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Lawyers Service Newsletter

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Editorial

Lisa O'Dwyer
Director, Medico-Legal Services

Despite continued uncertainty around Covid-19, we do at last appear to be emerging into something resembling *"normal"*. Ed Maycock recently delivered AvMA's first live conference meeting in about eighteen months, social distancing measures were in place and the event was well attended. For more details of our live conference events see: https://www.avma.org.uk/resources-for-professionals/events/ Also, 2022 marks AvMA's 40th year, please do read our CEO, Peter Walsh's appeal on the following page.

In September, government published its response to the Health and Social Care Committee (HSCC) report on the safety of maternity services. The report acknowledged that *"unacceptable variations in the quality of care and outcomes remain"* and that more needs to be done to address organisational leadership and poor culture in England. Government rejected the committee's recommendation to implement the Rapid Resolution and Redress (RRR) maternity scheme in full. HSCC then published a call for evidence on NHS Litigation Reform which invited views on a broad range of issues, from the way in which compensation is currently awarded in clinical negligence claims to fixing recoverable costs (FRC). The closing date for submitting evidence was 20th October but the terms of reference can be found here: https://committees.parliament.uk/call-for-evidence/590 AvMA contributed to the call for evidence although it should be noted that the government consultation on FRC is awaited.

With the HSCC focus on maternity care and their attempt to resurrect discussion around the RRR maternity scheme we highly recommend Janine Collier's two articles, the aptly named **"A reminder – The Rapid resolution and redress scheme: aims, review and proposals"** and **"Maternity safety in England"**. Janine is a very experienced clinical negligence practitioner and AvMA panel member, she is Head of Clinical Negligence and Personal Injury at Tees Law, and we are delighted to publish her insight into this very specialised and demanding area of work.

The Lawyer Service Newsletter provides an opportunity for practitioners to share experiences, views and learning with other clinical negligence specialists, we are always pleased to feature articles from our AvMA panel members. Suzanne Munroe, AvMA panel member, Head of clinical

negligence and Director at Switalskis Solicitors article **"High value complex neurological injury litigation"** gives an insight into funding challenges and delays in progressing cerebral palsy cases caused by poor funding processes. The article is especially pertinent given the HSCC apparent commitment to rapid resolution!

At a time when the cost of litigation and compensation is under scrutiny it is important to remember the difference proper compensation makes to the wellbeing of clients and their ability to progress. To this end, AvMA panel member, Alison Johnson, partner at Pennington Manches Cooper and her colleague Victoria Johnson an associate at the firm has provided us with two case studies which demonstrate **"The impact on claimants after settlement of damages"**.

The recommendations in the Justice Committee report on the Coroner Service published on 27th May were welcomed by AvMA: **https://committees.parliament.uk/publications/6079/documents/75085/default/**

The government's response to the recommendations less so. AvMA has brought together several charities and organisations, including INQUEST who support the committee's recommendations and collectively have written to the Secretary of State for Justice, the Home Secretary, the Chief Coroner, and the Chair of the Justice Committee (Bob Neill MP) to express disappointment at the response: See **https://www.avma.org.uk/wp-content/uploads/Coroners-service-letter.pdf** to view letter of 13.10.21. A Westminster Hall debate on the Justice Committee's report on the coroner service took place on 28th October and INQUEST briefed MPs in preparation for the event.

The Civil Justice Council final report on Guideline Hourly Rates (GHR) was published on 30th July: **https://www.judiciary.uk/wp-content/uploads/2021/07/Civil-Justice-Council-final-report-on-guideline-hourly-rates.pdf** the rates were implemented on 1st October. Colin Campbell's article **"The 2021 Guideline Hourly Expense Rates: will Claimant Lawyers be laughing all the way to the Bank?"** highlights how the GHR are expected to be applied. As many of you are aware Colin is a Consultant at Kain Knight Costs Lawyers, he is also an accredited mediator in costs and sits as a Deputy Costs Judge at the Senior Courts.

This edition of the Newsletter also welcomes the second part of Laurence Vick's article on Clinical guidelines entitled **"The potential flaws in clinical guidelines: The stenting v surgery controversy"**. Laurence has recently contributed a chapter to a published textbook *"Clinical Guidelines"* where he comments on the implications of guidelines and protocols from his perspective as a clinical negligence solicitor.

Bill Braithwaite QC from Exchange Chambers looks at some of his recent complex brain injury cases and shares what he has learned from those cases in his **"Medical negligence cases 2021 for AvMA"**. Marcus Coates-Walker, barrister at St John's Chambers (Bristol) another regular contributor to our Newsletter looks at the **"Scope of duty principle in light of *Khan v Meadows*"** and explores the Supreme Court's decision in this case and what it means for clinical negligence practitioners.

Recent decisions by the divisional court suggest a move towards restricting the circumstances when the operational duty under Article 2 European Convention Human Rights (ECHR) may arise, in turn restricting the scope of the coroner's inquiry. Jonathan Metzer, barrister at 1 Crown Office Row and Carl Rix, Litigation Executive at Fosters solicitors examine this more closely in their article **"The application of Article 2 ECHR at inquests"**. Nathan Davies, practises at Park Square barristers and has provided **"Case comment: *Dove v HM Assistant Coroner for Teeside and Hartlepool and Others* [2021] EWHC 2511"** although this case is also explored in the previous article Nathan emphasises the importance of appreciating that the breach need only be *"arguable"*.

I like to end the LS Newsletter editorial on a high note, where possible. 1st November saw the beginning of National Pro Bono week, we are delighted to share with you two client interviews that remind us of the value of the pro bono work we all do in one way or another: Helpline video: **https://youtu.be/xPSkZEXXRdU** and Inquest video: **https://youtu.be/VleEJtmNl5E**

I would like to acknowledge all our highly skilled and committed AvMA helpline volunteers, barristers who provide support to our inquest clients and others and to all of you who spend non chargeable time advising and supporting members of the public seeking redress – thank you!

Best wishes

2022 IS AvMA'S 40th ANNIVERSARY YEAR!

It's hard to believe it but 2022 marks the 40th anniversary of AvMA's creation. As this is a special anniversary, we will be taking every opportunity to celebrate how much has been achieved; raise awareness of the ongoing need to protect both patient safety and access to justice; and raise much needed funds for the charity.

There will be a range of fun local and regional events and activities through the year culminating in a big Gala celebration in London on the evening of **December 2nd**. Watch this space for details. *We would like your help to make the most of the opportunity this special year presents*. Here are a few ideas:

- If your firm chooses a charity of the year please put in a bid for it to be AvMA in 2022

- Could your firm put on some form of fundraising event for AvMA during 2022?

- We hope to hold bigger regional events during the year.

Could you help co-ordinate a regional dinner or other kind of event?

It could be anything from a dinner/dinner dance; quiz night; karaoke etc; or if you prefer something more cerebral, a conference or seminar on a particular relevant topic with a drinks reception or the like.

We are at hand to help plan, promote and support any event. Please contact Jane Smythson our Communications & Fundraising Manager for advice or to discuss ideas: jane@avma.org.uk

A Reminder – The Rapid Resolution and Redress scheme: aims, review and proposals

JANINE COLLIER
EXECUTIVE PARTNER, TEES LAW

In 2017, the government consulted on a new fast-track compensation scheme - a rapid, resolution and redress scheme (RRR) - for children left suffering brain injury as a result of medical error at the time of their birth.

The scheme was not implemented, but in July 2021, the Health and Social Care Select Committee Report into the safety of maternity care, amongst other things, recommended immediate implementation of RRR.

Following her national maternity review, in the 2016 report Better Births - Improving outcomes of maternity services in England: a five year forward view for maternity care, Baroness Cumberledge recommended that the government give serious consideration to introducing a *"rapid resolution and redress scheme"* which would pay out for birth injuries without families needing to bring legal action; provide more a more rapid, caring response to serious harm; and develop a stronger learning culture and improved outcomes.

The Government put more flesh on the bones and, in 2017, proposed and consulted on the RRR Scheme. This was intended to be a viable alternative to litigated medical negligence claims for families affected by severe avoidable birth injuries.

Whilst the Scheme seemed to have been largely *"shelved"*, the 2021 Report into the Safety of Maternity Care recommends that RRR be implemented immediately.

What would this mean?

What is RRR?

