1 CROWN OFFICE ROW

The 1COR Quarterly Medical Law Review

Updates and analysis of the latest legal developments

Winter 2021/2022 | Issue 11

Welcome to the eleventh issue of the QMLR, updating you on developments in Winter 2021/2022:

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NON-DELEGABLE DUTY HEALTHCARE LITIGATION: THE WIDENING WOODLAND BOUNDARIES

Robert Kellar QC

Hughes v Rattan [2022] EWCA Civ 107

In *Hughes v Rattan* [2022] EWCA Civ 107, the Court of Appeal answered the following question: was the owner and principal of a dental practice liable for the negligence of his self-employed associates? The claim arose from NHS care provided by three associate dentists. The Court held that, whilst vicarious liability did not arise, the practice owner was liable because he owed a non-delegable duty of care to his patients.

Non-Delegable Duty of Care

The Court analysed non-delegable duty by reference to the principles affirmed by Lord Sumption in *Woodland v Swimming Teachers Association and others* [2013] UKSC 66:

> *"(1) The claimant is a patient or a child, or for some other reason is especially vulnerable or dependent on the protection of the defendant against the risk of injury. Other examples are likely to be prisoners and residents in care homes.*
>
> *(2) There is an antecedent relationship between the claimant and the defendant, independent of the negligent act or omission itself, (i) which places the claimant in the actual custody, charge or care of the defendant, and (ii) from which it is possible to impute to the defendant the assumption of a positive duty to protect the claimant from harm, and not just a duty to refrain from conduct which will foreseeably damage the claimant. It is a characteristic of such relationships that they involve an element of control over the claimant, which varies in intensity from one situation to another, but is clearly very substantial in the case of schoolchildren.*
>
> *(3) The claimant has no control over how the defendant chooses to preform those obligations i.e. whether personally or through employees or through third parties.*
>
> *(4) The defendant has delegated to a third party some function which is an integral part of the positive duty which he has assumed towards the claimant; and the third party is exercising, for the purpose of the function thus delegated to him, the defendant's custody or care of the claimant and the element of control that goes with it.*
>
> *(5) The third party has been negligent not in some collateral respect but in the performance of the very function assumed by the defendant and delegated by the defendant to him."*

The Court held that the Claimant was a "*patient of the practice*", not just in layman's language but as a matter of law. The treatment plan signed by the patient clearly identified the practice owner/principal as the dentist who would be providing NHS treatment. It was also very significant that associates were required to sign stringent restrictive covenants. This prohibited them from treating "*patients of the practice*" for 12 months after ceasing employment.

As to the first *Woodland* factor, all that was required was for a claimant to be a "*patient*". This did not mean a patient in the old sense of someone who lacked mental capacity. Nor was the term confined to accident and emergency patients or those admitted to hospital overnight. There was no requirement that the patient needed to be especially vulnerable.

As to the second factor, the necessary "*antecedent relationship*" was established on each occasion when a patient signed a personal dental treatment plan. That was sufficient to place the practice owner under a positive duty to protect them from injury.

As to the third factor, patients had "*no control*" over how the principal chose to perform his obligations whether personally or through his associates. Patients could express a preference about which dentist they wanted to see but no more than that. The Court held that it was irrelevant that patients could exercise control by refusing

to be seen by anybody other than a particular dentist or by refusing to be treated at all. This would apply to all dental patients and to all hospital outpatients with mental capacity. The ability of patients to exercise control in this limited way was not sufficient to avoid a non-delegable duty.

Vicarious Liability

As to vicarious liability, the Court considered the correct approach to be applied following the Supreme Court's decision Court in *Various Claimants v Barclays Bank plc* [2020] UKSC 13. Baroness Hale said at [24] that:

> *"there is nothing…to suggest that the classic distinction between employment and relationships akin or analogous to employment, on the one hand, and the relationship with an independent contractor, on the other hand, has been eroded."*

At [27] she said that:

> *"the question therefore is, as it has always been, whether the tortfeasor is carrying on business on his own account or whether he is in a relationship akin to employment with the defendant."*

The Court considered that it was not sufficient, for the purposes of vicarious liability, that the associates were carrying on their activities as an integral part of the practice's business. Nor that that they were not conducting recognisably independent businesses of their own. The "*critical question*" was whether their relationship could properly be described as "*akin*" (or "*analogous*") to employment, with the focus being on the contractual relationship between tortfeasor and defendant.

On the facts, this test was not met. The points which, in combination, led to this conclusion were as follows:

> *"(1) The Associate Dentists were free to work at the Practice for as many or as few hours as they wished;*
>
> *(2) They were also free to work for other practice owners and business, and some in fact did so;*
>
> *(3) The Defendant had no right to control, and did not control, the clinical judgments they made or the way in which they carried out treatment;*
>
> *(4) They chose which laboratories to use and shared the cost of disbursements to laboratories;*
>
> *(5) They were responsible for their own tax and national insurance payments, and were treated as independent contractors by HMRC;*
>
> *(6) Although the Defendant took most of the financial risk by virtue of running the premises and paying ancillary staff, they shared the risk of bad debts;*
>
> *(7) They were required to carry personal professional indemnity insurance and to indemnify the Defendant against any claims made against him in respect of their treatment of patients;*
>
> *(8) They had to pay for their own professional clothing and professional development, and for any equipment they wished to use which was not provided by the Practice;*
>
> *(9) There was no disciplinary or grievance procedure."*

Comment

Whether private healthcare providers are liable for the actions of their independent contractors remains a hotly contested issue in clinical negligence litigation. The Court of Appeal's recent judgment is interesting in at least two respects.

First, it suggests a relatively low bar for establishing a non-delegable duty. For the purposes of establishing the first *Woodland* factor, all that is required is for the Claimant to be a patient undergoing treatment. There is no additional requirement for any special vulnerability. The existence of an "*antecedent relationship*" may be satisfied by the existence of a contract to provide medical care. Moreover, the ability of a patient to choose which of the defendant's practitioners should treat them does not negate a non-delegable duty. Ultimately the

Court will step back and ask itself whether, on the facts and contracts, the Claimant was "*a patient of the defendant.*"

Second, it suggests a relatively high bar for establishing vicarious liability. It is not sufficient to prove that a negligent practitioner was working as an integral part of the defendant's business. Nor that they were not in business on their own account. The correct focus is upon whether the relationship between the practitioner and the defendant is "*akin to employment*." There are no bright lines. The answer will depend upon an open textured exercise of evaluative judgment. The features of the relationship that resemble employment go on one side of the scales. The features that do not resemble employment go on the other. The court must decide whether the scales tip towards 'employee' or 'independent contractor'.

Following a decade of rapid development, the Court of Appeal's judgment is the latest example of judicial restraint in the application of vicarious liability. Conversely, it suggests that a wider range of private healthcare providers will be found to owe non-delegable duties in the future. The author predicts that *Hughes v Rattan* will be the first of many cases in which the *Woodland* boundaries are mapped out.

See past QMLR articles on non-delegable duty and vicarious liability here and here.

VICARIOUS AND DIRECT LIABILITY FOR HORSEPLAY

Dominic Ruck Keene

Chell v Tarmac Cement and Lime Limited [2022] EWCA Civ 7

The Facts

The Claimant was employed as a site fitter for Roltech Engineering Ltd who contracted his services out to Tarmac Cement and Lime Ltd. Tensions arose with Tarmac's own fitters and the Claimant spoke to his supervisor about the problems he was experiencing with other workers. One of the Tarmac employees, H, as a practical joke hit two pellet targets with a hammer causing a loud explosion close to the Claimant, who suffered a perforated eardrum, hearing loss and tinnitus as a result. The Claimant brought an action against Tarmac, on the basis that the company was liable for negligence and vicariously liable for the actions of H. The trial judge considered a number of authorities which included: *Cox v Ministry of Justice* [2016] UKSC 10, *Muhamud v WM Morrisons Supermarkets plc* [2016] UKSC 11, *Lister v Hesley Hall Limited* [2001] UKHL 22 and *Graham v Commercial Bodyworks Limited* [2015] EWCA Civ 47. He held that what H did was a prank, unconnected with his employment. H did not intend to cause the Claimant injury, just to make him "*jump*". Tarmac were not vicariously liable. Nor were they directly liable, because there was no reasonably foreseeable risk of injury from a deliberate act on the part of H such as gave rise to a duty to take reasonable steps to avoid that risk. Martin Spencer J in *Chell v Tarmac Cement and Lime Ltd* [2020] EWHC 2613 (QB) (covered by Michael Deacon here) upheld that judgment as to both the law and the facts, noting that even if the later decision of *Morrisons v Various Claimants* [2020] UKSC 12 had been available to the trial judge "*he would only have been fortified in the conclusions to which he had come and in his approach to this issue.*"

Vicarious Liability

Davies LJ at [25] identified that the fundamental issue was whether H's wrongful act was done in the course of his employment – "*Was it a wrongful act authorised by his employer, Tarmac, or a wrongful and unauthorised mode of doing some act authorised by Tarmac? It is only if the unauthorised act is so connected with what Mr Heath had been authorised to do that it may rightly be regarded as the mode of doing what was authorised*." She held at [26] that the detailed findings of fact were fatal to the appeal, as they demonstrated that there was not a sufficiently close connection between the act which caused the injury and the work of H so as to make it fair, just and reasonable to impose vicarious liability on Tarmac. She referred at [27] to the real cause of the injuries being the explosive pellet targets, which were not part of Tarmac's work equipment or materials. It was

not part of H's work to use pellet targets. There was no abuse of power as H did not have a supervisory role in respect of the work which the Claimant was carrying out and was not working on the task on which the Claimant was engaged at the time of the incident. Any friction between Tarmac and the Roltec fitters had eased in the run up prior to the incident, there were no threats of violence and the issue of tension was only raised once with a manager employed by Tarmac, and the Claimant had not asked to be taken off the site. Finally, the Claimant did not allege that H had been source of any tension. The risk created by H was not inherent in the business – Tarmac's business had provided the background and context for the risk and created the ground for it, but that was in itself insufficient to create the close connection, particularly in the absence of other factors.

Davies LJ also held at [28] that H's activity in no way advanced Tarmac's purposes and was in no sense within the field of activities authorised by Tarmac.

