it is often a form of bullying and it has the capacity, as in the present case, to go seriously wrong. Mark Twain was surely right when he said:*
>
> *"When grown-up persons indulge in practical jokes, the fact gauges them. They have lived narrow, obscure, and ignorant lives, and at full manhood they still retain and cherish a job-lot of left-over standards and ideals that would have been discarded with their boyhood if they had then moved out into the world and a broader life.""*

One can well understand Spencer J's ire at the very concept of a prank when the facts of the case which came before him are considered.

The facts

The Claimant's services as a fitter were contracted out to the Defendant company ("Tarmac") by his employer ("Roltech"). There had been on-site tension between Tarmac's own fitters and Roltech's fitters, a matter which the Claimant had raised with Tarmac's site supervisor.

In September 2014 one of Tarmac's own fitters, Mr Heath, demonstrated that he had failed to discard the standards of his boyhood by detonating two explosive pellets next to the Claimant. This was apparently intended as a practical joke but the Claimant, at the age of 34 years, was left with a perforated right eardrum, noise-induced hearing loss and tinnitus. Mr Heath, who also had a role as a health and safety assessor, was dismissed.

The decision at first instance

The Claimant brought a personal injury claim against Tarmac. The key issues at trial before HHJ Rawlings were, first, whether Tarmac was vicariously liable for the actions of Mr Heath, its employee, and secondly, whether Tarmac itself owed a direct duty to the Claimant to take reasonable steps to prevent his injury, and whether it was breached.

Both issues were decided in Tarmac's favour.

In relation to vicarious liability, applying the second stage of the test set out in *Lister v Hesley Hall Limited* [2001] UKHL 22, the judge found that there was not a sufficiently close connection between, on the one hand, the employer/employee relationship that existed between Mr Heath and Tarmac and in particular the field of activities entrusted to Mr Heath and, on the other, the practical joke. That conclusion was founded, *inter alia,* on the findings that:

i. The practical joke did not form part of, and was unconnected to, Mr Heath's work, and the explosive pellets were not site equipment but rather were brought to work by Mr Heath. As HHJ Rawlings put it: *"…work merely provided an opportunity to carry out the prank…rather than the prank in any sense being in the field of activities that Tarmac had assigned to Mr Heath."*

ii. While Tarmac had been made aware of tensions between the Tarmac fitters and the Roltech fitters, there had been no suggestion that those tensions might lead to physical violence and, in any event, the intention of Mr Heath had been humour rather than harm.

That there had been no indication that Mr Heath might be violent or volatile was also a key factor in the finding that there was not a reasonably foreseeable risk of injury from a deliberate act on the part of any Tarmac employee, and therefore there had been no duty on Tarmac to take reasonable steps to avoid that risk. HHJ Rawlings also found that, even if there had been such a duty, there would not have been a breach, because the site health and safety procedures had prohibited intentional or reckless misuse of equipment.

The decision on appeal

The Claimant's appeal to Spencer J was entirely unsuccessful.

In relation to vicarious liability, the Claimant argued that although HHJ Rawlings correctly identified the "close connection" test, he applied it too narrowly in that he wrongly excluded inter alia the following from his analysis:

- Mr Heath's evidence was that the prank had been intended to lighten the mood following recent tensions. Therefore, the prank arose out of an issue germane to Mr Heath's employment, which Tarmac had failed to address.
- The transition from regular working activity to the prank must have been seamless, and therefore was connected to Mr Heath's employment.

In reality, rather than a challenge on a point of law, this appears to have been an argument that the trial judge gave insufficient weight to factors said to be in the Claimant's favour and excessive weight to those said to be in Tarmac's favour. Such arguments are often an uphill battle, and Spencer J could find no fault in HHJ Rawlings' analysis. Further, Spencer J found that the trial judge's conclusions were strengthened by the Supreme Court's decision in *Morrisons v Various* [2020] UKSC 12 in two respects:

a) Lord Reed in Morrisons had reiterated the importance of the distinction between an employee who commits an act (however misguidedly) to further his employer's interests and one who commits an act to pursue his own interests. The present case was a clear example of the latter.

b) The decision in Morrisons, as counsel for the Claimant was forced to concede before Spencer J, reduced even further the significance of any temporal connection between the act complained of and the employment.