RRR is a voluntary administrative scheme intended to:

- reduce the number of severe avoidable birth injuries by encouraging a learning culture
- improve the experience of families and clinicians when things go wrong; and
- make more effective use of NHS resources

There are two stages to the Scheme.

1. Stage One focuses on the investigation of potentially avoidable instances of neurological birth injury.

2. Stage Two aims to provide a better service to families, including earlier support and a compensation package.

Stage one

The Scheme concentrates on a very small number of babies who have suffered severe avoidable birth injury in England.

Stillbirths, neonatal deaths, maternal injuries and maternal deaths, harm associated with pre-natal and antenatal care, multiple births and severe birth trauma (e.g. fractured skull following forceps delivery) are excluded.

Eligibility would be determined by considering specific clinical markers in the first seven days of life using the RCOG Each Baby Counts (EBC) criteria:

- hypoxic-ischaemic encephalopathy grade 3 (an indicator of asphyxia related neonatal neurological abnormality); or
- decreased central tone and comatose and seizures (of any kind);
- or any baby which receives active therapeutic cooling treatment.

It is not clear whether a family or consultant could appeal the eligibility of a baby they believe should be included, if that child does not meet the parameters of the scheme or whether a family could choose to enter the scheme having already pursued (unsuccessful) litigation.

How will cases be investigated?

The scheme proposes timely, standardised, independent too-cause analysis investigations of potentially avoidable instances of brain injury at birth, to understand the

common causes of avoidable harm and share learning to reduce future harm.

Families should have the opportunity to be involved in the investigation. There should be an early apology to families – *"an expression of regret for any harm that has occurred and commitment to thoroughly investigate the sequence of events to identify what went wrong and establish whether harm was avoidable, and to demonstrate how learning has been put into practice to avoid similar incidents in future"*

Implementing learning

Any learning should be shared across regional maternity networks.

On a national level, there should be implementation of a centralised system for learning, including analysing incident and claims data to identify areas for safety improvement.

Since the RRR scheme was proposed, there have been a number of developments in the investigation and notification of maternity incidents.

The **Healthcare safety investigation branch (HSIB)** has replaced the former local Trust Serious Incident Investigations to investigate certain maternity events including stillbirths, early neonatal deaths, severe brain injuries for babies delivered at term and maternal deaths is progress. The quality of investigations has improved in a number of respects: not only are families more involved and the investigation independent, the quality of the reports and recommendations are far superior.

Additionally, NHS Resolution (NHS R) introduced the **Early notification scheme** (ENS) which requires Trusts to notify NHS R of maternity incidents surrounding the birth of a child who has suffered potentially severe brain injuries (most commonly cerebral palsy) at birth where certain criteria are met. This was paused from 1 April 2020 to reflect the impact of the pandemic on trusts, albeit trusts were still required to report all cases to HSIB for investigation. HSIB as then reported all potential eligible ENS cases to NHS Resolution. This arrangement has now been made permanent.

Stage Two

A panel of independent experts (not those who investigated under stage one) would determine whether or not a family is eligible for stage two. Families should also have access to legal advice to help them understand their options.

The panel would consider the care received, the link between this care and avoidable harm and an initial assessment of the child's prognosis.

Two options are being considered for setting the threshold for eligibility:

1. optimal clinical practice: did the care fall below the standard to be expected of a leading clinical expert? **OR**

2. reasonable care: was the care provided akin to reasonable practice? This is similar to the current legal test applied in medical negligence cases

It is suggested that in either case, there would be more of a focus on system-level failure rather than individual blame / fault.

Supporting families

If a family is eligible for stage two, the scheme proposes early access to counselling and support in accessing state services, facilitated by a dedicated case manager.

How much compensation will they receive?

Once eligibility is established, a compensation package would be available.

The scheme provides for compensation to be paid in three parts:

1. An early up-front payment, in the range of £50,000 - £100,000 at around age 4

2. An annual payment, based on need, with assessments at, say age 5, 12 and 18

3. A lump sum award, to be managed by a dedicated Case Manager acting on behalf of the family

A *one-off payment* of £50,000 - £100,000 at around age 4 is too little, too late. Waiting four years for help may cause avoidable financial and emotional stress for families.

By this time families are often needing to move to suitable housing, with level access accommodation and other adaptations. Equipment (e.g. wheelchairs) may be required. Therapies such as physiotherapy, speech and language therapy and occupational therapy are needed, is insufficient to meet the significant capital costs at or about this age.

Further, the literature shows that timely, appropriate rehabilitation improves long-term outcomes. Delaying the initial payment to age 4, may, in the long run, end up costing the taxpayer more.

The scheme promotes that the *annual payments* be made *"in-kind"* through a personal budget type approach administered by a case manager. It is, however, unclear how that case manager would be chosen, what their skills or expertise would be. Also unclear is what autonomy the family would have, for example, to choose between stage and private care, who cares for their child etc.

Other concerns are that there is the potential for the line between local authority personal budgets and any RRR personal budget to become blurred and it is not at all clear how the child's best interests would be determined under the scheme.

Most families do not want to have to rely on state services, which are already over-stretched, with long waiting times and frequent cancellations compared to private care. Some are reluctant to rely on a state provider, who caused the harm in the first place.

Whilst a shift towards more staged periodical payments is, in principle, a positive step, cash payments would be preferable to give families independence, certainty and financial security provided the initial lump sum payment is sufficient to meet all capital needs, in particular housing and equipment.

Re-assessment of provision could be beneficial. However, in practice, extreme care would need to be taken to ensure that this did not create additional stress for families and that there would be capability and expertise to undertake full and proper re-assessments. Further, fixing re-assessments at certain ages is arbitrary and there should be provision for the family to trigger a review.

Whilst glossed over in the consultation document, the expectation is that the average total value of compensation under RRR would be approximately 90% of that currently awarded in the courts.

The amounts currently awarded in birth injury claims by the courts reflect the enormous impact on the families and the amount of money required to provide them with the lifetime care and support they require. If the scheme does result in lower awards, then it is likely that some families will not be able to fund the care and support they need.

Who will administer the scheme?

NHS Resolution would administer the scheme.

This is not appropriate. NHS Resolution *"holds the purse strings"* as the defendant in any legal case. There would be a clear conflict of interest and the lack of any independence would be a significant barrier to families choosing to access the scheme.

Overall, is RRR a good scheme or bad?

As with most proposals, with the good, comes the bad.

Any measures that improve learning and ensure proper redress without the need for litigation without the need to resort to litigation, are to be welcomed.

Eligibility is however, so tightly defined that only a very small number of babies are deemed eligible every year. Broadening the eligibility criteria to include stillbirths, child and maternal deaths should be considered.

The suggestion that NHS Resolution administer the scheme is a grave concern – the conflict is clear and will result in loss of public confidence.

There are significant doubts that proper redress will be available under the existing scheme.

Compensation will likely be 10% lower than that awarded by the courts.

The payments will be rigidly structured, such that this will not provide sufficient flexibility to meet families' needs.

Families already under significant emotional and financial strain are likely to lose autonomy, with little clarity over how case managers will be appointed, who they will be and/or the input that families will have into how payments are used to best meet their child's needs.

Overall, in all the circumstances, if appropriately advised it seems likely that families will opt for litigation, and this means that the scheme will fail.

That is not to say that such a scheme should not be considered, but it would, perhaps, be best devised by a working group of key stakeholders, including representatives from those affected by severe birth injury: patient safety charities; clinicians; trusts; professional bodies; legal professionals; the DOH and MOJ.

On 21 September 2021, the Government Response to the Committee Report rejected the recommendation that RRR be immediately implemented, noting that the scheme had previously been consulted on; "several of the benefits it may have delivered had been achieved through our other parallel initiatives" including ENS and HSIB's independent maternity investigations; and RRR did not address the high and rising costs of clinical negligence cases.

Maternity Safety in England

JANINE COLLIER
EXECUTIVE PARTNER, TEES LAW

In July 2021, the Health and Social Care Select Committee published its report into the *Safety of Maternity Services in England*. Janine Collier, Partner and Head of Clinical Negligence at Tees Law highlights why lessons are not being learned and identifies the urgent need for improvements in above all else, funding, culture and communication.

With around 700,000 babies being born each year, giving birth is the most common reason for admission to hospital in England.