Direct Liability

Davies LJ held at [33] that horseplay, ill-discipline and malice could provide a mechanism for causing such a foreseeable risk of injury to H. However, it was not made out on the facts. There was no indication of the potential for H to behave in this way. The mere fact that heavy and dangerous tools were available did not in itself create a reasonably foreseeable risk of injury due to misuse of a tool. Further at [36] "*Even if a foreseeable risk of injury could be established, on the facts of this case, the only relevant risk which could have been included in an assessment was a general one of risk of injury from horseplay. If it is seriously suggested that there should have been a specific instruction not to engage in horseplay, I regard the same as unrealistic. Common sense decreed that horseplay was not appropriate at a working site. The fitters were employed to carry out their respective tasks using reasonable skill and care, and by implication to refrain from horseplay. It would be unreasonable and unrealistic to expect an employer to have in place a system to ensure that their employees did not engage in horseplay. Further, the general Site rules include a section that "No one shall intentionally or recklessly misuse any equipment". This was a warning against exactly what Mr Heath did*." Lastly there were no express or implied threats of violent conduct, and no complaints about named individuals.

Comment

This judgment is an example of a broader trend towards tighter judicial control of the ambit of vicarious liability – both by way of not finding any relationship akin to employment, and, as here, by focussing on the practical realities of the relationship between employer and employee, and on the exact nature of the employer's business, when determining whether an act is properly to be seen to be as within the scope of employment.

PRIMARY VICTIMS

Lizanne Gumbel QC

Andrew Turton v Clinton Devon Farms Partnership (County Court (Exeter)) [2021] 6 WLUK 718

Following the decision of the Court of Appeal in the joined cases of *Paul v Royal Wolverhampton NHS Trust, Polmear v Royal Cornwall Hospital NHS Trust, Purchase v Ahmed* [2022] EWCA Civ 12 (see Jo Moore's piece here) there is considerable uncertainty in respect of the criteria for secondary claims resulting in psychiatric damage. Pending the decision of the Supreme Court in these cases, Claimants are still searching for alternative routes to recover for psychiatric damage following the witnessing of traumatic events. The two recognised routes are firstly to establish the Claimant is a primary victim and secondly to establish the Claimant is a rescuer.

In the case of *McLoughlin v O'Brian* [1983] AC 410, Lord Wilberforce described the position of rescuers as follows:

> *"5. A remedy on account of nervous shock has been given to a man who came upon a serious accident involving numerous people immediately thereafter and acted as a rescuer of those involved. (Chadwick v. British Railways Board [1967] 1 W.L.R. 912) 'Shock' was caused neither by fear for himself nor by fear*

> *or horror on account of a near relative. The principle of 'rescuer' cases was not challenged by the respondents and ought, in my opinion, to be accepted. But we have to consider whether, and how far, it can be applied to such cases as the present."*

In *Alcock and Others v Chief Constable of South Yorkshire Police* [1992] AC 310, Lord Oliver explained the position of rescuers and innocent participators in events as follows:

> *"So in Chadwick v. British Railways Board [1967] 1 W.L.R. 912 , the plaintiff recovered damages* ***for the psychiatric illness caused to her deceased husband through the traumatic effects of his gallantry and self-sacrifice in rescuing and comforting victims of the Lewisham railway disaster.***
>
> *These are all cases where the plaintiff has, to a greater or lesser degree, been personally involved in the incident out of which the action arises, either through the direct threat of bodily injury to himself or in coming to the aid of others injured or threatened. Into the same category, I believe, fall those cases such as Dooley v. Cammell Laird & Co. Ltd. [1951] 1 Lloyd's Rep. 271 , Galt v. British Railways Board (1983) 133 N.L.J. 870 , and Wigg v. British Railways Board, The Times, 4 February 1986 , where the negligent act of the defendant has put the plaintiff in the position of being, or of thinking that he is about to be or has been, the involuntary cause of another's death or injury and the illness complained of stems from the shock to the plaintiff of the consciousness of this supposed fact. The fact that the defendant's negligent conduct has foreseeably put the plaintiff in the position of being an unwilling participant in the event establishes of itself a sufficiently proximate relationship between them and the principal question is whether, in the circumstances, injury of that type to that plaintiff was or was not reasonably foreseeable."*

These cases were distinguished from secondary victim cases by the fact that in the rescuer cases and innocent participant cases the Claimant has been directly involved in the events themselves. In the secondary victim cases by contrast: *"the injury complained of is attributable to the grief and distress of witnessing the misfortune of another person in an event by which the plaintiff is not personally threatened or in which he is not directly involved as an actor".*

In the *Alcock* case Lord Jauncey also referred to the position of rescuers and pointed out that the position of the rescuer was recognised by Cardozo J. in *Wagner v International Railway Co., 232 N.Y. 176 , 180*:

> *"Danger invites rescue. The cry of distress is the summons to relief. The law does not ignore these reactions of the mind in tracing conduct to its consequences. It recognises them as normal. It places their effects within the range of the natural and probable. The wrong that imperils life is a wrong to the imperilled victim; it is a wrong also to his rescuer."*

Further Lord Jauncey pointed out that:

> *"Lord Wilberforce in McLoughlin v. O'Brian [1983] 1 A.C. 410 , 419B considered that the principle of rescuers ought to be accepted. This is a particular instance where the law not only considers that the individual responsible for an accident should foresee that persons will come to the rescue and may be shocked by what they see but also considers it appropriate that he should owe to them a duty of care. I do not however consider that either of these cases justify the further development of the law sought by the plaintiffs."*

In the case of *Andrew Turton v Clinton Devon Farms Partnership* the background was that an employee of the Farm (Kevin Dorman) had been killed when driving a tractor on the farm after his tractor crashed through a hedge and fell five metres onto the lane below with the tractor falling on top of him. Mr Turton was another employee on the farm and he was the first on the scene after the accident and he described the accident and his role in it as follows:

> *"There was an almighty bang as the tractor crashed onto the road below and the trailer landed on top of it. It was horrifying sight. I was in shock but managed to stop my tractor immediately to rush down to try and help Kevin. I called George via my mobile phone to raise the alarm and so he could call an*

> *ambulance and the fire brigade. Where the tractor had gone through the hedge there was now a big hole where I managed to climb through and down to where the tractor had ended up. I climbed down and looked inside the tractor and I could see Kevin was trapped there."*

Mr Turton also described how he reached into the tractor cab and tried to find a pulse, however he found his co-worker lifeless. He waited for the ambulance and fire brigade and then helped by finding chains that could be used to try and move the tractor.

As a result of his involvement in the accident and its aftermath the Claimant suffered shock and the development of acute post-traumatic stress disorder and depression.

HHJ Cotter found that:

> "*Mr Turton was plainly a participant in the immediate aftermath of the accident. He had just driven past Kevin in the field and witnessed the accident from a short distance away. He headed immediately to the wreckage whilst telephoning Mr Perrott so that the emergency services could be called. As the first person at the scene he reached into the wreckage and tried to find a pulse."*

The Judge explained that:

> "*Not surprisingly given that the policy of the law should favour rescue, an altruistic person who takes no time to have regard to their own safety when assisting others is not necessarily precluded from recovery as a primary victim if he/she subsequently developed psychiatric injury arising out of their involvement in an incident. There is a second potential route to classification as a primary victim, which is if, objectively, the rescuer exposed him/herself to danger even though they gave no thought to it."*

This reflects Lord Wilberforce's analysis that:

> *"…the law not only considers that the individual responsible for an accident should foresee that persons will come to the rescue and may be shocked by what they see but also considers it appropriate that he should owe to them a duty of care."*

The Judge quoted Lord Steyn's comments in *White v Chief Constable of South Yorkshire Police* [1999] 2 AC 455:

> *"The law has long recognised the moral imperative of encouraging citizens to rescue persons in peril. Those who altruistically expose themselves to danger in emergency to save others are favoured by the law. A rescue attempt to save someone from danger will be regarded as foreseeable… The meaning given to the concept of a rescuer in these situations is of no assistance in solving the concrete case before the House. Here the question is: who may recover in respect of pure psychiatric harm sustained as a rescuer?"*

The Judge therefore found the Claimant satisfied the criteria for recovery for psychiatric damage as a rescuer.

A further issue arose as the Judge had earlier found that the deceased Kevin Dorman was 60% liable for his own death. On this issue the Judge found that the deceased and the Defendant were joint tortfeasors and:

> *"In my judgment there is no authority to the effect that a rescuer who qualifies as a primary victim cannot recover against a tortfeasor who negligently caused the accident which invited his/her rescue a fortiori cannot recover against a joint tortfeasor. As set out above the appellate Courts have made it clear policy favours rescue. The Courts have found it necessary to impose thresholds upon recovery by rescuers but in the present case the threshold has been met. There would need to be weighty policy reasons to deny a rescuer, who has no relationship with the person injured, recovery for psychiatric injury arising from the rescue. I can see no such reasons. Indeed the only policy consideration which weighs against the existence of a duty is that it impinges upon self-determination. However, I agree with the view of the authors of the Law Commission report that a competing argument is that persons who deliberately or negligently place themselves in danger should foresee the possibility of the consequences of their actions for others (and specifically the need for rescue) and take responsibility for*

> *them. In my view absent the policy issues which arise with secondary victims issues of self-determination are insufficient to weigh against the recovery of rescuers who satisfy the threshold test for recovery. Properly considered the policy bar in Greatorex v Greatorex is limited to secondary victims.*

Further the Judge found:

> *"I respectfully adopt the view authors of the Law Commission report that it would be contrary to the principle that the defendant owes a separate duty of care directly to the claimant, and would mean that the claimant was unable to obtain full compensation for his or her psychiatric illness."*

The case illustrates the importance of establishing the route by which a duty of care may be owed, the importance of foreseeability and the importance of distinguishing rescuers and those innocent participators in an accident from secondary victims. The rescuers and innocent participators are primary victims to whom a separate duty is owed; they are not piggy-backing on a primary victim claim in the way a secondary victim is.

BREACH FOUND IN PRE-CONCEPTION CLAIM

Matthew Donmall

Toombes v Mitchell [2021] EWHC 3234 (QB)

The Claimant suffered from a congenital defect, as a result of her mother not having taken folic acid before her conception. Her claim alleged that, at a pre-conception consultation on 27 February 2001, Dr Mitchell, the Defendant, negligently failed to advise her mother, Mrs Toombes, to take folic acid supplements. Had she been properly advised, Mrs Toombes said that she would have delayed conception. In those circumstances, it is said that the Claimant would not have been born, rather a genetically different sibling, conceived later, would have been born without the neural tube or any other defect.