Spencer J also rejected the Claimant's argument that the judge had been wrong to find that there was no direct duty on Tarmac and no breach of the same, endorsing HHJ Rawlings' reasoning.

Comment

While decided on its facts, this case is of assistance as a recent application of the law on vicarious liability, following Morrisons, to a situation where a practical joke in the workplace caused injury (not an uncommon occurrence). The way in which the "close connection" test is analysed is of broader assistance.

Further, it is noteworthy that, although rejected, Mr Heath's evidence was that he played the prank to improve workplace relations. Had that evidence been accepted, one could conceive of an argument that the prank was played to further his employer's interests, and therefore the connection between the prank and his employment was sufficiently close. The other factors at play – including that the prank was not connected to the tasks involved in Mr Heath's employment – may have proved decisive in any event, but it seems possible following Morrisons that the altruistic prankster may yet leave an employer with damages to pay.

Whether Spencer J would look more kindly on such a practical joker is open to interpretation.

COURT OF PROTECTION UPDATE

Matt Flinn

Cumbria County Council v A [2020] EWCOP 38

Tower Hamlets LBC v PB [2020] EWCOP 34

The Court of Protection has confirmed that where a Deputy wishes to stop acting, they cannot do so by simply withdrawing their consent to act. An application to cease acting must be made to the court, which does have some discretion when considering whether to allow such a change.

If a Property and Affairs Deputy for a protected party wishes to cease acting in that capacity, can they be forced to continue? The answer is more nuanced than one might initially think.

In this matter, a professional Deputy (a solicitor) applied to the court to be appointed as Property and Affairs Deputy in seven cases. The existing Deputy in each case was Cumbria County Council, which had devised certain criteria, the application of which led to the conclusion that it no longer wished to act as Deputy in respect of the seven cases. It therefore asserted its desire to relinquish its position and supported the professional Deputy's application to be appointed in its place.

The Court noted that under section 19(3) of the Mental Capacity Act 2005, a person could not be appointed Deputy without their consent. It did not follow, however, that after their appointment, they could withdraw their consent and cease to act without reference to the court. Reasoning by analogy from the case of *Bradbury v Paterson* [2014] EWHC 3992 (QB) (which dealt with applications to discharge the Official Solicitor as a litigation friend) the court confirmed that an application to the court had to be made. Nor did it follow that such an application would inevitably succeed. The court would consider all the facts of the case and determine the application based on what was in the best interests of the protected party concerned.

Relevant considerations would include the extant Deputy's reasons for wishing to cease acting (e.g. it would be extremely difficult to force an individual Deputy to continue acting beyond their retirement), the size and complexity of the estate, and the nature and state of the relationship between the protected party and the Deputy. The cost to the estate of switching, for example, from a public body to a private professional, could also be relevant.

In practical terms, this judgment is likely to be of most interest to public bodies providing Deputyship services, such as local authorities. Although it is clear that a refusal to continue acting as Deputy is not sufficient to achieve

that result, it is only where the court is dealing with something like a local authority that declining an application to cease acting is a realistic possibility - it is only in such cases that the court could require a Deputy to continue acting whilst having confidence that a proper and professional service would continue to be provided to the protected party.

Tower Hamlets LBC v PB [2020] EWCOP 34

In this case involving a man with a long history of severe alcohol misuse, the Court of Protection emphasised the importance of preserving autonomy under the scheme of the Mental Capacity Act 2005, and reiterated the distinction between making very unwise decisions, and lacking capacity to make them at all.

PB had a long history of severe alcohol misuse, to the extent that he had sustained brain injury and developed features of a dissocial personality disorder. He also had a range of physical co-morbidities, including Chronic Obstructive Pulmonary Disease ("COPD"), Hepatitis C and HIV.

Following a period of street homelessness and a stay in hospital in 2019, PB was discharged to a supported living placement in a unit operated by the applicant Council, and subjected to a very vigorous regime intended to restrict his access to alcohol (for example, he was not permitted to leave the facility without an escort). PB deeply resented the restrictions on his ability to drink, and although he recognised he had a drinking problem, he felt that he should be permitted to work towards a habit of drinking in moderation.

The Council applied to the Court of Protection to determine whether PB had capacity to take decisions as to his care and living arrangements, and sought guidance more generally on the proper approach to the assessment of capacity in respect of individuals who are alcohol-dependent.