The vast majority of maternity care is excellent, but when things go wrong, it can result in serious, life-changing, life-long injuries for babies; still births; neonatal deaths; or maternal deaths. Not only is this a tragedy for the family, but it is also upsetting for clinicians and, when litigation ensues, costly for the NHS.

Back in 2015, the government launched the National Maternity Ambition to reduce the rate of stillbirths, brain injuries, neonatal deaths and maternal deaths in England by 50%.

Since then, patient safety has improved, with a 30% reduction in neonatal deaths and a 25% reduction in still births, but England remains far behind the likes of Sweden and whilst progress in these areas is welcomed, there has been little progress towards reducing pre-term births, brain injuries or maternal deaths.

As someone who witnesses the impact that substandard maternity care has on patients and their families every day, and, as a taxpayer who foots the bill when things do go wrong, it is both heart-breaking and hugely frustrating to see reports of the *Shrewsbury and Telford Hospitals NHS Trust maternity scandal* (more than 40 babies died because of a culture that denied women choice and subjected hundreds of families to unsafe care); the death of baby Harry Richford who died after a catalogue of errors by maternity staff and *concerns about the quality and outcomes of maternity and neonatal care at East Kent Hospitals University NHS Foundation Trust*; and most recently to hear that dozens of babies have died or been left with brain injury in the *Nottingham maternity units* accused of bad care and neglect.

The lessons identified from the *Morecambe Bay investigations* in 2014 - poor levels of clinical competence, dysfunctional teams, a determination among midwives to pursue *'normal'* childbirth at any cost, poor quality investigations, without learnings taking place and a defensive culture - have clearly not been learned.

What are the key areas addressed in the report?

The Committee Report focuses on three areas:

- Staffing numbers and funding, leadership, and training
- Learning from patient safety incidents, including investigations and the current medical negligence system
- Women's experience of care and the changes needed to ensure safe care is a reality for every mother and her baby

Why are lessons not being learned?

The need to improve funding, culture and communication pervade the report. So why are lessons not being learned?

This demands a change in workplace culture, a positive patient safety culture, an openness to learning, psychological safety for staff, teamwork, and leadership. The NHS Patient Safety Strategy launched in 2019 with this aim, but culture change takes time, and this is far from embedded across the NHS.

In a healthy workplace with a learning culture where psychological safety is embedded, complaints, litigation, or any other form of investigation should be welcomed as an opportunity to reflect, analyse, learn, and improve. Alarmingly, the Committee Report highlights evidence

that this is not the case – rather there was a tendency for employers to say *"who is to blame here?"*

Issues that need to be addressed

There are a number of issues that need to be addressed in order to bring about much-needed improvements in maternity services:

• *Complaints should be independently investigated, and families should be compassionately engaged with and meaningfully involved throughout*

We see progress in that the Healthcare Safety Investigation Branch (HSIB) has replaced the former local Trust Serious Incident Investigations to investigate certain maternity events including stillbirths, early neonatal deaths, severe brain injuries for babies delivered at term and maternal deaths. The quality of investigations has improved in a number of respects: not only are families more involved and the investigation independent, but the quality of the reports and recommendations are far superior.

However disappointingly, some Trusts do not own recommendations made locally and fail to maximise learning at the local level.

• *Effective communication and dissemination of learning must be an essential component of a patient safety culture*

Healthcare professionals (barring the rogue exceptions) want to provide a good patient experience and safe and effective care. And yet, front-line clinicians are sometimes unaware of the investigations, are not kept up to date and do not know the outcome.

This is profoundly disempowering, disengaging and limits opportunities to learn and change. Reports should be shared with every person who had involvement with that particular patient's care to ensure valuable learning. Why on earth would you not?

• *Maternity services have been subject to chronic underfunding*

Astonishingly, Trust Boards often refuse to fund the necessary midwifery posts to meet accepted safe levels of midwifery staffing. When 40% of all claim payments (£2.3 billion in 2020/2021) relate to maternity care, why would a Board not agree to fund safe levels of staffing? Is it because the right arm is not talking to the left? Are budgets restricted?

The Committee Report recommends that the budget for maternity services be increased by £200 - £350m per annum with immediate effect to facilitate safe staffing levels.

If funding safe staffing levels reduces the number of avoidable brain injuries suffered by just 10-15%, the investment would pay for itself before even beginning to think about the human cost saved.

Seems pretty straightforward, or is it? Whilst the increased funding would be welcome, it is unrealistic to expect that the NHS will be able to fill all vacant and fully-funded posts.

There are 844 vacant but funded midwifery posts and even if adequate funding were in place, there is a widespread shortage of midwives (1,932), it is estimated that there is a shortfall of around 496 consultants working in Obstetrics and Gynaecology and a workforce gap of around 1,054 anaesthetists.

It is not possible to *"wave a magic wand"* such that midwives and doctors appear from thin air. This will require a sustained programme of investment in education and training. Even then, as trainees arrive on the ward, they require mentoring and supervision and yet mentors are already over-stretched with their own clinical duties. Inadequate staffing is not a problem that can be solved overnight by money alone.

• *Staff need to be given time to have meaningful communication with the patient*

As they work additional hours to fill rota gaps and work even harder during their own short-staffed shifts, women report that midwives often appear *"harassed and overworked"*. On average around 5-6 minutes is allowed per woman in a hospital-based antenatal clinic. How can this be sufficient to make time and space to educate women and families about their choices, the risks and benefits? Apart from discussing place of delivery, there should be discussions about mode of delivery and pain relief in labour.

Women should be empowered to make decisions that are right for them and their baby. Disturbingly, the Committee heard evidence that some Trusts are still placing pressure on women to have a *"normal"* birth, rather than a Caesarean, with emphasis on the mode of delivery, rather than achieving *"a safe, healthy, positive experience of birth and to come home with a baby"*. This is a culture frequently witnessed in medico-legal practice. Most notably, Nadine *Montgomery* was pressured towards a vaginal delivery when she requested a Caesarean section, and her son was severely injured during a traumatic birth.

Unacceptably, there are huge disparities and inequalities in outcome. *Black women are four times more likely to die in pregnancy or childbirth*, with women from Asian ethnic backgrounds facing twice the risk. Continuity

of care has shown dramatically improved outcomes for mothers and babies, including a 16% reduction in neonatal mortality, 24% reduction in preterm birth as well as providing a better experience for mothers.

Despite this, continuity of care is an area where little progress has been made. So, once again, we have a report which highlights concerns about maternity safety.

What is different about this report and its recommendations and other reports, public inquiries, initiatives and programmes in recent years?

In reality, very little. The same barriers to delivering safe maternity care have been highlighted time and time again. We all know what the problems are and few, if any, would disagree that we all want to improve the safety of maternity services in England.

The million-dollar question is how? Transforming the culture in an institution the size of the NHS takes strong leadership, a clear and consistent vision, and a commitment to implementation. It takes collaboration between clinicians, management, patients, their families, and others. It takes time. It takes resource. It takes laser sharp unremitting focus.

The Government's Response to the Committee Report was published on 21 September 2021.

In headline terms, the Government:

• said it is considering the committee's recommendation that the maternity budget be increased by £250m - £300m with immediate effect;

• acknowledged the importance of safe staffing levels and appropriate training; and

• advised that they will be consulting on a wider legal reform of both the process and how compensation is calculated.

There are a number of areas where recommendations have been accepted *"in part"*.

It is encouraging to see that the Government has, with immediate effect, abolished the use of caesarean section rates to penalise trusts, instead focussing on the use of the Robson criteria to measure caesarean rates more effectively. It is to be hoped that women will now be empowered to make the right decision for them and their baby, with the focus on safe delivery, rather than what culturally in some hospitals has still been termed a *"normal"* delivery.

It will be interesting to see what action is now taken by the Government in relation to progress those recommendations accepted or accepted *"in part"*. Actions speak louder than words.

Hot off the Tail of the Government's Response to the Committee Report, the Health and Social Care Select Committee launched their own Inquiry into NHS Litigation reform.

It remains to be seen whether rather than prioritise improving the safety of maternity care, the Committee decides that it is, instead, easier to cut the financial cost of the devastating harm families suffer through other means, such as re-thinking the current approach to medical negligence litigation, by restricting access to justice and/or reducing the compensation payable for those who have been injured at the hands of the NHS through no fault of their own.