A preliminary issue was tried before Mrs Justice Lambert in December 2020 as to whether the claim disclosed a lawful cause of action, [2020] EWHC 3506 (QB). As reported by Robert Kellar QC in the QMLR Issue 8, Lambert J answered the question with a resounding 'yes'. A disabled claimant can bring a claim alleging that, but for the index negligence, she would not have been conceived; she is entitled to bring a claim for damages for being born in her injured state.

The legal dispute having been resolved, the trial turned essentially on the factual matters relating to the alleged breach, and related questions of causation. Much depended on the credibility of the Claimant's mother; for his part, Dr Mitchell had no actual recollection of the consultation, and his note was "*inadequate*". The Judge found that Dr Mitchell should have advised Mrs Toombes to take folic acid daily before conception and did not do so. The Judge placed reliance on a subsequent record two years later, which cohered with her case that Dr Mitchell had advised her that if she had a good diet, she would not need folic acid supplements. Breach was, therefore, established.

In respect of causation, the first thing that the Claimant needed to establish was that she had not, in fact, already been conceived prior to the consultation. Mrs Toombes' last menstrual period had started on 13 February 2001, two weeks before the consultation, having taken her last contraceptive pill on 11 February 2001. The judge accepted that it was possible that she was already pregnant at the time of the consultation on 27 February 2001, but believed Mrs Toombes' evidence that she did not have sexual intercourse at all until after the consultation. The second issue on causation was whether Mrs Toombes would have delayed attempts to conceive and taken the folic acid supplements: on this point, too, the Judge accepted the evidence of Mrs Toombes. It might be noted, however, that the Judge considered this "*not a common situation*", namely that the couple had sought out a preconception consultation. Mrs Toombes had specifically asked about whether it would be safe to try for a family, and had herself raised the issue of folic acid with the Defendant. Given that breach of duty was found on that very point, it was perhaps unsurprising that the court found causation made out too.

PSYCHOSIS, OPERATIONAL DUTY AND ILLEGALITY

Lucy McCann

Traylor v Kent and Medway NHS Social Care Partnership Trust [2022] EWHC 260 (QB)

In *Traylor v Kent and Medway NHS Social Care Partnership Trust* [2022] EWHC 260 (QB) the High Court considered the liability of an NHS Trust when a patient stabbed his daughter during a psychotic episode allegedly resulting from negligent mental health treatment in the context of a clinical negligence and a Human Rights Act ("HRA") claim.

The facts

Marc Traylor ("MT") had a diagnosis of paranoid schizophrenia manifesting in morbid jealousy syndrome. The Defendant knew of his history of violence towards his wife and assessed the risk he posed to those around him. He was under a community treatment order ("CTO").

In June 2014, MT met with a new psychiatrist and requested that he change his antipsychotic medication regime from long-acting injections to oral tablets. The psychiatrist agreed. In December 2014, the same psychiatrist discharged MT's CTO. MT never took his antipsychotic tablets and lied about taking them to his family and the Defendant's mental health care team during numerous home visits. He then suffered a relapse.

The following February, during a psychotic episode, MT held his daughter Kitanna Traylor ("KT") hostage in her bedroom. Armed police were called to the scene and shot MT three times but were not able to prevent him from stabbing KT. Both survived the incident but were left with serious lifelong injuries. MT was charged with the attempted murder of KT but was found not guilty by reason of insanity.

MT's claim

MT brought a personal injury claim arising from his gunshot injuries against the Defendant, alleging that he received negligent treatment for his schizophrenia which resulted in the psychotic episode.

Breach and causation

The Defendant accepted that the decision to discharge MT's CTO was negligently handled but it was agreed that this decision did not make a difference to the outcome [82]. MT's two remaining allegations were:

1. The risk that MT would not take his medication was not sufficiently assessed
2. MT was not advised that he should remain on his injections

Johnson J was satisfied, despite no contemporaneous notes of the relevant discussions had at the consultation, that MT's psychiatrist did consider and appreciate the risk that MT might not take his oral medication and the consequential risks that flowed from that [85], and that it was likely that MT was advised to continue with injections [96].

Even though MT could not establish a breach of duty, Johnson J considered causation. He found that, in any event, no amount of advice would have changed MT's "*fixed views*" about the (in)efficacy of antipsychotic medication, and so he failed to establish factual causation [99]. In terms of the strict legal cause of MT's relapse, Johnson J indicated that MT's free and informed decision to stop taking his medication would not have broken the chain of causation due to the nature of the duty of care that the Defendant owed to MT [101]. On that same basis, he also rejected the Defendant's further argument that MT voluntarily accepted the risk created [103].

However, had MT's claim otherwise succeeded, the Court considered that any award of damages would have been reduced by 75% to reflect the fact that MT bore primary responsibility for what transpired [122].

Illegality

The Court considered whether the illegality defence was available to the Defendant in circumstances where MT was 'insane' within the meaning of the *McNaughten* rules. This issue had not been settled in this jurisdiction, having been explicitly left open in *Gray v Thames Trains Limited* [2009] 1 AC 1339 *per* Lord Hoffman at [42].

The Defendant argued that although MT was found not guilty by reason of insanity, he was nevertheless guilty of a criminal act [108]. Johnson J held that MT was not to be treated as having committed a criminal act, as those who satisfy the test in the *McNaughten* rules "*are not regarded in law as having committed the act or having any responsibility for the act*" [110]. Johnson J determined that central to the availability of the illegality doctrine was the notion of culpability and an awareness on the part of the perpetrator that they were acting unlawfully [111 -115]. Therefore, the illegality defence was not open to the Defendant in this case.

KT's claim

KT brought an HRA claim on the basis that the Defendant, as the Trust responsible for her father's mental health treatment, knew or ought to have known of a real and immediate risk to her life and failed to take positive steps to protect her pursuant to articles 2 and 3 of the European Convention on Human Rights.

Johnson J held that, in principle, the *Osman* duty could apply in the context of requiring NHS Trusts to protect third parties against the risk of violence posed by one of its patients [126], in the same way the duty may protect against a risk of suicide (see [34] of *Rabone v Pennine Care NHS Foundation Trust* [2012] UKSC 2). In his analysis, Johnson J did not accept that a choice must be made between two alternative positive operational duties owed under article 2: a 'systems' duty owed by hospitals to protect lives primarily in a clinical setting and a duty to protect against suicide or criminal violence in a protective setting [127-128]. Rather, the two may co-exist.

In the context of KT's claim, the Court found that the risk to KT's life was a real and known risk that, once created, was present and continuing, even though the precise way it ultimately materialised could not be predicted [133-135]. The agreed evidence was that without medication MT's risk of relapse was in the region of 80% [132], which was a known risk to his wife's life. Johnson J held that KT did not need to be identified as a victim in advance; it was enough that there was a clear risk that she might be caught up in such violence [137].

However, the Court concluded that the Defendant took reasonable steps to avert the risk, such that KT's HRA claim ultimately failed [144].

Comment

The judgment provides useful clarity on the parameters of the doctrine of illegality, and the principles underpinning it. The defence of illegality is not available when the claimant is not culpable for their acts (not guilty by reason of insanity) but is available in cases such as *Henderson v Dorset Healthcare University NHS Foundation Trust* [2020] UKSC 43 (see Rob Kellar QC's article here) where a claimant pleads guilty on the grounds of diminished responsibility.

This decision offers insightful comment on the application of the *Osman* operational duty in the context of clinical negligence claims. The Court took an expansive approach to the duty in a clinical setting, such that it can apply where an NHS Trust knows that a patient poses a real and immediate risk to a third party even in circumstances where such a risk may not materialise for a significant period and where the precise identity of the third party is not known.

This case is also an important reminder that when patients have capacity and have firm views on their treatment, those views have an overriding effect on the options of clinicians in a way that is necessarily factored into determinations on breach and causation.

FOURNIER'S GANGRENE AND MATERIAL CONTRIBUTION

Thomas Hayes

Dalchow v St George's University NHS Foundation Trust [2022] EWHC 100 (QB)

The Claimant brought proceedings alleging a delay in the diagnosis and treatment of Fournier's Gangrene. The condition is one in which there is necrotising fasciitis of the perineum and scrotum. The Claimant had undergone a day case elective removal of an epididymal cyst the day before and had reattended hospital the following morning complaining of severe pain at the operative site.

The case hinged on whether the Claimant ought to have urgently undergone either CT or ultrasound scanning following his review at 11.00 that day, and whether if he had been, his outcome would have been different. He did not undergo an ultrasound scan until 15.12 that afternoon and it was not until 18.15 that the diagnosis was made on clinical examination. Thereafter the Claimant was taken to theatre for emergency debridement. He ultimately underwent several procedures which amounted to radical debridement, skin grafting and bilateral orchidectomy.

Inference from Absence

One interesting feature of the judgment was the judge's consideration of the extent to which he could draw an inference from the absence of evidence. The Court considered the case of *Wisniewski v Central Manchester Health Authority* [1998] EWCA Civ 596, in which Brooke LJ gave the following guidance:

> *"(1) In certain circumstances a court may be entitled to draw adverse inferences from the absence or silence of a witness who might be expected to have material evidence to give on an issue in an action.*
>
> *(2) If a court is willing to draw such inferences they may go to strengthen the evidence adduced on that issue by the other party or to weaken the evidence, if any, adduced by the party who might reasonably have been expected to call the witness.*
>
> *(3) There must, however, have been some evidence, however weak, adduced by the former on the matter in question before the court is entitled to draw the desired inference: in other words, there must be a case to answer on that issue.*
>
> *(4) If the reason for the witness's absence or silence satisfies the court then no such adverse inference may be drawn. If, on the other hand, there is some credible explanation given, even if it is not wholly satisfactory, the potentially detrimental effect of his/her absence or silence may be reduced or nullified."*

Upon reviewing the Claimant, the Defendant's treating clinicians had decided that an ultrasound scan would be beneficial. This scan was not requested for over two hours. There was no explanation for the delay given by the Defendant's witnesses, who suggested only that in some cases clinicians might encounter difficulty in arranging such scans. The Judge applied the approach of the court in *Wisniewski* in holding that in the absence of an explanation not only was he entitled to find that the scan could have been conducted quicker, but also that there had been no good reason for the delay. In effect, the Court found that arranging the scan had been overlooked.

Application of Bolitho

The Court also undertook a detailed consideration of the legal principles pertaining to breach of duty, in particular, the requirement from *Bolitho v City and Hackney Health Authority* [1998] AC 232, [1997] UKHL 46 that a body of opinion relied upon be reasonable, responsible, and ultimately logical.