The judgment of Hayden J provides an extremely useful digest of the core principles guiding capacity assessments, and a salient reminder as to the philosophy underpinning the Mental Capacity Act 2005 ("MCA 2005").

Most prominently, Hayden J emphasised the cardinal importance of the presumption of capacity enshrined in section 1(2) of the MCA 2005, saying that it is "every bit as important as the presumption of innocence in a criminal trial" and that *"[t] he philosophy informing the legal framework illuminates the point that this case highlights, namely 'a person is not to be treated as unable to make a decision merely because he makes an unwise decision'"* [6].

In the case at hand, the consultant psychiatrist who reported on PB initially concluded that he had an impairment of the functioning of the mind or brain, caused by alcohol-related brain damage and a dissocial personality disorder, but that he nevertheless had capacity to make decisions concerning his care and residence. Although the expert felt that PB seriously overestimated his ability to control his drinking, he said that:

(a) *minimisations, rationalisations and justifications despite all evidence to the contrary are typical of people with substance dependence who are not generally considered to lack capacity;*

(b) *[PB] did not exclude the possibility he could die and defended his decision to continue drinking on grounds of autonomy ("it's my life") and fatalism ("I've not got long to live"); and*

(c) *his answers showed "sufficient understanding and acceptance of the risks to his health and well-being that would result from a decision to go back to drinking". Although [PB's] aim to keep drinking in moderation was unrealistic, "he was using the information that returning to more excessive drinking would be dangerous".*

However, after an unsuccessful trial period in which PB was allowed to leave the unit unescorted for limited periods and came back intoxicated (and behaving abusively), the psychiatrist revised his position, on the basis that PB was not able to appreciate and weigh up the fact that "beyond doubt" he was likely to drink to excess if not supervised.

Hayden J felt that this imposed a test which was too demanding, and which would potentially place alcohol-dependent people in an invidious position. At [29] he said:

> *"…It strikes me as imposing a very challenging test of capacity to expect an alcoholic, who continues to drink, to be required to concede or acknowledge "beyond doubt" that he is unable to control his drinking and to such a degree that it has become a "certain" fact that he will drink to excess if not supervised. A test which is so absolute and unyielding is difficult to reconcile with the fundamental principles of the MCA, set out above. The effect of such a test strikes me as eroding, very significantly, "the space"…between a decision which is unwise and one which an individual does not have the capacity to take. The application of Dr Costafreda's test would have the alarming effect of rendering most addicts incapacitous if they are unable to agree with the precepts of the test whilst, to my mind, making a deprivation of liberty almost inevitable to those who are able to agree "beyond doubt" that they are "certain" to drink to excess. Thus, a paradigm catch 22 scenario is created."*

He emphasised that when deciding whether an alcohol-dependent person had capacity to take decisions relating to their care and living arrangements, the court should focus not on whether the person has capacity to decide whether to drink alcohol or not, but on whether that person is able to appreciate and weigh up the consequences of drinking to excess on their care and living circumstances. In that regard Hayden J said at [42]:

> *"…PB analyses his dependency on alcohol in a way which is both articulate and rational. He is also clear as to the dire consequences of his drinking to excess. He makes the association between the consequences of drinking to excess and the impact on his care arrangement. He reconciles the two in his own mind by his conclusion that he should stay where he is but moderate his drinking to reasonable limits. There is within his plan an inherent recognition that drinking to excess and the sustainability of the placement are irreconcilable. There is much evidence from PB's history that he is unlikely to be able to achieve this, but the potential gulf between his aspiration to moderation and the likely reality, does not negate the thought processes underpinning his reasoning. In any event I do not consider that there is evidence here which is sufficiently choate to rebut the presumption of capacity. The plan that PB identifies may not be sustainable long term but that does not permit an inference that he is unable to foresee the consequences of drinking to excess on the sustainability of the placement."*

He went on to say at [44]:

> *"It is difficult to resist the conclusion that Dr Costafreda, having plainly identified a regime of abstinence and sobriety as being in PB's best interest, considered that his resistance to it and the stark consequences that might flow from it, must indicate an incapacity in his reasoning. The far more obvious conclusion, on the evidence, is that Dr Costafreda recoiled from PB's bad decision. The decision may hasten PB's death but PB, like any of us and for the reasons foreshadowed above, is entitled to make bad decisions if he chooses to do so. This is the respect for individual autonomy which courses through the MCA .*

As a result, PB was found to have capacity to make decisions as to his care and living arrangements.