Such an approach would be morally reprehensible.

The Inquiry is no longer accepting evidence and no date appears to have been set for the Committee to report on the results of the Inquiry.

High Value Complex Neurological Injury Litigation

SUZANNE MUNROE
DIRECTOR, SOLICITOR AND HEAD OF CLINICAL NEGLIGENCE, SWITALSKIS SOLICITORS

Switalskis Solicitors

Insight into Funding Challenges for Claimant Clinical Negligence Lawyers

The history of funding neurological injury claims

On 1 April 2013, the landscape for funding clinical negligence claims radically changed as a result of the Legal Aid, Sentencing and Punishment of Offenders Act 2012 (LASPO 2012). This limited the scope of Legal Aid (LA) and rewrote the way in which a Conditional Fee Agreement (CFA) and After the Event Insurance (ATE) operated regarding the recovery of additional liabilities, namely Success Fees and ATE premiums as between the unsuccessful defendant and the successful claimant. For claimant clinical negligence lawyers the previous wide ranging availability of Legal Aid funding for this work seems a dim and distant thing of the past and we are now rapidly heading towards the 10th anniversary of these changes.

The Government had originally introduced CFAs to reduce the financial strain Legal Aid placed on the public purse – and today CFAs remain the primary overall funding source for clinical negligence claims with ATE available to cover the costs of lost cases.

The Government's initial plan was to remove Legal Aid for all clinical negligence cases involving children as this was said to be *"unnecessary and wasteful"*[1]. The objections to the sweeping amendments came from all sides, including APIL, Action for Victims of Medical Negligence (AvMA) and the then NHS Litigation Authority (NHSLA). Many referred to an independent report commissioned by the Law Society which concluded that the proposed cuts to Legal Aid would have a knock on effect of actually costing more than the proposed savings. In the House of Commons debate before the LASPO Bill was passed, Kenneth Clarke (the then justice secretary) confirmed the Government's agreement to retaining Legal Aid funding for damaged babies with neurological injury in obstetric cases. The LASPO Bill was fiercely contested and went back and forth between the two houses. Amongst their objections, the House of Lords had also wanted to retain Legal Aid for obtaining medical reports in clinical negligence cases but this did not make its way into the Act.

When the Act was eventually passed, Legal Aid was effectively removed for all but obstetric/neonatal claims causing a neurological injury during pregnancy, childbirth or during the eight week post-natal period thereby severely limiting its availability. We claimant clinical negligence lawyers have to work within significant constraints whilst investigating these complex claims.

To remind us all I make no apology for quoting the exact provision in LASPO 2012 setting out legal aid eligibility is Schedule 2, Part 2, paragraph 23:

(1) Civil legal services provided in relation to a claim for damages in respect of clinical negligence which caused a neurological injury to an individual ("V") as a result of which V is severely disabled, but only where the first and second conditions are met.

(2) The first condition is that the clinical negligence occurred—

a) while V was in his or her mother's womb, or

b) V

i) if V was born before the beginning of the 37th week of pregnancy, the period of 8 weeks beginning with the first day of what would have been that week;

ii) if V was born during or after the 37th week of pregnancy, the period of 8 weeks beginning with the day of V's birth.

(3) The second condition is that—

a) the services are provided to V, or

b) V has died and the services are provided to V's personal representative

1 https://www.parallelparliament.co.uk/lord/kenneth-clarke/vs/bill-esterson

I now turn to the interplay between Legal Aid and CFAs with ATE and the funding landscape claimant clinical negligence practitioners have to navigate.

Funding - An Overview

Legal Aid

Who can offer Legal Aid funding and why?

Only law firms with a Legal Aid franchise can offer Legal Aid. Franchising of clinical negligence work was created in October 1998 by the then Lord Chancellor Lord Irvine who said that he wanted a *"quality-assured service"* and not, simply, the nearest solicitor *"doing their best"*. He went on to say that *"Restricting these cases to a group of highly-competent specialised solicitors will give people the best possible chance of resolving disputes successfully"*.

The statistics provided by the then Legal Aid Board (LAB) at the time (now Legal Aid Authority) made a compelling case for change. For every £1 clinical negligence solicitors cost the taxpayer in legal aid fees, the specialists won £4.10, personal injury solicitors won £2.50, and other practitioners won £1.70.

To attain a franchise, firms must have lawyers who are *'specialists'* – either members of the Law Society's clinical negligence panel or the AvMA panel.

In 1998 3261 firms claimed legal aid for medical negligence (now clinical negligence) work and the recommendation was to franchise 172 firms. Through market consolidation and firms exiting clinical negligence, there are now only 91 franchised firms.

My view echoes that of claimant practitioners who were consulted at the time, in that I believe that the vast majority of clinical negligence claims are, by their nature, challenging to conduct (not simply based on value), but there is no doubt that neurological birth claims are a particularly complex and niche area of clinical negligence work. Law firms that wish to conduct these claims should never dabble outside of their expertise.

Those of us conducting these claims have a huge responsibility to these catastrophically injured claimants to successfully prove liability in claims where NHSR and their panel lawyers have significant financial resource and expertise to defend them. Once we establish liability we must then also secure the best lifelong rehabilitation and support for claimants and their families, and to do so in a timely manner. Complex cases run the inherent risk of taking significant time to investigate. In my view, specialist lawyers at franchised firms continue to be the ones that are best placed to do this with the on-going regulatory requirements set by the Legal Aid Authority (LAA), which do not apply to non-franchised firms.

Sign-posting claimants to franchised firms

As mentioned, it is crucial that specialised and experience lawyers run these claims and put the most appropriate funding in place for claimants.

There are only 91 franchised firms and unless a claimant instructs one of these firms, Legal Aid will not be offered. Instead a claimant will be offered a CFA with ATE which means the claimant could be at an immediate double disadvantage in not only are they instructing a law firm that does not have the recognised legal expertise of a franchised firm, but also being immediately responsible for the additional liabilities of a success fee and the ATE premium cost and not being offered the financial benefits that Legal Aid provides.

It is of course open to a firm to offer a CFA without a success fee (or a reduced one) and ATE cost varies depending upon the relationship a law firm has with the ATE sector – with more specialised firms attracting lower ATE premiums for their clients. If non-franchised firms don't signpost clients to a franchised specialist and carry out initial investigation on a CFA with 100% ATE the potential costs are increased immediately.

I have taken over several cerebral palsy claims from non-franchised firms who haven't really had the expertise to know how to conduct the claims properly – wasting time and increasing costs for claimants and the defendant. This is not unusual and was a feature of the initial objections raised when the LASPO Bill was being considered.

Judicial approval of additional liabilities

Fortunately, there is now judicial input as to the appropriateness of a claimant who is a protected party having to pay these additional liabilities from their compensation in the event of a successful claim, and this affords protection. Under CPR Part 21.12(1) and practice Direction to Part 21 paragraph 11.1 the Litigation Friend (who is responsible for paying the success fee and ATE premium from the claimant's compensation) must seek court approval of the amounts by providing the court with all advice on funding provided to the claimant/Litigation Friend. In this way the court is able to forensically analyse

the advice on funding and costs that has been given and ensure any deductions are approved formally by way of court order.

However, where at all possible, it is most beneficial for claimants to have the security that Legal Aid provides to cover the costs of initial investigation of a clinical negligence claim by a franchised firm, so it is that area which is the focus of this article.

Challenges to obtaining Legal Aid funding for complex neurological injury litigation

I have an experienced team that work on our most complex neurological injury claims, and yet, despite this, obtaining Legal Aid funding remains a laborious and difficult process for us – and at times causes unconscionable delay to the timeline for investigating these claims.

Medical records first

Over the last few years the LAA has refined their criteria for granting certificates for these cases. We now are asked to obtain medical records first – which presents it's own challenges. Claimant lawyers have to decide how to fund this cost:

- Do we foot the bill for obtaining the records?
- Do we ask the parents of the brain-injured child to obtain disclosure of the records?
- Once we have the records we then have to persuade the LAA that we have sufficient evidence to establish a prima facie case to investigate.

Risk assessment and advice

After a detailed and forensic analytical internal review of medical records and evidence available, we risk assess the prospects of the case and advise the claimant on whether we think there is a case worthy of further investigation and are in a position to then submit an application to the LAA.