The Claimant had presented to hospital complaining of pain which the Defendant's treating clinician accepted was a "*very, very unusual presentation for post-operative pain or small haematomas*". Nevertheless, the Defendant's expert witness expressed the view that a working diagnosis of post-operative haematoma or infection was reasonable on the grounds that "*common things are common*". The Judge rejected this analysis as

flawed. Given the evidence that the extent of the Claimant's pain was so unusual, it could not be logical for him to then advance an expert opinion predicated on the basis the Claimant's presentation represented something typical or ordinary. In respect of the Claimant's case that an ultrasound scan needed to be arranged urgently, the Judge commented "*Professor Sethia disagrees but it appears to me that his conclusions are undermined by the flaw in logic I have just identified. That is the failure to grapple with the level of pain being experienced by the Claimant. That appears to have been unusual."* The court thereby applied *Bolitho* to prefer the evidence of the Claimant's expert over that of the Defendant as to the appropriate timing and urgency of the ultrasound.

Material Contribution

Both the Claimant and Defendant's experts were in broad agreement that whilst earlier surgery would have reduced the necessary debridement, it was not possible to state to what extent. The allegation in the Particulars of Claim read:

> *"the delay in administering antibiotic therapy and performing surgical debridement materially contributed to an indivisible injury, namely skin and soft tissue necrosis and loss"*

The Court considered the nature of the Claimant's condition. Fournier's Gangrene is a condition in which bacterial infection causes death of soft tissues. The condition is progressive with the area of tissue affected increasing over time. In *Ministry of Defence v AB* (2011) 117 BMLR 101 the Court of Appeal commented that:

> *"(a) disease or condition is "divisible"… (when) an increased dose of the harmful agent worsens the disease. ... Cancer is an indivisible condition; one either gets it or one does not. The condition is not worse because one has been exposed to a greater or smaller amount of the causative agent"*

The Court held that there is a clear distinction between cases where there is a dose/exposure relationship between the effect of the breach of the duty and the degree of harm caused and cases where there is no such relationship. In this case the effect of the breach was delay. As the delay increased so too did the harm suffered by the Claimant. The loss could therefore not be pleaded as an indivisible injury. In the circumstances, it was inappropriate to allow an amending of the pleadings at such a late stage.

Comment

Ultimately, the issues above were to prove largely academic in the context of the case as a whole. Having established that there was no good reason for delaying the ultrasound, the question then arose as the consequence of that delay. Forensic analysis and application of the case law could not overcome the fundamental flaw in the Claimant's case, namely that an earlier ultrasound would have shown at most the same appearances as that which was ultimately performed. The Defendant's position that they would not in any event have performed surgery on the basis of the scan results obtained was accepted by the Court. In such circumstances, the claim was dismissed on causation grounds. The case does however highlight the need for experts to carefully apply their minds to the facts of the case, and the willingness of judges to scrutinise the logic underlying their conclusions.

DAMAGES: ADEQUACY OF STATE-FUNDED PACKAGE OF CARE

Jasper Gold

Martin v Salford Royal NHS Foundation Trust [2021] EWHC 3058 (QB)

Introduction

The Claimant in *Martin* suffered a sub-trochanteric stress fracture to the right proximal femur in the shower whilst undergoing inpatient mental health treatment at Prestwich Hospital. The fracture is of a kind which is spontaneous, rather than arising from a stressor accident.

In an earlier trial of liability before Andrews J, it was found that there was a negligent delay in the treatment of the fracture, with conservative treatment unreasonably attempted before surgical intervention. The eventual surgical intervention led to a deep-seated intraoperative surgical site infection, which would have been avoided had surgery been attempted earlier.

At the trial on quantum before Bird J, a number of issues arose but the most significant was whether the Claimant could claim for the costs of future private physical care despite currently being on a state-provided care programme conccerning which there was no suggestion that it had to be withdrawn, but which it was argued was inadequate.

Background

The Claimant was a 47-year-old woman and had an "*extensive psychiatric history which began before the defendant's negligence*" including emotionally unstable personality disorder (EUPD), suicide attempts and frequent hospital admissions for mental health assessment and treatment ([3]-[4]). Since the Defendant's negligence, however, she had become physically dependant on others for all aspects of her daily life, and used an electric wheelchair. Her movement was restricted and her balance poor ([6]).

Whilst the Claimant was happy with the mental health care she was receiving ([16]), she was not satisfied with her physical care. She was receiving personal care, domestic support, companionship laundry and meal preparation through five daily visits each week. Each visit lasted 4 to 5 hours. The programme was not flexible, and no care was available outside pre-set visit times. There was no night cover ([17]-[18]).

The Claimant was not happy with this situation, in particular with the lack of any way to go to the toilet at night, which left her "*effectively incontinent through lack of provision*" ([29]). She also wished to be able to be more spontaneous, for example by visiting museums at the time of her choice as she was able to previously ([30]).

There was no dispute as to the legal basis of the damages assessment ([33]). In relation to physical care, the issues between the parties at the hearing were the extent of the Claimant's needs and the extent of recoverability ([36]-[64]).

The Claim for Physical care

At the time of trial, the Claimant's physical care (along with her mental health care, the need for which was independent of the Defendant's negligence) was provided through a care and support package funded through section 117, Mental Health Act 1983 (after-care for person detailed under section 3/admitted under section 37, MHA 1983).

An issue arose between the parties because the Claimant would have an ongoing right to physical care through s.117 which was non-means-tested and could not be displaced ([38]). The Defendant argued that if damages were awarded for future physical care, this would give rise to a significant prospect of double recovery ([39]).

Bird J approached the question of fact – whether the Claimant would in fact continue with s.117 physical care – as raising in turn three questions: (1) whether a split care package would be detrimental; (2) whether the current physical care package was adequate; and what the Claimant had to say about the matter ([41]). The Defendant's expert failed to support any argument that, where there was holistic oversight, a split package would be detrimental, so the meat of the issue was the adequacy of physical care under s.117.

Relying on the standard basic principle that a care package must be adequate to put a claimant in the position they would have been but for the defendant's negligence, Bird J held that the s.117 physical care was not adequate: the Claimant's overnight effective incontinence and lack of flexibility of timing made this clear ([48]). Bird J also rejected the Defendant's argument that increased care would lead to dependence which would harm her mental health. Although not an impossible argument to make, it would have needed very clear support from expert evidence ([49] – [50]).

The Claimant's evidence was that she got on well with her carers, found them professional and had developed a relationship of trust with them. However, Bird J did not accept that this meant the care package was adequate,

holding that even if she had been fully happy with it, that would not require a finding of fact, if it was in fact inadequate, that she would continue with it in future ([54]).

Comment

Martin illustrates the fact-sensitive nature of claims for future care in cases where the claimant is already in receipt of state-funded care. The focus will not necessarily lie on an assessment of the claimant's attitude towards that care, but on an objective assessment of whether it is suitable for meeting the basic goal of tortious damages: to put the claimant in the position they would have been in had the tort not been committed.

Claimants are entitled to live autonomous lives free of indignity and inconvenience, and a care package which prevented toilet access overnight and restricted the Claimant's ability to enjoy her city as she was accustomed to, and where these things could be provided privately, did not meet that goal.

Liability Determination Does Not Automatically Lead to Entitlement to Detailed Assessment

Richard Smith

ABA v University Hospitals Coventry and Warwickshire NHS Trust [2022] EWHC B4

This case confirms a point of some significance for Claimant lawyers which must be borne in mind when liability issues are resolved either by judgment or settlement, leaving the quantum of damages to be assessed. The short point is that an order resolving the issue of liability alone, which leaves damages to be assessed, but granting the Claimant an entitlement to the costs of establishing liability, does not give rise to an entitlement to apply for detailed assessment of those costs unless the order makes express provision for immediate assessment.

In *ABA* the Claimant issued a claim alleging clinical negligence on 22 December 2017. Master Cook made an order that liability be tried as a preliminary issue on 6 February 2019. The parties agreed a liability split giving the Claimant 65% of the damages, which were to be assessed. This was recorded in an order dated 11 January 2021 which also provided for costs to be subject to detailed assessment if not agreed. The matter then returned to Master Cook who made directions leading to a quantum trial in a window between 6 February and 26 May 2023.

In the meantime, on 13 August 2021, the Claimant served a notice of commencement of detailed assessment of the liability costs, based on the 11 January 2021 order. The Defendant applied for the notice to be set aside on the grounds that the notice was premature as the claim had yet to conclude.

The relevant provisions of the CPR are to be found at CPR 47.1 and Practice Direction 47, paragraphs 1.1 to 1.4. CPR 47.1 reads:

> *"The general rule is that the costs of any proceedings or any part of the proceedings are not to be assessed by the detailed procedure until the conclusion of the proceedings, but the court may order them to be assessed immediately. (Practice Direction 47 gives further guidance about when proceedings are concluded for the purpose of this rule.)"*

The Practice Direction says:

> *"1.1 For the purposes of rule 47.1, proceedings are concluded when the court has finally determined the matters in issue in the claim, whether or not there is an appeal, or made an award of provisional damages under Part 41.*
>
> *1.2 The court may order or the parties may agree in writing that, although the proceedings are continuing, they will nevertheless be treated as concluded.*

> *1.3 A party who is served with a notice of commencement (see paragraph 5.2 below) may apply to a costs judge or a District Judge to determine whether the party who served it is entitled to commence detailed assessment proceedings. On hearing such an application the orders which the court may make include: an order allowing the detailed assessment proceedings to continue, or an order setting aside the notice of commencement.*
>
> *1.4 A costs judge or a District Judge may make an order allowing detailed assessment proceedings to be commenced where there is no realistic prospect of the claim continuing."*

The Claimant argued that the order of 11 January 2021 was a final order and the claim should be treated as concluded notwithstanding that the quantum of the claim had yet to be assessed. This was said to be on the "*doctrine of merger*", or that judgment on liability had established the cause of action (negligence) and the claim was thus concluded (the cause of action had "*merged*" into the judgment).