At the conclusion of his judgment, Hayden J summarised some useful principles to be borne in mind when considering capacity issues and the operation of the MCA 2005 in relation to alcohol-dependent people. They provide a fitting way to conclude this article:

i. *The obligation of this court to protect P is not confined to physical, emotional or medical welfare, it extends in all cases and at all times to the protection of P's autonomy.*

ii. *The healthy and moral human instinct to protect vulnerable people from unwise, indeed, potentially catastrophic decisions must never be permitted to eclipse their fundamental right to take their own decisions where they have the capacity to do so. Misguided paternalism has no place in the Court of Protection.*

iii. Whatever factual similarities may arise in the case law, the court will always be concerned to evaluate the particular decision faced by the individual (P) in every case. The framework of the Mental Capacity Act 2005 establishes a uniquely fact sensitive jurisdiction.

iv. The presumption of capacity is the paramount principle in the MCA . It can only be displaced by cogent and well-reasoned analysis.

v. The criteria for assessing capacity should be established on a realistic evaluation of what is required to understand the ambit of a particular decision by the individual in focus. The bar should never be set unnecessarily high…The professional instinct to achieve that which is objectively in P's best interests should never influence the formulation of the criteria on which capacity is assessed.

vi. It follows from the above that the weight to be given to P's expressed wishes and feelings will inevitably vary from case to case.

COSTS UPDATE

Sarah Lambert QC

Re PLK [2020] 9 WLUK 364

An end to the 2010 level of costs recovery set by the Guideline Hourly Rates for Costs Review is under way, some comfort in the meantime comes from Master Whalan in the SCCO in *Re PLK [2020] 9 WLUK 364.*

For the past decade hourly rates have been based on the Solicitors' Guideline Hourly Rates, guideline figures for carrying out a summary assessment of court costs, listed by pay band and grade for different parts of the country, found at https://www.gov.uk/guidance/solicitors-guideline-hourly-rates. Practitioners have been frustrated for years by the lack of updating, not least when a review of the rates due in 2014 under the Foskett committee made no recommendations for any increase due to lack of evidence.

In the meantime, receiving parties have been spending their time advancing well worn (and meritorious) arguments that (1) the guideline rates are 10 years old and at the very least should be adjusted for inflation; (2) they are guidelines, not tramlines; (3) they are at best a starting point; (4) they are suitable only for the assessment of costs in cases lasting 1 day or less (being for summary assessment, with cases lasting over 1 day having their costs sent to detailed assessment rather than summarily assessed.) Judges have in turn become adept at making their own assessments of an appropriate hourly rate for any particular case, having regard to all the circumstances, including the conduct of the parties, the value of the claim, the importance of the matter to the parties, the complexity of the issues, and the skill, time and effort spent: CPR 44.4.

Matters however progress. In the autumn of this year Mr Justice Stewart was commissioned by the Master of the Rolls to chair a working group tasked with gathering evidence of rates allowed in practice by costs judges and costs officers on detailed assessments (including provisional assessments), in order to make recommendations to the Deputy Head of Civil Justice and to the Civil Justice Council. Members of the group include Senior Costs Judge Andrew Gordon-Saker, Judge Bird (DCJ Greater Manchester) and District Judge Simon Middleton, as well as solicitors, a barrister, representatives of CILEx, consumers and the MoJ. A member of the Civil Justice Council has also joined the group. Evidence is being gathered between 1 September and 27 November, with a view to reporting by the end of this year, with updated rates hopefully being published in the first half of 2021.

There has also been recently more vocal judicial pronouncement on the lack of contemporaneous utility of the 2010 rates. Firstly in *Ophen Operations Ltd v Invesco Fund Managers Ltd* [2019] EWHC 2504 (TCC) O' Farrell J had the following to say, [14] "*As to the first point, the hourly rates of the defendant's solicitors are much higher than the SCCO guideline rates. It is unsatisfactory that the guidelines are based on rates fixed in 2010 and reviewed in 2014, as they are not helpful in determining reasonable rates in 2019. The guideline rates are*

significantly lower than the current hourly rates in many London City solicitors, as used by both parties in this case. Further, updated guidelines would be very welcome."