Detailed Lists of Issues

In those cases that have merit in proceeding to an application for Legal Aid, a detailed List of Issues must be produced to support the application. This document takes several hours to prepare and is extremely thorough, often running to 10 pages or more. We think very carefully about each case and have risk assessed it fully before even making an application to the LAA.

The waiting game

Following the substantial amount of time and work that has been carried out over several weeks or months – taking instructions, preparing draft summary of case (the precursor to witness statements), obtaining and analysing medical records and preparing a Statement of Issues and Legal Aid documentation and providing advice all along the way to the client – the application is submitted to the LAA via the portal. We then have to wait several weeks (or months in some cases) for a decision and increasingly we are experiencing further delays occasioned by the LAA that are set out below.

I should add that all of this time is not chargeable and it's only in the event of a successful case that the non-funding aspects of the work we do are put into a bill of costs for payment.

Hurdles, delays and appeals

We are increasingly finding that the LAA push back on initial applications for Legal Aid, for example, by stating that they don't agree that causation will be made out, or that there isn't evidence of hypoxic brain injury. We then enter into correspondence in relation to the points raised and why we believe there is a case to investigate, which delays a decision again. If we then have to appeal a refusal this further adds to the delay.

Increasing medical expertise required of lawyers

Several colleagues and myself are all approved panel (either Law Society or AvMA) solicitors. As a firm we have held a LA franchise for many years (I was at a firm that was awarded one of the first franchises in 1999 and have since then always worked at franchised firms) and yet we find that we are back and forth with the LAA providing more and more detail as to why a case is one that should be investigated.

The LAA now appear to seek expert level detail as to the precise mechanism of injury. Plainly, neurological injuries are complex in nature and it is not often possible to provide definitive answers at early stages of a case without the assistance of experts, despite us setting out our views on the cases with the benefit of our experience and the knowledge of investigating hundreds of similar cases over many years. I think it important to consider why franchises were set up in the first place: to avoid *'dabbling'* and to ensure Legal Aid was only granted to a group of *"highly competent specialised solicitors"* who know how to conduct this work properly.

Investigation delays caused by Legal Aid funding hurdles

Once we are eventually granted Legal Aid funding – or we are refused and then enter into a CFA with ATE – no matter how quickly we push on with the initial investigation stage, it's going to be at least a couple of years before we are in a position to send a Letter of Claim to the defendant(s). Problems with funding delays at the start make this process much longer than it needs to be.

Restrictions

Even when a Legal Aid certificate is granted, it is done so in stages for specified work with a maximum allowance set that can be awarded to fund each stage. Not all cases will pass through each funding stage. Once Legal Aid funding is obtained, the case will be at initial investigation stage - a limited certificate of £22,500 is granted. Only then, after obtaining breach and causation reports and thoroughly analysing the case, is a decision made as to whether the case can proceed to the next stage at which point the LAA are asked to extend funding.

It is important to stress that the initial £22,500 invariably does not cover all the initial investigation costs. More often than not we have to use all of the initial phase for experts fees and one conference with Counsel and the crucial experts – even then it is often not enough. An increasing number of cases require more than 5 experts and in those circumstances we have no chance of covering al the costs within the first phase, so the firm foots the balance of the cost.

Restriction of expert choice

It is crucial that claimants have equality of arms in investigating these catastrophic cases for claimants and their families. Defendant panel firms not only have their own experts in the clinicians who are effectively both witnesses and experts but they also have free access to their own choice of experts and are not limited in the way that claimant lawyers are if their client's claim is funded via Legal Aid. Claimant lawyers are having to justify to the LAA why a particularr expert is key to their investigation.

Unrecoverable costs

The complex and time consuming work associated with obtaining LA funding and providing detailed applications, appeals and correspondence with the LAA is also non-charegeable and cannot be recovered from the LAA thus in any typical case, thousands of pounds of fee earner time is spent in this work that is routinely written of. This forensic approach to funding which takes hours and days of time is completely out of kilter with the written off costs involved in setting up a CFA with ATE, thus penalising the law firms who are franchised and have the approved specialism.

Pressure on clients and their families

Additionally, it is worth noting that explaining funding advice to clients and the uncertainty about Legal Aid eligibility adds additional frustration, disappointment and confusion to the families of clients who are already dealing with the challenges of neurological injury and the likely psychological trauma of what they have experienced. Navigating the current system of Legal Aid adds to their burden no matter how sensitively we deal with them.

Extent of Legal Aid Funding

Even if full LA funding is granted in most of these neurological injury cases, even if we have managed to make LA work and have sufficient funding and the right experts to investigate and prosecute the claim successfully, at some point we will exhaust the funding – as the limit simply isn't enough to take the claim through contested liability and through to a quantum trial. At some stage consideration will then have to be given to transferring funding from Legal Aid to a CFA with ATE.

CFA and ATE

Unfortunately due to the multiplicity of constraints that attach to Legal Aid funding, even when a certificate is granted, it is unlikely that this will support the claimant's investigation of the case properly to the case's conclusion as set out above and that is why sometimes s decision has to made by a claimant to move from Legal Aid funding onto a CFA with ATE.

If the LAA are restricting the financial scope or choice of experts, a claimant's case will be impossible to investigate to ensure that a claimant has equality of arms with a defendant.

Reasonableness of changing funding

The process of advising a claimant to consider funding options and to switch from Legal Aid to CFA has to be meticulously explained to the claimant so that they understand the advantages and disadvantages of:

• Remaining on Legal Aid with restrictions that fetter full investigation of their claim

• Their responsibilities under a CFA with ATE including liability to pay for the following from their compensation in the event of a successful claim:

~ Unrecovered base costs

~ Success Fee

~ ATE premium

Informed consent on costs

It is here where the importance of demonstrating that the claimant has *'informed consent on costs'* cannot be over-stated. Following the landmark decision of the Court of Appeal in Herbert v HH Law [2019] EWCA Civ 527 the way claimant lawyers explain CFA and ATE funding arrangements was given a major overhaul. We now know that failing to deal with this aspect with meticulous perfection can land practitioners in hot water, not only with the likes of law firms that sue claimant lawyers for failing to get their retainers right and thus making unlawful client deductions, but also from the judiciary in the approval process of CPR Part 21.12(1).

Obstetric claims dominate discussion

Unfortunately these claims continue to dominate discussion and media coverage. Despite only accounting for 10% of claims, obstetric claims represent around 50% of compensation paid out. Systemic issues have been highlighted in several NHS Trusts in the last two years, following national publicity of high-profile cases and recommendations made by the Health and Social Care Committee in The *Safety of Maternity Services in England* report.

It is important for all engaged in this work that the claims are investigated thoroughly and in the most cost effective way. There is responsibility on both sides not to add to the costs burden for the NHSR. By limiting the investigation to franchised firms with specialist lawyers is one way of maintaining standards. From discussions with colleagues at defendant firms they agree wholeheartedly with specialism on both sides when conducting these claims.

Conclusion

This article provides a high level overview of the many hurdles facing claimants in navigating the funding in these complex claims. In conclusion, I believe the system could be improved for claimants by considering the following:

• Legal Aid should be retained for investigating these complex and valuable cases but it has to be workable as it currently holds up the crucial investigation stage unnecessarily and does not provide accessibility to the best and appropriate experts across the board.

• There needs to be transparency and clarification as to the merits criteria for Legal Aid eligibility, in order to avoid wasted solicitor and claimant time/costs and all adding to delay.

• In the event that the LAA consider the merits of a case are *'unclear'* and investigations could be carried out, after which it should be possible to make a reliable estimate of the prospects of success, they may grant a limited certificate to cover investigations which make prospects clearer. This criteria appears to be being used in a way that hinders progress and amounts to micromanaging specialist lawyers to a degree that is not helpful or needed. Legal Aid franchised firms are having to make a case when requesting initial investigative funding with almost expert level detail expected, and no funding in place.

• It is incumbent on the LAA to take full account of the work that has gone into this detailed application – at the moment it feels as though the Legal Aid process is stacked against the Claimant lawyers and that the intention is to refuse Legal Aid wherever possible which is not what was intended when the franchises were first set up.

• The Legal Aid system is ripe for re-assessment or refinement for complex neurological injury cases.