The Costs Judge (Master Leonard) rejected that argument as contrary to authority and to the CPR. As to authorities, it appears that the question of whether the costs of a preliminary issue could be subject to detailed assessment has only been considered in one case since the advent of the CPR and that was at first instance in the SCCO (and it was not a personal injury split trial case). Master Campbell ruled in that case that the costs of the preliminary issue could not be assessed immediately in the absence of an order to that effect. Master Leonard also found support from the approach taken to interlocutory appeals. As to the interpretation of the CPR, the Costs Judge found that on a proper analysis of the rules the claim was ongoing and had not been concluded by the judgment on liability. Quantification of damages was an essential part of the Claimant's pleaded case, and that had yet to be determined. Thus, it could not be said that the matter had reached *"the conclusion of proceedings"* or that *"the court has finally determined the matters in issue in the claim."*

As the Costs Judge had no power to make an order for immediate assessment under r47.1 (per David Richards LJ in *Kharia v Shergill* [2017] EWCA Civ 1687), he determined that the notice of commencement must be set aside. In the absence of an order for immediate assessment or an agreement between the parties for immediate assessment, the Court did not have jurisdiction to undertake a detailed assessment until the final conclusion of the claim.

In some concluding comments, the Costs Judge observed that it is not uncommon for receiving parties to commence detailed assessment when only liability has been determined, or even for paying parties to serve Points of Dispute without realising that detailed assessment is premature. I would add that, on that premise, it is likely that agreements have been reached between the parties on the amount of such costs. It is not inconceivable that detailed assessment hearings have proceeded in spite of the provisions of r47.1. However, in the absence of express agreement between the parties that the detailed assessment should proceed despite quantum being at large, then such proceedings can always be derailed by the paying party or the Court pointing out an absence for an order for detailed assessment. The Costs Judge ruled that it was not sufficient to establish an agreement for immediate assessment for a paying party to have entered into correspondence or negotiations on costs.

This situation can be avoided by obtaining or agreeing an order for immediate assessment when the issue of liability is concluded. If the matter is raised in settlement negotiations and the Defendant is unwilling to agree to such a provision then at least this is clear and the Claimant can consider whether it affects their willingness to settle or their approach to seeking a payment on account of costs.

In this regard it is relevant to bear in mind Master Leonard's concluding comment:

> *"I will only say, with apologies for perhaps stating the obvious, that the default position being that interest will accrue upon the Claimant's unpaid liability costs at 8% per annum, it might be to the parties' mutual advantage to use the work done to date in an effort to settle what would appear to be a substantial claim for costs."*

JOCKEYS AND NEGLIGENCE

Andrew Kennedy QC

Tylicki v Gibbons [2021] EWHC 3470 (QB)

Introduction

The Claimant and the Defendant were professional flat-racing jockeys. Tylicki alleged that Gibbons' negligent riding on the all-weather track at Kempton in October 2016 caused his horse to trip and fall leaving him a T4 AIS complete paraplegic. Following a 5-day hearing on liability only, Deputy High Court Judge Karen Walden-Smith found that during a 4-second spell of riding Gibbons had shown a reckless disregard for Tylicki's safety.

Findings

The Judge found that, as the horses entered the right-hand bend four furlongs into the race, there was sufficient space for Tylicki to bring his horse between Gibbons' horse and the rails, and that after this Tylicki's horse continued to move up the inside to a point where his horse's head was level with Gibbons' stirrup and boot. She rejected Gibbons' evidence that he had been unaware of Tylicki's presence on his inside, finding that it was more likely than not that he did know Tylicki was there. She found that Gibbons had exerted more tension on his right rein than was necessary to maintain his progress round the right-hand bend and stop his mount drifting left, and that he was pulling his mount across to the rail on the right leaving Tylicki no space.

Duty of care

The judge referred to the leading authority of *Caldwell v (1) Maguire and (2) Fitzgerald* [2001] EWCA Civ 1054 recognising that cases are fact specific and Caldwell differed from the present case at least to the extent that it arose from a National Hunt race (i.e. over jumps) whereas the present case was a flat race on an all-weather track. She listed the following propositions that she derived from a review of the authorities by the trial judge (Holland J) in Caldwell.

- Each contestant in a lawful sporting contest (and in particular a race) owes a duty of care to each and all other contestants. Although the participants may be held to have accepted the risks inherent in the contest that does not mean that no duty of care can arise in the case of one participant to another.
- The duty is to exercise the skill and care that is objectively reasonable given the particular circumstances to avoid injury to fellow contestants.
- The particular circumstances include the object of the contest, the demands made on the contestants, the inherent dangers, the rules, conventions and customs and the standards, skill and judgment reasonably expected from the participants.
- Given the particular circumstances the threshold for liability is high; proof of a breach of duty will not flow from proof of no more than an error of judgment or a momentary lapse of skill when subject to the stresses of the race, as these are no more than incidents inherent in the nature of the sport.
- In practice it may therefore be difficult to prove breach of duty absent proof of conduct that amounts to a reckless disregard for the safety of a fellow contestant.

Comment

These cases are fact specific, but in finding for the Claimant:

1. The judge was unimpressed by Gibbons' failure to disclose in his witness statement that he had lost his racing licence (albeit for unrelated reasons) and noted that this went to his credibility [9].
2. The judge was clearly struck by the fact that when Tylicki shouted to Gibbons to warn him of his presence, Gibbons continued to pull his horse to the right [88].

3. She found that the conclusion of the Stewards' Enquiry that the collision was accidental was not determinative or binding upon her and she suggested that in the circumstances the Enquiry should have been adjourned [55].

The judge was at pains to stress that this case should not be taken as setting a precedent within horse-racing or sport more generally. At [95] she said:

> *"In making that finding, I stress that the threshold of liability for negligence is a high one and has been determined as made out in this case, on its own particular facts. The finding does not set a precedent either within horse-racing or in sport generally."*

This affirms the concluding remarks in an Australian case cited by the Court of Appeal in *Caldwell*:

> *"Thoroughbred horse racing is a competitive business, which is played for high stakes. Its participants are large animals ridden by small men at high speed in close proximity. The opportunity for injury is abundant and the choices available to jockeys to avoid or reduce risk are limited."*

FRESH INQUESTS

Gideon Barth

Mays v HM Senior Coroner for Kingston Upon Hull & East Riding of Yorkshire [2021] EWHC 3604 (Admin)

Earl v HM Senior Coroner for East Sussex [2021] EWHC 3468 (Admin)

R (on the application of Ginn) v HM Senior Coroner for Inner London [2022] EWHC 28 (Admin)

Three recent applications by bereaved families have resulted in fresh inquests being ordered by the High Court or Divisional Court. Each case offers some helpful guidance on how coronial investigations and inquests should be conducted.

Fresh evidence: Mays v HM Senior Coroner for Kingston Upon Hull & East Riding of Yorkshire [2021] EWHC 3604 (Admin)

This case concerned an Article 2 inquest into the death of 22-year-old Sally Mays. The Coroner identified a number of failings including a refusal to admit her to an acute inpatient psychiatric ward. Those failings constituted neglect and caused or contributed to her death later that same evening.

There was no criticism of the way in which the Coroner conducted the inquest. Rather, after the inquest concluded, the Coroner was informed for the first time that there had been a conversation between a Community Psychiatric Nurse and a Consultant Psychiatrist in a carpark, shortly after the inpatient admission was refused. This information had been intentionally withheld from the Inquest; a police investigation concluded there was insufficient evidence to prosecute because the information was withheld because it was considered not clinically relevant, rather than an intention to pervert the course of justice.

The outcome of the inquest was unlikely to be substantially affected by evidence about this conversation – the Coroner already found numerous failings which constituted neglect. But this was an Article 2 inquest and there had been no fact-finding investigation into this conversation and whether it was an opportunity to reverse the poor assessment decision and admit Ms Mays to the unit. The fact that this point had not been explored by the inquest meant the Article 2 investigative obligation had not yet been discharged and a fresh inquest was ordered.

Insufficiency of inquiry: Earl v HM Senior Coroner for East Sussex [2021] EWHC 3468 (Admin)

This application concerned an inquest into the death of Jessie Earl, a 22-year-old who went missing in May 1980 and whose remains were found 9 years later. The circumstances in which her remains were found – in an almost inaccessible area and without any of her property other than a tightly knotted bra – did not result in a full murder investigation. A subsequent police inquiry found that the police investigation at the time was flawed and inadequate. On the basis of that investigation, the Coroner reached an 'open' conclusion at the inquest.

It was not simply the case that the police investigation was flawed and inadequate, although the Coroner was clearly not assisted by such an unsatisfactory investigation. The Coroner's decision to reach an 'open' conclusion was unreasonable under public law principles: the circumstances in which she was found clearly indicated that this was likely to be an unlawful killing and, furthermore, there were irregularities in the inquest proceedings.

The Court recognised the family's lengthy pursuit of justice, and a fresh inquest was ordered, in large part because the Court felt it had to do its best to put right an injustice for the family and maintain public confidence in the coronial process.

Inadequate directions to jury: R (on the application of Ginn) v HM Senior Coroner for Inner London [2022] EWHC 28 (Admin) 11 Jan 2022

While the information which fed into the investigation was inadequate in the other two cases, this was a case where it was the Coroner's errors which undermined the inquest process and required a fresh inquest to be ordered.

The inquest concerned the suicide in custody of Richard Ginn, a 56-year-old prisoner with a history of recurrent depressive disorder and emotionally unstable personality disorder. Despite submissions from the Interested Persons, the Coroner decided not to give the jury any written directions, a questionnaire or a list of issues to consider.

In circumstances where the Chief Coroner's Guidance No. 17 on Conclusions strongly encourages coroners to give jurors written directions in complex cases, the Court clearly thought that this was a poor decision. But it was not a public law error.

However, her guidance on the jury's task did fall into error. Notably, she failed to direct the jury that they were required to make a determination on whether the core issues which were raised during the inquest caused or contributed to Mr Ginn's death. As this was an Article 2 inquest, the investigative obligation would only be satisfied if the jury reached a *conclusion on the disputed factual issues at the heart of the case*. Instead, her guidance gave the impression that there was no need for them to make determinations on the central issues. As a result, the jury returned a meaningless conclusion and a fresh inquest was ordered.

Comment

These cases are all instructive. *Mays* and *Earl* are both indicative that coronial investigations are always more effective when there is careful, considered and appropriate engagement with the inquest, from police officers or clinicians who are involved in the circumstances of the death or the investigation thereafter. Withholding information – whatever the motivation – is damaging to justice, and to the trust of the public in the coronial process. Also, it is unlikely to be advantageous in the long run.

But coroners cannot hide behind the inadequacies of the investigation of others. Their investigation must be full, frank and fearless. Even if a police investigation, or a Trust's serious incident report, does not properly grapple with the key issues, it is incumbent on a Coroner to initiate investigations to satisfy him or herself that their statutory duty is complied with.