The court recognized the reasonableness of a market rate for skilled legal services as follows, [15] … *"Although the value of the case is not particularly high for this court, the technical nature of the dispute justifies the engagement of solicitors with the appropriate skill and expertise to ensure proper and efficient conduct of the litigation. Solicitors providing such skill and expertise are entitled to charge the market hourly rate for their area of practice. The hourly rates charged cannot be considered in isolation when assessing the reasonableness of the costs incurred; it is but one factor that forms part of the skill, time and effort allocated to the application. It may be reasonable for a party to pay higher hourly rates to secure the necessary level of legal expertise, if that ensures appropriate direction in a case, including settlement strategy, with the effect of avoiding wasted costs and providing overall value."*

Most recently, and significantly, is the decision of Master Whalan in the SCCO in *Re PLK EWHC [2020] B28 (Costs).* This 30 September 2020 decision puts the commercial reality of 2020 costs, of Deputies, fully in the spotlight. A chosen selection of 4 Deputies, responsible for the management of property and affairs of protected parties, had their costs assessments consolidated specifically to allow the SCCO to address the perceived unfairness of basing costs on the guideline rates. The 'test' cases were chosen specifically to represent regional variations. Of the 4, 2 represented parties who suffered brain injuries at birth, and 2 had sustained head injuries as a result of RTAs. The assessments raised a common point of principle applicable to the decisions of Costs Officers and Costs Judges when assessing costs incurred in the Court of Protection ('COP') by a court appointed Deputy (and his/her associates) in the general management of the affairs of a protected party. The issue for determination concerned the method of assessment of the hourly rates claimed by Deputies. The applicants challenged the application of the Guideline Hourly Rates as being unjust, and sought a more flexible exercise of the discretion conferred by CPR 44.3(3), whereby the GHR are utilised as merely a 'starting point' and not a 'starting and end point'.

Master Whalan did not accept that Deputies' own costs and overheads had increased such as to render an increased hourly rate automatically appropriate, but broadly accepted he was [35] "*satisfied that in 2020 the GHR cannot be applied reasonably or equitably without some form of monetary uplift that recognises the erosive effect of inflation and, no doubt, other commercial pressures since the last formal review in 2010. I am conscious equally of the fact that I have no power to review or amend the GHR. Accordingly my finding and, in turn, my direction to Costs Officers conducting COP assessments is that they should exercise some broad, pragmatic flexibility when applying the 2010 GHR to the hourly rates claimed. If the hourly rates claimed fall within approximately 120% of the 2010 GHR, then they should be regarded as being prima facie reasonable. Rates claimed above this level will be correspondingly unreasonable. To assist with the practical conduct of COP assessments, I produce a table below which demonstrates the effect of a 20% uplift of the 2010 GHR. I stress again that I do not purport to revise the GHR, as this court has no power to do so; instead this is a practical attempt to assist Costs Officers and avoid unnecessary delay (caused by individual re-calculation) in a busy department conducting over 8000 COP assessments per annum*."

Whilst a blanket % uplift simply for inflation was expressly rejected, in reality this is the effect of the decision.

Following *PLK* the Senior Costs Judge has published a new practice note setting out the meaning and limitations of the decision, at https://www.judiciary.uk/wp-content/uploads/2020/10/Practice-Note-COP-1.pdf. The judgment recognised that costs officers should *exercise some broad, pragmatic flexibility when applying the 2010 GHR to the rates claimed* and that *if the rates claimed fall within approximately 120% of the GHR they should be regarded as prima facie reasonable* [35]. The judgment does not disapply or abrogate the indemnity principle. Consequently, costs officers will have no discretion to allow higher hourly rates than have been claimed. The judgment will be of relevance only where rates in excess of the 2010 GHR have actually been claimed in the bill.

The increase applies only to recent work: the judgment is limited to the years 2018 and following [35]. While it is recognised that every bill is fact specific, it was noted [30] that the approach taken in the cases of *Louise Smith* and *Yazid Yahiaoui* remains applicable. It follows that bills up to 31 December 2017 will continue to be assessed

by costs officers on that basis and that *save in exceptional circumstances* the 2010 guideline hourly rates (GHR) will continue to apply.