The Impact on Claimants after Settlement of Damages: Alfie & Sarah's Stories

ALISON JOHNSON, PARTNER
VICTORIA JOHNSON, ASSOCIATE
PENNINGTONS MANCHES COOPER

PENNINGTONS MANCHES COOPER

As clinical negligence lawyers, we work closely with our clients during the investigation of their claims and, in doing so, we gain a good understanding of their individual circumstances and often get to know them well.

Once a claim settles, our clients receive their damages (financial compensation) and the litigation process is concluded for them. They get on with their lives and, hopefully, the acceptance of liability and potentially a formal apology from the defendant, along with the financial damages, provides them with the chance to achieve some closure.

Financial compensation rarely makes up for what may have been a life-changing injury or loss but damages is the only formal remedy that the law provides. Our clinical negligence team takes pride in achieving the best results possible for our clients in the hope that it does indeed allow them to get their lives back on track and offers them the level of independence, security and professional support they may need.

Probably the most complex cases that we investigate are for children who are brain-damaged at birth and whose parents are thrown into a world of caring for a severely disabled child. A damages settlement for a family in this situation, which may be into seven figures, can be life-changing as the award will fund the child's accommodation needs such as an adapted home with room for a carer as well as professional care, therapies and equipment for life.

For others, the most important thing is the reassurance that their claim has been investigated properly, their concerns have been listened to, and lessons from mistakes made have been learned in the hope that other patients can be saved from suffering the same injury in the future.

Two members of our clinical negligence team, partner Alison Johnson and associate Victoria Johnson recently got in touch with two of their former clients to find out how the settlement of their claims had affected their lives.

Alfie's story

Alfie* was born in a poor condition after a traumatic delivery and was diagnosed at a young age with cerebral palsy, epilepsy, partial blindness and autism. His parents approached Penningtons Manches Cooper for specialist advice after repeat brain scans showed that Alfie's brain damage was likely to have occurred around the time of his birth.

The investigation into the potential claim was hugely complex, requiring expert evidence from experts in the fields of obstetrics, midwifery, paediatric neurology and paediatric neuroradiology. The investigation was funded by what was then known as legal aid.

As Alfie was still so young, it took many years of investigations to understand and evidence what had happened, how his brain damage had occurred, whether with better medical care Alfie's brain damage would have been avoided, and to negotiate a liability settlement.

Once this was achieved, a tranche of further expert evidence was obtained to determine Alfie's likely prognosis and life expectancy and what his needs would be for the rest of his lifetime. Ultimately, a settlement was agreed out of court for a lump sum of several million pounds to enable the purchase and adaptation of a safe home for Alfie, with additional annual payments throughout Alfie's life to cover his professional care, therapies, aids and equipment needs. Alfie is now a young man in his twenties and is living with as much independence as he can.

When our team asked Alfie's parents how they felt about the litigation process in retrospect, they said: *"We understood it would be difficult and would place additional stress on our already difficult lives but we wanted above all else to fight for Alfie's future and security."*

They added: *"When the case was finally settled for an amount which would allow us or others to look after Alfie for the rest of his life, this felt almost unbelievable and, of course, we were elated. This was due to the efforts of everybody involved with his clinical negligence case.*

"However, at the same time, the understanding and acknowledgment that our child was injured because a team of doctors in a hospital who we trusted broke that trust, whether through complacency, lack of knowledge or understaffing, was so overwhelming.

"To this day when we think about what happened, it still rocks us to our core and that feeling will never go away. However, the biggest relief is the knowledge that Alfie will be provided for after we are no longer here to look after him and that his brother can now live his own life without the burden of being a sibling carer."

Sarah's story

Sarah* was 26 years old when she underwent foot surgery in 2017 under the care of a private surgeon. Following her surgery, Sarah suffered a severe wound infection that required emergency treatment in hospital, followed by a prolonged recovery period leaving her with scarring and significant psychological injuries.

After investigating the circumstances of Sarah's foot surgery and the causes of her infection through analysis of her medical records and obtaining independent expert evidence, we successfully brought a claim on the basis that Sarah had not been taken through the consenting process thoroughly for her surgery. Neither was she offered conservative treatment options as she should have been and was likely to have tried first.

The claim settled in 2020 after negotiations with the private surgeon's legal representatives.

We recently followed up with Sarah to see how she was and how her situation had changed following the conclusion of her claim. Sarah gave up a high-paying career in the financial sector due to her physical and psychological injuries.

She told us that: *"Through the settlement of my claim it felt good to have it recognised that what I've been through has cost me financially and that I had a career I was proud of."* She also said that she had put some of her compensation towards relocating to another country and paying a business coach to help her launch her own business.

Like many of our clients, however, Sarah did not feel that financial compensation was the only important aspect of pursuing a clinical negligence claim. She is hopeful that lessons have been learned that will benefit future patients and said: *"I didn't want this to happen to anyone else and getting a settlement meant that the wrong has been brought to light and acknowledged. It will hopefully mean he [the surgeon] has it in his mind to treat others with the dignity, time and care they deserve.*

"The main thing for me was finally getting the recognition and apology I was after. I was not a nobody to be ignored and what I went through was real and it mattered. I mattered."

**Names have been changed*

The 2021 Guideline Hourly Expense Rates: will Claimant Lawyers be laughing all the way to the Bank?

KAIN KNIGHT
COSTS LAWYERS - LEADING THE WAY

COLIN CAMPBELL, CONSULTANT, KAIN KNIGHT COSTS LAWYERS. COSTS JUDGE 1996-2015, DEPUTY COSTS JUDGE

For at least the past three decades, the accepted method of costing a solicitor's file in order to draft a bill for the client or to claim costs from the losing opponent, has been by the use of an hourly expense rate applied to each hour worked. That total is calculated by reference to the qualification or date of admission onto the Roll of Solicitors of the fee earner who did the work. Thus, a four-hour meeting with the client at £250 per hour would result in a charge of £1,000. Easy.

The so-called *"expense of time"* method of charging as this formula is known, has had its critics. When he was Master of the Rolls, Lord Neuberger commented in 2012 that: *"...hourly billing fails to reward the diligent, the efficient and the able..."*.

By then rates, in the form of tables were available, with fee earners being graded A-D, with partners at the top and trainees at the bottom, and their charges being dependent upon where their firm was located, London *"City"* being the best remunerated and Band 3 *"National"* being the least.

Those in favour of using hourly expense rates have bemoaned the fact that for the past decade, they have not kept up with inflation. In 2010, Guideline Rates for Summary Assessment (*"GHR"*) had been published for the use of judges carrying out summary assessments, principally as an *aide memoire* about how to undertake the task. In due course, those guidelines also became the starting point for the assessment of costs not only for summary assessment, but also for detailed assessment, so that despite what is said on the tin *"Guide for Summary* [emphasis added] *Assessment"*, the rates became the benchmark for assessments proceeding under section 1 of Civil Procedure Rule (*"CPR"*) 47 - Detailed Assessment.

That all said, no updating of the 2010 GHR occurred subsequently to take account of inflation or to changes in the marketplace. An abortive attempt to do so was made in 2015 through work undertaken by a committee overseen by Mr Justice Foskett, but its recommendations were singlehandedly consigned to the wastepaper basket by the then Master of the Rolls, Lord Dyson, so the rates did not change.

To the dismay and irritation, therefore, of those solicitors who have represented successful claimants, the fact that the GHR have remained unaltered, led, predictably, to heated arguments at detailed assessments.

"The 2010 rates were for 2010 work. It is now 2020. Inflation has gone up by X%. The updated rate taking inflation into account, is now £Y. That is what we should be allowed", would argue those representing receiving parties.

"Not so", would submit those solicitors acting for the paying parties. *"Lord Dyson rejected any upwards variation, so what you get is 2010 rates, plus a small uplift of, say, 10% because we fought tooth and nail on liability, causation and quantum"*.

In 2020, however, a different Committee overseen by Mr Justice Stewart undertook a fresh review of the GHR. It produced a preliminary Report in January this year, which provided for a period of consultation until the end of March. Taking account of the consultees' comments, the Committee produced its recommendations in a Final Report in July.