That duty encompasses an obligation on a Coroner to elicit a jury's conclusions (or set out their own conclusions) on the key issues in the case. That is essential in order to comply with the investigative duty under Article 2 but likely to be necessary in traditional *Jamieson* inquests anyway. Coroners would be sensible to follow the Chief

Coroner's guidance that they should give clear, written guidance on the law to juries, whose conclusions can otherwise betray a lack of understanding of the proper scope of their role.

DISHONESTY AND DENIAL – PART 2

Richard Smith

Ahmedsowida v General Medical Council [2021] EWHC 3466

Sawati v General Medical Council [2022] EWHC 283

I wrote last year about developments in the guidance given by the High Court in cases of professional regulation on the effect on sanctions of unsuccessful denials of dishonesty (link here). The issue continues to be a live one, to which further judicial gloss has been applied in two further cases – *Ahmedsowida v General Medical Council* [2021] EWHC 3466 and *Sawati v General Medical Council* [2022] EWHC 283.

The Rejected Defence Issue

A question that frequently arises in regulatory tribunals is what the consequence should be for a registrant who denies the charge, but whose evidence is rejected. Should the fact that the charge was denied, and the version of events which was disbelieved persisted with, count against the registrant when considering whether their fitness to practice is impaired and, if so, what the appropriate sanction should be? In essence, the issue is one of fairness, namely:

> *"[H]ow a professional can have a fair chance before a Tribunal to resist allegations, particularly of dishonesty, without finding the resistance itself unfairly counting against them if they are unsuccessful."* (per Collins-Rice J at [75] of *Sawati,* emphasis in original).

This is a question of particular importance given the weight that regulators tend to place on the registrant's insight into what brought them before the Tribunal. If they have denied a central and fundamental aspect of the case against them then must this lack of insight into their wrongdoing be held against them over and above the wrongdoing itself?

The position taken in the cases considered in the previous article (*Towuaghantse v GMC* [2021] EWHC 681 (Admin) and *Al Nageim v General Medical Council* [2021] EWHC 877 (Admin)) was that:

> *"[I]t is not procedurally fair for a registrant to face the risk of enhanced sanctions by virtue of having robustly defended allegations made against him before the MPT, or before another court."* per Mostyn J in *Towuaghanstse*

But where there was blatant dishonesty in the registrant's denial of primary concrete facts alleged before the Tribunal then that would impact on a consideration of impairment and fitness to practise in the future.

Further, while it may be unfair to expect a *"Damascene conversion"* from a registrant who had unsuccessfully defended the fact-finding stage it was not unreasonable to expect a developing understanding of the wrongdoing found if there was a significant gap between the fact-finding and the impairment/sanctions stages.

The Recent Cases

I do not propose to summarise the facts of *Sawati* and *Ahmedsowida*, which are complex in their own ways. The rejected defence issue arose in both cases and was dealt with as an individual point. In each case the GMC sought to argue that it was open to the Tribunal to consider the rejected defences as further evidence of dishonesty which could be taken into account when assessing the registrant's level of insight and the sanction to be imposed. The Court declined to do so on each occasion.

In *Ahmedsowida* Kerr J agreed with the approach in *Towuaghantse* and held that:

> *"I do not think that the principle is sophisticated or complicated. It is just ordinary due process. Contesting the charges, even robustly, should not be treated of itself as evidence of lack of insight; something more must be shown. A finding that blatant lies were told to the tribunal is one possibility. A long hiatus between the fact finding and impairment and sanction stages may be a contributing feature."* [146].

The appeal against the Tribunal's determination was allowed, in part, on the basis that it had impermissibly held against the registrant his refusal to admit dishonesty without anything additional being shown. The matter was remitted to a differently constituted Tribunal.

In *Sawati*, Collins-Rice J carried out a thorough review of the caselaw, from which she extracted the following relevant factors – a lengthy extract from the judgment is set out below given its centrality to the subject matter of this article:

> *"103. The principle of due process may not be sophisticated or complicated. The principle of protecting the public from practitioners who cannot accept or deal with findings of fault, and are at risk of repeating their failings, is not complicated either. Reconciling the two may however be difficult in an individual case, and is undoubtedly fact-sensitive. So the question is how best to approach the facts of a given case. I have recounted the caselaw at some length, to identify not just guidance of principle, but also the pattern of relevant factors to which the appellate courts have consistently attached importance. The following stand out.*
>
> *104. First: the primary allegations against the doctor. The proper place of dishonesty (or other states of mind such as 'deliberate' and 'knowing') in the scheme of the allegations matters.* ***A rejected defence of honesty may be more fairly relevant to an overall assessment of conduct where dishonesty (the noun) is the primary allegation - deceit, fraud, forgery or similar – than where 'dishonestly' (the adverb) is a secondary allegation, aggravating a primary allegation of other misconduct which may or may not be done honestly*** *– or not a formal allegation at all. As Lord Hoffmann emphasised, particular alertness is needed to the 'charging trap': adding 'dishonestly' to a primary allegation to aggravate it disproportionately, colour any denial of the primary allegation with dishonesty, or characterise denial of the dishonesty as itself dishonest or lacking insight. But even short of oppressive charging, the fair relevance to sanction of a doctor's rejected honesty defence depends on its relationship to what they were primarily defending.*
>
> *105. Second: what if anything the doctor is positively denying. There is a difference between denying 'primary facts' – what happened and what the doctor did or did not do – and denying 'secondary facts' – the evaluation of the primary facts through the lens of what the doctor knew or thought and the choices available to them. Resistance to the objectively verifiable is potentially more problematic behaviour (and more relevant to sanction) than insistence on an honest subjective perspective. This is not of course an exclusive binary classification: what a doctor thinks or knows will often have to be deduced evidentially from objective circumstances. A secondary fact such as dishonesty may be inferred in some defended cases from an overwhelming accumulation of primary facts.* ***If a doctor denies their alleged state of mind with a defence at the unreal, unreasonable or 'frankly ludicrous' end of the spectrum, that may be more fairly relevant to sanction than one where the only thing being denied is that dishonesty rather than honest mistake gives the better account of things.***
>
> *106. Third:* ***whether there is evidence of lack of insight other than the rejected defence****. Before a rejected defence is held to be relevant evidence of 'lack of insight', it is necessary to consider what other evidence of insight or lack of insight is present. There are cases, including some of the sexual impropriety cases, where being 'in denial' up to and including sanction proceedings is a richly evidenced course of conduct, in which a range of supportive and restrictive interventions have demonstrably failed to bring a doctor to a proper, fair and reasonable acknowledgment of the reality of their established problems and failings. At*

the other end of the spectrum, there are cases in which the only evidence of failure of insight seems to be robust defence at the fact-finding stage. Damascene conversions aside, a rejected defence which on a fair analysis adds to an evidenced history of faulty understanding is more likely to be relevant fairly to sanction than one said to constitute such faulty understanding in and of itself.

107. (I am not myself assisted by analogy with criminal proceedings in this respect. A plea of guilty can secure a mitigation of sentence because it spares the victim and the public purse the human and financial cost of a trial. The risk the offender may or may not pose to the public is dealt with in other ways. Insight is a genuine and proper issue in professional regulatory proceedings in and of itself. But as such it needs to be properly considered on a substantive and not just a procedural basis.)

108. Fourth: the nature and quality of the rejected defence. 'Not telling the truth to the Tribunal', when not freshly charged in separate proceedings as akin to perjury, has to amount to something more than a failure to admit to an allegation (especially a secondary allegation of dishonesty) or a putting to proof, before it can properly count against a doctor. It is likely to have to amount to more than offering an 'honest' alternative explanation of events alleged to be explicable as dishonesty, or it is hard to see how a dishonesty charge is to be effectively defended. It is going to require some thought to be given to the nature of the rejected defence. Was it a blatant and manufactured lie, a genuine act of dishonesty, deceit or misconduct in its own right? Did it wrongly implicate and blame others, or brand witnesses giving a different account as deluded or liars? Or was it just a failed attempt to tell the story in a better light than eventually proved warranted?

109. In short, before a Tribunal can be sure of making fair use of a rejected defence to aggravate sanctions imposed on a doctor, it needs to remind itself of Lord Hoffmann's starting place that doctors are properly and fairly entitled to defend themselves, and may then find it helpful to think about four things: (i) how far state of mind or dishonesty was a primary rather than second-order allegation to begin with (noting the dangers of charging traps) – or not an allegation at all, (ii) what if anything the doctor was positively denying other than their own dishonesty or state of knowledge; (iii) how far 'lack of insight' is evidenced by anything other than the rejected defence and (iv) the nature and quality of the defence, identifying clearly any respect in which it was itself a deception, a lie or a counter-allegation of others' dishonesty.

110. These are all evaluative matters. Tribunals need to make up their own minds about them, and their relevance and weight, on the facts they have found. But they do need to direct their minds to the tension of principles which is engaged, and check they are being fair to both the doctor and the public. They need to think about what they are doing before they use a doctor's defence against them, to bring the analysis back down to its simplest essence." [emphasis added].

The appeal was allowed, in part, due to the Tribunal's failure to consider these sorts of issue at all, simply finding that the registrant's dishonesty and her failure to admit it were matters of sufficient seriousness to justify erasure. The Judge remitted the matter to a differently constituted Tribunal.

Discussion

Collins-Rice J's four relevant factors in rejected defence cases merit some further reflection. The Judge had clearly in mind that this was a recurring issue in appeals to the High Court and has provided a careful analysis of the caselaw in an attempt to provide clarity and assistance to regulatory tribunals. I speculated in the previous article whether the GMC would amend its Sanctions Guidance to reflect *Towuaghantse,* given the absence of it advocating a different approach in *Al Nageim*. That was premature given the line taken in the cases discussed above, where the argument that rejection of the registrant's evidence was enough to rule out insight and aggravate the sanction imposed. It may be optimistic to think that the *Sawati* approach will be adopted given the factors now held to be relevant go further than those expressed in *Towuaghanstse*.

The first factor draws a new distinction between allegations of dishonesty and allegations of carrying out an action dishonestly. The distinction is between things which are necessarily dishonest (deceit, fraud, forgery etc)

and things which might have an honest explanation. The latter should not impact on insight. Allegations of carrying out an action dishonestly are much more common than allegations of dishonesty per se, at least among clinical professional regulation. Thus, this factor will draw special attention to the relatively rare cases of fraud or forgery, understandably elevating them to a position from which it is harder to demonstrate insight.