Whilst *PLK* applies specifically only to Deputy / Court of Protection costs, it is inevitable that it assists with all other areas of costs. For personal injury and clinical negligence practitioners there is scope within the decision itself to argue for potentially even higher increase than the 20%, the Master having referred expressly to the higher expenses incurred in such areas as follows, [29] "*However reliable the figures produced may be, they do not, in my view, demonstrate that the burden is one that is exclusive to COP work or that it is atypically high in comparison with that experienced by practitioners in comparable areas of practice. Fee earners in personal injury, medical and professional negligence, for example, incur invariably time and expense that is irrecoverable, in marketing, accessing cases that are not proceeded with or, indeed, pursued and lost. These are burdens which do not apply to Deputy's sources of work (on a case by case basis) which is often consistent and predictable over many years.*"

Further decisions are highly likely, but for now, for 2018 work onwards, there is much to be hopeful for personal injury and clinical negligence fee earners.

EVENTS & NEWS

News

Chambers is delighted to announce that Andrew Kennedy has been appointed to Queen's Counsel.

Congratulations to John Whitting QC on his reappointment to the Welsh Government Panel of Queen's Counsel and Christian Howells for his promotion to the Welsh Government A Panel of Counsel.

Podcast

Rachel Marcus and Jim Duffy discuss **essential Inquest Law updates** with Emma-Louise Fenelon on **Law Pod UK**. Further news, events, webinars and previous QMLR issues can be found on our website.

Letters to the Editor

Feel free to contact the team at medlaw@1cor.com with comments or queries. Follow us on Twitter @1corQMLR.

Stay tuned for an exciting announcement in the next issue.

CONTRIBUTORS & EDITORIAL TEAM

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

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

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

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

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

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

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

Dominic Ruck Keene (Call: 2012) – Editorial Team

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

Lizanne Gumbel QC (Call: 1974, QC: 1999) - Contributor

Elizabeth-Anne Gumbel QC is a leading practitioner in clinical negligence and personal injury claims. Lizanne has a distinguished reputation for representing Claimants with highly complex claims for catastrophic injury. In clinical negligence she has particular expertise and experience in birth damage and neo-natal claims but acts in claims arising in a wide range of circumstances. In personal injury she acts for Claimants with head injuries, spinal injuries and other complex multiple injuries.

John Whitting QC (Call: 1991, Silk: 2011) - Contributor

John has been recognised as a leading silk by the legal directories for a number of years. He is a specialist in all aspects of healthcare law, including clinical negligence, product liability and inquests. His expertise also extends to a wider range of professional negligence. John is a noted trial advocate and has appeared in a number of the leading cases in those fields.

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

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

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

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

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

Matthew Hill (Call: 2009) – Contributor

Matthew practises in public law, medical law and inquiries and inquests. He has acted as First Junior Counsel to the Hillsborough Inquests, and is currently instructed as Lead Junior Counsel to the Infected Blood Inquiry and the Independent Inquiry into Child Sexual Abuse.

In medical law, Matthew acts for both claimants and defendants in clinical negligence litigation, including in catastrophic birth and spinal injury cases. He also undertakes disciplinary cases before the Medical Practitioners Tribunal Service and the General Dental Council. He acts for families, doctors and medical bodies in inquests. He advises on a wide range of medico-legal issues including those relating to consent, capacity, confidentiality and data protection.

Michael Deacon (Call: 2014) – Contributor

Michael Deacon has a busy practice encompassing the main areas of Chambers' work, including clinical negligence and personal injury, inquests, costs, public law, data protection law, professional discipline and employment law.

Further, building on his experience as a commercial litigation solicitor with a prominent city firm, Michael has also developed a busy independent practice in general contractual disputes.

Charlotte Gilmartin (Call: 2015) – Contributor

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

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

Henry Tufnell (Call: 2018) - Contributor

Henry Tufnell joins chambers as a tenant following the successful completion of his pupillage at 1COR. He is developing his practice in all areas of chambers work.

Before commencing pupillage, Henry acted as a Trade Union representative for The Cleaners and Allied Independent Workers Union (CAIWU) representing claimants in the Employment Tribunal in unfair dismissal, wages and discrimination cases. During his legal studies, he was a Student Director of The School Exclusion Project. Prior to coming to the Bar, Henry majored in history at Brown University, Rhode Island. After graduating, he ran professionally in the 800m and 1500m.