On 16 August 2021, the Committee's recommendations were accepted by Sir Geoffrey Vos, the present MR, and the latest guidance about what rates to allow from 1 October 2021, can be found in the recently published Guide to the Summary Assessment of Costs (*"The Guide"*). Those rates, with the percentage increase on the 2010 rates appearing in brackets, are the following:-

	Grade A	Grade B	Grade C	Grade D
London 1[62]	£512 (25.2%)	£348 (17.6%)	£270 (19.5%)	£186 (34.8%)
London 2[63]	£373 (17.8%)	£289 (19.5%)	£244 (25%)	£139 (10.4%)
London 3[64]	£282 (13.7%)	£232 (15.8%)	£185 (11.9%)	£129 (7%)
National 1	£261 (20.2%)	£218[65] (13.5%)	£178 (10.7%)	£126 (6.8%)
National 2	£255 (26.78%)	£218 (23.2%)	£177 (21.3%)	£126 (13.5%)

At paragraph 28, the Guide says this: -

"The guideline figures are intended to provide a starting point for those faced with summary assessment. They may also be a helpful starting point on detailed assessment"

So far, so clear, but it is important to remember the GHR are just that, guidelines and that uplifts can be achieved depending on other factors : Paragraph 29 says this:

"....the value of the litigation, the level of the complexity, the urgency or importance of the matter, as well as any international element, would justify a significantly higher rate."

Given that the new GHR have now been in force for a few weeks, what changes can we expect in practice, or, put another way, what arguments will paying parties deploy on summary or detailed assessments when hourly rates are the focus of argument before the Court?

The first point to establish is whether the new GHR are retrospective.

In his acceptance address, the Master of the Rolls acceptance said this: -

"I am satisfied with the evidence and arguments set out by the working group. I plan to implement all the recommended changes from Friday 1 October 2021."

That intention could not have been expressed with more clarity: the new GHR would take effect on 1st October 2021. No mention of any back-dating or transitional arrangements. Implementation day would be 1st October. No earlier, no later.

Already, however, three High Court decisions have adjudicated that that is not to be the case. In *ECU Group plc v Deutsche Bank* [2021] EWHC 2083 (Ch), *Axnoller Events Ltd v Brake* [2021] Costs LR 685 and *Goodwin v Avison* [2021] EWHC 2754 (Ch) , respectively, Miles J, HHJ Matthews and HHJ Davis-White have spoken with one tongue. The 2010 GHR are of limited or no value. It is the 2021 GHR which should be taken into account, not only from 1st October 2021 onwards, but also for work undertaken before.

In *ECU*, that meant that Miles J was willing to allow £571 to £577 for a City of London Grade A for acting in a security for costs application involving £500,000 where the work had begun in February 2021.

In *Goodwin*, the upshot was that the court allowed £250 for the Grade A in Leeds as claimed, being a figure within the new GHR, albeit well above its predecessor's rate of £217. For a grade A in Central London, be allowed £400 per hour against the guidelines for 2010 and 2021 respectively of £317and £373, for work done in June 2021.

In *Axnoller*, the result was less clear. Having found that London solicitors had been justified for a case proceeding in Bristol, that leading counsel was reasonably retained and that the 2021 GHR should apply, the judge went on to hold that the rates were far too high and *"If anything, it justifies less"*, he had said, a judgment which was somewhat against the findings he had just made.

Putting aside the decision in *Axnoller* as being out of kilter with the other two judgments, what will all this mean for claimants who have won their cases before 1 October 2021, and whose bills have already been served, or are with the court for assessment under CPR 47?

In the first place, there is no possibility that such claimants will be permitted to withdraw their bills in order in order to amend the rates to claim the 2021 GHR if they have not been claimed. When the Court of Protection (*"COP"*) rates were increased in 2020 by 25% (see *PLK, Thakur, Chapman and Tate [2020] Costs LR 1349*), there was a scramble in the Senior Courts Costs Office (*"SCCO"*) by those acting for protected parties, to remove their bills so that they could be re-drafted to claim, retrospectively, the 25% increase. That was stamped upon by the SCCO through a Practice Note issued in October 2020, that such bills could not be withdrawn without the consent of the client or the permission of the court.

Applying that logic to bills which are *"between-the parties"* and are not CPO, which have already been served or are with the court for Detailed Assessment, the outcome will be the same. It will be nigh impossible to justify circumstances in which it will be valid to remove or re-serve them so that they can be increased if the best argument advanced for doing so is limited to *"Please Sir, I want some more"*.

The position will be different for those who are now settling their cases on favourable terms or are obtaining judgments with costs to be assessed. First, as mentioned above, a triumvirate of judges have held that the 2021 GHR apply to work undertaken before 1 October 2021. That means that in all likelihood, allowances will be somewhere between the 2010 GHR and the 2021 GHR, according to when and where the work was done. Particularly important and relevant in this respect, will be the uplifts which the courts will allow to reflect the factors such as complexity identified in paragraph 29 of the Guide.

Second, City rates will apply to City type work, and only to City type work, that is to say in commercial litigation where

the matter is complex, high value, or with an international element. Thus, even in catastrophic personal injury or clinical negligence cases, claimant firms should not have any reasonable expectation that they will recover City rates even where the damages will run into the millions.

Third, so far as summary assessment is concerned, where the work was done before 1st October 2021 and the assessment undertaken before that date, it is a case of *"Done Deal"*, at whatever rate the judge then allowed. From 1st October, however, judges carrying out summary assessments will be applying the 2021 rates. It follows that to the extent that some of the work may have been undertaken earlier, that will be the receiving party's good luck, as the 2021 GHR will used as the starting point in line with *ECU Group, Anoxeller and Goodwin*. That said, as time marches on, there will come a moment when all tasks undertaken and subject to the assessment in question, will have been carried out after 1 October 2021, so the point will be academic: 2021 rates will reign supreme until the next GHR review.

The outcome of the Report and the implementation of the new GHR ought to mean that claimant lawyers will be better remunerated, but that will not end the arguments at Detailed Assessment about how much Defendants should pay. In addition to the issues identified above, the usual submissions about the *"local solicitor"* will persist: was it objectively reasonable for the incurably ill claimant with just months to live, to instruct a Central London firm when he lived in Cornwall not London, having regard to *Sullivan v The Co Operative Society Ltd [1999] 2 Costs LR 158* and *Wraith and Sheffield Forgemasters Ltd [1997]1 Costs LR 23*? If it was not, lower than Central London rates will apply, meaning that either the client or their solicitors will have to stand the shortfall.

The implementation of the 2021 GHR, therefore, will not be a case of claimant lawyers laughing all the way to the bank, but there is one point of note and encouragement for those who act for litigants who have been injured or damaged. The Master of the Rolls has recognised that updating rates once a decade is an absurd. Therefore, within the next two years, another Committee will be given the task of undertaking a further review, so that the rates do not again fall behind, as has been the case in the past, with the consequential *"ding-dong"* in the courts about what is a fair and reasonable figure for the paying party to meet, and for the receiving party to recover.

The potential flaws in clinical guidelines: The Stenting V Surgery Controversy

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This follows my first article commenting on the HSIB final report of 17 December 2020[1], following their investigation into safety concerns over placement of nasogastric (NG) feeding tubes published in the LS Newsletter in June 2021 (see also Medico-Legal Magazine, Issue 16).

Despite patient safety alerts and warnings, and the fact that misplacement had continued to result in severe complications and avoidable harm to patients, some practitioners had admitted to HSIB investigators that they were aware of the existence of guidelines issued by the Society of Radiographers in 2012 intended to avoid this preventable error – an NHS *"Never Event"* - but had not read them as they were *"too long to read"*.

The failure of individual Hospital Trusts to ensure awareness and implementation of the established guidelines by their staff through rigorous clinical governance came as a major surprise.

In recent years there has been a significant increase in clinical guidelines and protocols issued at local, national and international level by professional bodies, regulators, Royal Colleges, NHS Trusts and other organisations. They provide the courts with a benchmark by which to judge clinical conduct. Although they do not set legal standards for clinical care, inevitably guidelines and protocols are likely to play an increasingly important part in a clinical negligence claim. As more cases are reported in which the relevance and effect of a guideline is a material issue, we will gain a better idea of the weight a court may give to a guideline and the implications for a negligence claim of a medical practitioner complying or, on the other hand, failing to comply with a particular guideline.

Where a guideline relevant to a particular form of treatment is endorsed as authoritative by an expert, the Court will usually give significant weight to that evidence, but only as part of the overall expert evidence.