The second factor considers whether the defence to the allegation goes to secondary facts (such as knowledge and understanding) rather than the primary facts of what was done or not done. Again, if the defence is honest mistake rather than a wholesale denial of the events alleged, or a "*frankly ludicrous*" explanation (such as Dr Al Nageim's belief that he was entitled to a salary from a hospital where he no longer worked), then that should not impact on insight.

The third factor is a reminder to consider matters in the round and, if there is evidence that the registrant lacks insight generally, then the rejected defence might be further evidence of this.

The fourth factor broadly reflects the first two, but would catch any relevant matters which had not arisen in consideration of those features in a given case.

These factors could provide a useful aide memoir to Tribunals considering how to approach a rejected defence and prevent unjustifiably harsh treatment for those who were simply standing their ground in their defence.

Martin Forde QC appeared as counsel for the appellant in both of these cases. He has had no input into the writing of this article.

LESSONS IN DISHONESTY

Andrew Kennedy QC

GMC v Armstrong [2021] EWHC 1658 (Admin)

Bakare v GMC [2021] EWHC 3278 (Admin)

The Professional Standards Authority v (1) GDC & (2) Amir [2021] EWHC 3230 (Admin)

Are there lessons to be learned from three recent High Court decisions concerning allegations of dishonesty? It is instructive that the cases involved the three types of appeal that can bring a disciplinary/regulatory case before the High Court.

1. *GMC v Armstrong* [2021] EWHC 1658 (Admin) - A s.40A Medical Act 1983 appeal by the GMC against a finding Dr Armstrong's fitness to practise was not impaired.
2. *Bakare v GMC* [2021] EWHC 3278 (Admin) - A s.40 Medical Act 1983 appeal by Dr Bakare against a direction for erasure.
3. *The Professional Standards Authority v (1) GDC & (2) Amir* [2021] EWHC 3230 (Admin) - A s.29 National Health Service Reform and Health Care Professions Act 2002 appeal by the Professional Standards Authority ('PSA') against a direction for suspension of Mr Amir's registration for 3 months.

Armstrong

Dr Armstrong made admissions that she had worked as a GP whilst not on a Medical Performers List ('MPL'), that she had falsely stated that she was on a MPL, and had failed to disclose an order for interim suspension when applying for two jobs in the UK and when applying for a GP post in Australia. She gave evidence before the Medical Practitioners Tribunal ('MPT') at the impairment stage accepting full responsibility for her actions, showing remorse, a "*high level of insight*" and acknowledging that fellow practitioners would be "*disgusted*" by

her conduct. The MPT determined that there were exceptional circumstances that permitted it to find that her fitness to practise was not impaired. The GMC appealed.

The High Court recognised that "*it is very rare indeed for a person who has committed serious professional misconduct by reason of dishonesty to escape a finding of impairment"* and reviewed three appeal cases in which a finding of dishonesty did not lead to impairment. The common features from that review were that the cases were ones of isolated lapses in otherwise unblemished careers where the risk of repetition was extremely low and there was good insight.

The High Court concluded that Dr Armstrong's case was not exceptional as the dishonesty was not isolated, it was repeated and there was financial gain. Moreover, the MPT had placed wholly excessive weight on personal mitigation; rather, it should have recognised that personal mitigation has only a limited role in cases of dishonesty. The impairment decision was quashed and replaced with a decision that Dr Armstrong's fitness to practise is currently impaired. The case was remitted to the MPT for a decision on sanction.

Bakare

Dr Bakare's case concerned clinical allegations and allegations of dishonesty. The clinical allegations can be disregarded as the MPT found that they did not amount to current impairment and had no relevance to the direction for erasure and therefore the issue to be addressed by the High Court.

The dishonesty allegations ranged from more minor dishonesty concerning scheduling leave from a tutorial with her educational supervisor to CV or application fraud (failing to declare ongoing fitness to practise investigations on two application forms and one declaration) and prescription fraud (failing to return a prescription pad and writing a prescription in the name of a family friend and signing the prescription in another doctor's name). The prescription fraud allegations were investigated by the Police which resulted in Dr Bakare wrongly being commended by the Police for her cooperation in their investigation. Six years after writing the prescription and on the fourth day of the MPT hearing faced with the evidence of the GMC handwriting expert, Dr Bakare admitted the prescription fraud. Her name was erased.

Dr Bakare appealed against the direction for erasure on the grounds of disproportionality, adequacy of reasons for rejecting suspension as an alternative disposal, and the failure to attach appropriate weight to mitigating factors. The High Court rejected the appeal.

After a helpful review of the authorities on dishonesty [36-42] Calver J concluded that the direction for erasure "*cannot be said to be wrong and indeed was undoubtedly correct"* for the following reasons:

1. Dishonestly concealing an ongoing investigation on three occasions over a five-month period is conduct that lies *"at the top end of the spectrum of gravity of misconduct"* as it undermines "*something fundamental to the system of medicine*" [60-61].

2. The prescription fraud was particularly serious because it involved a breach of trust, potentially endangered patient safety, and demonstrated a complete lack of candour towards fellow professionals [63].

3. This serious dishonesty was covered up for many years, involved misleading the Police and the fact that it was only admitted very late in the day suggested a complete lack of insight [64-66].

4. Personal mitigation should be given limited weight, as "*the reputation of the profession in such a serious case of dishonesty is more important than the fortunes of an individual member"* [74] – see *Bolton v Law Society* [1994] 1 WLR 512.

Amir

Mr Amir was charged with making claims that various medical conditions (including ataxia, depression & anxiety, learning difficulties, MS & heart palpitations) could be attributable to a dysfunctional jaw joint which as a registered dentist he could treat. He was consulted by a patient who suffered from spinocerebellar ataxia. The

case against him was that the only appliance which he offered to his patient was not clinically justified and that his claims were dishonest in that he knew that there was no reasonable body of evidence to support them.

In the High Court the PSA challenged, inter alia, the decision of the Professional Conduct Committee ('PCC') that Mr Amir's claims were not dishonest and the determination to suspend his registration for 3 months. The High Court concluded that the PCC had fallen into error when answering the second limb of the *Ivey v Genting* [2017] UKSC 67 test when it found that Mr Amir's conduct *"would not be considered dishonest by reference to the standards of ordinary and decent people, as they would consider that you genuinely believed that a reasonable body of opinion existed to support your statements."* The effect of the PCC's decision was to allow Mr Amir to set his own standards and would permit him to flout the GDC's standards because he had concluded that he knew better. The High Court replaced the PCC's finding that he had not been dishonest with a finding that he had and the direction for three months' suspension with a direction for erasure. It did not remit sanction as it was satisfied that there was no possibility that Mr Amir would achieve insight. Rather, his position was fixed.

Comment

1. Do these cases demonstrate a hardening of the line taken by the High Court in dishonesty cases? Probably not. They affirm the approach that the High Court has taken to dishonesty by professional people from *Bolton* (supra) through cases such as *NMC v Parkinson* [2010] EWHC 1898 (Admin). What these cases illustrate is the importance of obtaining the right result at first instance. This may not always be the best result. The superficially "*good*" results in *Armstrong* and *Amir* were inevitably going to be challenged. Indeed, the direction for three months' suspension in *Amir* may have been challenged even if the PCC had made a finding of dishonesty given the absence of insight. As these cases and the review of the exceptional circumstances cases in Armstrong demonstrate, central to achieving the right result is showing insight.

2. The review of the second limb of the *Ivey* test for dishonesty in *Amir* is helpful. As *Bakare* demonstrates a late admission of dishonest conduct can be fatal to demonstrating insight. Practitioners understandably struggle with the proposition that they may be thought to have acted dishonestly but leaving this issue for the disciplinary tribunal to resolve can be to leave it too late.

COURT OF APPEAL REFUSES PERMISSION TO JUDICIALLY REVIEW INFECTED BLOOD COMPENSATION SCHEME

Lucy McCann

CN v Secretary of State for Health and Social Care [2022] EWCA Civ 86

In a judgment handed down on 4 February 2022, the Court of Appeal dismissed an appeal for permission to apply for judicial review concerning the lawfulness of the England Infected Blood Support Scheme (EIBSS) (the "Scheme"). The Court of Appeal concluded that the Scheme's exclusion of those infected with hepatitis B was not discriminatory. In any event, the Secretary of State's justification for who was to be compensated under the *ex gratia* Scheme was to be given a wide margin of appreciation by the courts.

Background

The Appellant, CN, suffers from hepatitis B virus ("HBV") which he alleges he contracted when given blood transfusions on or after 14 April 1989. Consequently, CN has suffered from serious health problems, and was forced to abandon his business to receive medical treatment; he has been reliant on state benefits for the last 13 years. CN is a core participant in the ongoing infected blood inquiry, which was established to examine the circumstances in which NHS patients in the UK were given infected blood and blood products.

In 1995, CN issued a civil claim against the NHS and the National Blood Authority (now the NHS Blood and Transplant Service). Despite obtaining expert evidence to the effect that his infection was obtained from infected blood, he had to discontinue his claim when legal aid was withdrawn.

Infected blood and the England Infected Blood Support Scheme (EIBSS)

The Scheme was set up on 1 November 2017, to provide *ex gratia* support to people historically infected with hepatitis C virus ("HCV") and/or human immunodeficiency virus ("HIV"). Specifically, the 2017 Directions set out the EIBSS's purpose as:

> *'a scheme to make payments and provide support in respect of individuals infected with HIV or Hepatitis C (or both) from blood or blood products used by the NHS and to provide support to family members of such individuals'.*

The Scheme addresses the ongoing social issues concerning those infected and affected by HIV and HCV from unscreened products. The Scheme recognises a moral imperative to compensate those infected with HCV and HIV in circumstances where attempts to allege negligence against the NHS would run into significant difficulties of fault-based liability and evidential issues surrounding the state of scientific knowledge at the time. It also helps families and partners after the death of someone infected, who would otherwise be unable to make a civil claim.

Those infected with HBV do not fall within the remit of the Scheme. In basic terms, this is because the NHS screened blood and blood products for HBV from the mid 1970s, so the number of patients infected with HBV were low after screening. Within the Scheme, the cut-off date for HCV claims is September 1991, when screening was introduced. For HIV there is no cut-off, but the eligibility criteria make clear that after October 1985, when the NHS screened for HIV, it was very unlikely that HIV would be transmitted through infected blood.

Therefore, CN could not access compensation for his HBV infection through the Scheme and cannot pursue a further claim in negligence against the NHS. It is against this backdrop that CN sought to challenge his exclusion from the Scheme by way of judicial review.

CN's challenge

CN's challenge to the decision confirming that those infected with HBV fell outside the scope of the Scheme was threefold:

1. The Scheme was discriminatory, contrary to article 14 EHCR (freedom from discrimination) combined with article 8 ECHR (respect for private and family life) and article 1 protocol 1 ECHR ("A1P1") (right to property).
2. The Scheme amounted to disability discrimination contrary to s.15 of the Equality Act 2010.
3. The Scheme was unreasonable.

Spencer J refused CN permission to apply for judicial review on the papers. Permission was then further refused at an oral hearing by Stacey J. CN was then granted permission to appeal Stacey J's decision to the Court of Appeal by Holroyde LJ.

Is the Scheme discriminatory and if so, can it be objectively justified?

The central question in the appeal was whether it was arguable that the exclusion of those infected with HBV from the Scheme was discriminatory contrary to article 14.

Article 14 is not a free-standing right to non-discriminatory treatment; one must be able to show discrimination that interferes with other convention rights. For the sake of the decision, the Court of Appeal was willing to assume that CN had an arguable case that the alleged discriminatory conduct, namely the eligibility criteria of the Scheme, was within the ambit of article 8 and A1P1. The Court of Appeal also accepted that CN arguably had an 'other status' for the purposes of article 14.

The Court of Appeal considered two main questions on the discrimination point:

1. Was it arguable that CN was in a relatively similar position to HIV and HCV sufferers?
2. In any event, could the Secretary of State justify differential treatment?

CN contended that the reason he was treated differently was simply because he was infected with HBV rather than with HIV and/or HCV, and that there is no material difference between them for the purposes of the Scheme. The issue of screening, CN argued, was not relevant since the 2017 Directions make no reference to unscreened blood or blood products, and because the distinction between screened and unscreened blood products was historically not so clear, as effectiveness was not guaranteed and not all blood and blood products were screened.

The Court of Appeal concluded that while it was true that the stated purpose of the Scheme contained in the 2017 Directions does not draw a distinction between screened and unscreened products, the question of relevant similarity could not be understood without examining the objective justification for the scheme.

Turning to the question of the justification of the eligibility criteria of the Scheme, the Court of Appeal adopted the approach of Lord Reed in R (SC) v Secretary of State for Work and Pensions [2021] UKSC 26 at [158]:

> *'… a low intensity of review is generally appropriate, other things being equal, in cases concerned with judgments of social and economic policy in the field of welfare benefits and pensions, so that the judgment of the executive or legislature will generally be respected unless it is manifestly without reasonable foundation.'*

In this instance, the Court of Appeal adopted a 'sliding scale' of intensity of review: the Scheme is concerned with ministerial judgments of social and economic policy (requiring a less intense review), but also involved provision for disabled sufferers (requiring a more intense review). The fact that the EIBSS was an *ex gratia* scheme, such that CN had no statutory entitlement to, or legitimate expectation of, compensation was also relevant. Other schemes like the Criminal Injuries Compensation Scheme were therefore distinguished. Accordingly, the Court of Appeal afforded the Secretary of State's judgement of who to include in the EIBSS a wide margin of discretion.

Having adopted a sliding scale of intensity of review, the Court of Appeal concluded that the operation of the EIBSS, such that it excluded CN, could be justified for the following reasons:

- It existed to overcome the moral dilemma posed by the regime of fault-based liability which shut off access to compensation to those infected by HCV and HIV.
- The nature of such a scheme, in contrast with the approach in negligence claims, is that there is no mechanism by which the court can judge who is more or less deserving of compensation.
- Despite the historical issues with screening, the distinction between screened and unscreened blood and blood products is intelligible and comprehensible.

On this understanding of the rationale for the Scheme, the Court of Appeal concluded that the true comparison with CN was either HCV sufferers who contracted their infection from unscreened blood or blood products, and/or HIV sufferers who would be very unlikely to be able to claim if they received treated blood or blood products.

On this basis, both the article 14 claim, along with the question of unreasonableness and irrationality, were not arguable.

Was the claim out of time?

Having refused permission on the substance of CN's claim, the Court of Appeal turned to consider whether CN's application was out of time.

CN sought permission to judicially review a decision made on behalf of the Department of Health and Social Care dated 12 May 2020 which explained why there was no plan to expand the eligibility criteria for the Scheme. However, the Scheme was established in 2017, from which point CN has been excluded from seeking compensation for his infection with HBV. The question for the court was whether time ran from 2017, or from the 2020 decision.

CN argued that the operation of the Scheme was a 'continuing act', relying on the decision in *R (Johnson) v Secretary of State for the Home Department* [2016] UKSC 56 where the Supreme Court held that the scheme in question '*had a current and direct effect upon the claimant who is currently liable to action by the state'* [28].

However, in line with R (Delve) v Secretary of State for Work and Pensions [2020] EWCA Civ 1199, the Court of Appeal maintained that the effects of the EIBSS were unchanged since 2017. There were no continuing activities of the state beyond CN's initial exclusion which aligned CN's challenge with that in *Johnson.* Therefore, time started running from 2017 and CN was out of time.

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

EVENTS & NEWS

We are delighted to announce **Marcus Coates-Walker** has joined chambers, effective from 11th April 2022. Marcus was called in 2013 and has a specialist practice in clinical negligence, inquest and personal injury work. He regularly appears in court and is a trained mediator. He is recommended as a leading junior in both Chambers and Partners and the Legal 500, who describe him *"very keen, understands the issues very quickly and is very approachable."*

We are **recruiting** energetic, experienced and able prospective tenants at all Junior levels in the fields of Clinical Negligence, Tax, Professional Discipline, Personal Injury/Abuse, Inquests/Inquiries, and Public Law, due to the high volume of work from leading Claimant and Defendant firms. See our website for more information.

Podcast

On **Law Pod UK** find Jon Metzer talking to Emma-Louise Fenelon about the most significant cases of 2021, Rob Kellar QC discussing healthcare reform with Rosalind English or Sarah Lambert QC and Dominic Ruck-Keene discussing loss of a chance.

Further news, events, and webinars can be found on our website.

Letters to the Editor

Feel free to contact the team at medlaw@1cor.com with comments or queries. Explore our website at www.1corqmlr.com and follow us on Twitter @1corQMLR.

CONTRIBUTORS & EDITORIAL TEAM

Rajkiran Barhey (Call: 2017) – Editor in Chief

Rajkiran (Kiran) accepts instructions in all areas of Chambers' work and is developing a broad practice, particularly in clinical negligence, personal injury, inquests, tax, environmental and planning law, immigration, public law and human rights.

From January to April 2022 Kiran worked as a Judicial Assistant in the Administrative Court, gaining invaluable experience which informs her practice.

She has a wide range of advocacy experience, both led and unled, having appeared in the County Court, in the Coroners' Courts, in the First-tier and Upper Tribunals, in a planning inquiry, and in the Employment Tribunal.

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

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

Shaheen Rahman QC (Call 1996, QC: 2017) – Editorial Team

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

Suzanne Lambert (Call: 2002) – Editorial Team

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

negligence, apportionment between defendants, and consent.

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.

Darragh Coffey (Call: 2018) – Editorial Team

Darragh Coffey accepts instructions in all areas of Chambers' work and is developing a broad practice with a particular focus on public law. He appears in courts and tribunals on behalf of both Claimants and Defendants in a range of civil hearings.

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.

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

Robert Kellar QC has a broad practice which encompasses clinical negligence, professional discipline, public law and personal injury. In clinical negligence he is instructed by both claimants and defendants in complex, multi-party and high value litigation. Robert also acts for healthcare professionals in complex cases before the major regulatory bodies.

Andrew Kennedy QC (Call: 1989, QC: 2021) - Contributor

Andrew has a practice that focuses primarily on clinical negligence and regulatory and disciplinary law, and the public law aspects of these areas. He has a wide experience of clinical negligence representing both Claimant and Defendant principally in complex or high value claims. In the regulatory field, he has been involved in some of the most significant and high profile GMC enquiries in the last 10 years, and has appeared before all of the major regulatory bodies in the healthcare field. In addition, he undertakes personal injury work and professional negligence work arising from his primary areas of practice.

Richard Smith (Call: 1999) – Contributor

Richard Smith's practice focuses on professional discipline, clinical negligence, professional negligence, personal injury and costs. He is recommended as a leading junior by Chambers & Partners and Legal 500. Richard is instructed on behalf of both Claimants and Defendants in cases of clinical negligence of all types. He has a broad experience and active caseload including multi-million pound claims and is involved in claims at all stages from pre-action to trial.

Matthew Donmall (Call: 2006) – Contributor

The son of two doctors, Matt has medicine in the family. His expertise in clinical negligence spans both liability and quantum issues, and the difficult points of causation that can intersect them. He acts for both claimants and defendants, and finds doing so helps to give insight into how opponents may act. Matt has extensive experience in clinical negligence claims representing claimants and defendants across a wide range of medical areas. These include obstetric / perinatal injury; gastroenterology; delayed cancer diagnosis; orthopaedic and other surgery; general practice and dentistry.

Gideon Barth (Call: 2015) - Contributor

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

Jasper Gold (Call: 2021) – Contributor

Jasper joined chambers as a third six pupil in 2021, having completed pupillage at a leading commercial law set. He is developing a practice in all areas of chambers' practice.

Before coming to the bar, Jasper was an Oxford Human Rights Hub-Rhodes University Travelling Fellow in human rights law, spending time researching and teaching at Rhodes University in South Africa, and as an intern with the Legal Resources Centre, South Africa's leading public interest law firm, assisting with constitutional rights litigation.

Lucy McCann (Call: 2020) – Contributor

Lucy joined chambers as a pupil in October 2021 and is building experience in all of chambers' practice areas.

Prior to commencing pupillage, Lucy edited OUP's practitioner text, Judicial Review: Principles and Procedure (2nd ed forthcoming 2022) and was a visiting lecturer in public law at City Law School. During her legal studies, Lucy volunteered for the School Exclusion Project, representing pupils appealing their exclusion from school.

Thomas Hayes (Call: 2020) – Contributor

Thomas joined chambers as a pupil in October 2021 and is building his experience in all of chambers' practice areas.

Thomas was a practising surgeon before turning to a career in law and, in addition to a full time medical practice, led a safe surgery initiative in the Democratic Republic of Congo and has acted as an expedition medic for a field study undertaken in the Peruvian Amazon. Before joining chambers, he volunteered at the Free Representation Unit (FRU).