The Sepsis 6 guidelines (reflected in NICE guideline 51[2]) are perhaps the closest we get to Commandments: protocols that are clear and unambiguous, known and respected universally, which must be obeyed without good reason. Negligence claims on behalf of injured patients in which the guidelines for the diagnosis and early management of this life-threatening illness have not been followed would be difficult to defend.

There must be a presumption that doctors should be aware of current guidelines relevant to their practice areas as part of their duty to exercise reasonable skill and care, even in those specialties in which keeping up to date with journals and guidelines amounts to a significant burden. Many clinicians are likely to feel that they now face a deluge of guidelines from multiple sources. GPs, for example, will often see patients with multi-morbidities, so compliance with a number of single disease guidelines is not without its difficulties.

It is doubtful that a Court would be sympathetic to any suggestion that guidelines should not apply because they were prolix, and practitioners, although aware of their existence, don't have time to read them. Similarly, ignorance of an authoritative, relevant guideline would be unlikely to afford a defence.

In this article I have considered the potential arguments that might be raised to challenge the validity of an apparently trustworthy, authoritative guideline.

It isn't clear to what extent a Court will be prepared to consider detailed argument between the parties over the validity of a particular guideline, how it was developed and the process by which it has been adopted by professional organisations and other bodies. To be accepted as authoritative in a particular area of clinical practice a guideline should result from an unquestioned process, reflecting evidence-based research.

1 https://www.hsib.org.uk/news/hsib-highlights-patient-safety-risks-nasogastric-tube-never-events/

2 https://www.nice.org.uk/guidance/ng51

NICE recommendations, for example, are stated to be based on *'systematic reviews of best available evidence and explicit consideration of cost effectiveness. When minimal evidence is available, recommendations are based on the guideline development group's experience and opinion of what constitutes good practice'*.

The European Society of Cardiology (ESC) states on its website[3]:

"A great number of guidelines have been issued in recent years by different national and international organisations. However, this profusion of documents can endanger the authority and validity of guidelines, which can only be guaranteed if they have been developed by an unquestionable decision-making process. This is one of the reasons why the ESC and others have issued recommendations for formulating and issuing guidelines".

Guidelines - usually based on the results of extensive research and randomised controlled trials - may provide more up-to-date evidence of a current standard of care than a textbook, which may have taken several years to be published. As such they provide evidence to which a Court can refer in assessing the appropriate standard of care.

The problem of conflicts of interest

The validity of a guideline may be in dispute where research or the guideline development process has been tainted by an actual or potential conflict of interest or bias reflecting a perceived lack of impartiality. The process by which the authors of a research study cherry-pick the positive results that support the conclusions they are seeking to achieve and ignore or downplay any adverse results that are nevertheless relevant is known as *'selective outcome reporting'*.

As it was put in the Lancet 31 August 2019 study **Managing Conflicts of interest in Clinical Guidelines**[4] *"Conflicts of interests are pervasive in medicine, and their influence on guidelines impacting on patient care has been a major concern."*

Ideally there should be clear separation between those running clinical trials and those responsible for formulating guidelines arising from those trials, however, the difficulty is that in the absence of industry support, expensive trials – in some cases taking place over many years - would not take place.

There have also been instances of conflict between guidelines issued by different organisations representing practitioners in the same field.

Published guidelines provide guidance to facilitate and promote good medical practice. It is unlikely they will be accepted as a substitute for conventional expert evidence in a clinical negligence trial. Claimant and Defendant lawyers need to be alive, however, to the potential for challenging an expert's assertion as to an appropriate standard of care by pointing to differing opinions evident from the body of contemporaneous information that has informed and led to the adoption of a particular guideline. A relevant research study resulting in the adoption of an evidence-based guideline may well be preferred over an individual expert's assertion, for example, to support a *Bolam 'reputable minority'* defence. Since the 1997 *Bolitho* case[5] the court will in any event examine the expert evidence and may subject a form of treatment and any relevant guideline to logical scrutiny and conclude that negligence has been established even if a body of medical opinion suggests otherwise.

Guidelines are introduced into the court process by expert witnesses as evidence of accepted and customary standards of care. The mere fact that a guideline exists can neither establish its authority nor support the view that in the circumstances before the court, compliance with the guideline would be reasonable and non-compliance negligent.

Guidelines and protocols did not play a significant part in the paediatric cardiology and cardiac surgery cases in which I specialised following my involvement for the families in the Bristol Royal Infirmary Public Inquiry[6] into the shortcomings at the children's heart unit and related litigation (see **Medico-Legal Magazine**, Issues 15 and 16). In this high-risk specialty the experience and skills of the medical and surgical team are crucial. The liability issues are likely to be multifactorial and may depend on the age of the child, the type of congenital heart defect, the form of surgery involved, the complexity of the child's medical condition and any co-existing cardiac defects and co-morbidities, the accuracy of diagnosis and timing of surgery, the post-operative care and the way in which the unit or surgeon was able to cope with the complications inherent in these procedures.

3 https://www.escardio.org/Guidelines/Clinical-Practice-Guidelines/Guidelines-development/Writing-ESC-Guidelines

4 *Managing conflicts of interests in clinical guidelines Lancet 2019 Aug 31;394(10200):710*

5 https://publications.parliament.uk/pa/ld199798/ldjudgmt/jd971113/boli01.htm

6 https://www.thebristolreview.co.uk/Bristol-Review--FINAL-REPORT.pdf

Achieving the appropriate level of scientific significance in paediatric cardiac surgical and cardiological procedures, in order to formulate evidence-based guidelines, has been a problem as a result of the lack of sufficiently large cohorts of comparable cases. Single centres may not deal with adequate operation numbers to enable proper classification and comparison, making it difficult to establish standards of care and form robust conclusions. With low patient numbers there may otherwise be a tendency to lump similar but technically different conditions together because the necessary granularity of data isn't available.

Those practicing in adult cardiology, on the other hand, have to be familiar with multiple guidelines. A substantial number of guidelines and methodologies in the adult cardiovascular field have been published by the European Society of Cardiology (ESC) and it's US counterpart the American Heart Association (AHA). These cover a wide range of cardiology procedures and treatments including coronary artery bypass grafting (CABG) and stenting, management of thrombolysis, diabetes and pre-diabetes, heart failure, myocardial infarction, as well as the use of aspirin and statins.

The majority have been accepted as authoritative and reliable but there have been instances of conflict between the guidelines issued by the European and American bodies. Differences of opinion between professional bodies can occur across other areas of clinical practice, but the issues of contention that have arisen in cardiology demonstrate the importance of examining the guidelines development process itself.

A number of cardiovascular and adult cardiology trials and guidelines have generated controversy. The large-scale EXCEL study[7] (Evaluation of XIENCE versus Coronary Artery Bypass Surgery for Effectiveness of Left Main Revascularization) into the merits of coronary artery bypass grafting (CABG) over stenting is a case in point. CABG involves open-heart surgery, with longer hospital stays and a longer period of recovery and rehabilitation than occurs with stenting. Stenting (percutaneous coronary intervention - PCI) is a minimally invasive procedure involving coronary angioplasty using a balloon catheter to widen blocked or narrowed arteries, combined with a drug-eluting stent coated with medication to help prevent blood clots inserted into the artery to allow blood to flow more freely.

As a minimally invasive procedure enabling a speedier recovery and a shorter period of hospitalisation, stenting has a number of advantages over CABG. A question has nevertheless remained over the comparative effectiveness of the two procedures over the longer term.

The EXCEL trial sponsored by the US medical technology company Abbott Laboratories followed 1900 volunteers with left main stem (coronary) disease (LMS) over a five-year period.

The coronary stent market in the US, dominated by major companies including Medtronic, Boston Scientific as well as Abbott Laboratories is currently worth approximately US $10.31 billion annually, an annual compound growth rate of 7.6% over the last 5 years.

The study's authors concluded that bypass surgery and stents were equally effective in the prevention of deaths in patients with less severe forms of LMS and that clinical outcomes after 5 years were similar. This led in 2018 to the European Association for Cardio-Thoracic Surgery (EACTS) and the European Society of Cardiology (ESC) revising and updating their guidelines.

The study was dogged by controversy over the reported rates of mortality following heart attacks and the actual definition of heart attack (myocardial infarction) which was felt to be crucial to the analysis of outcomes. This was the subject of a BBC Newsnight programme on 18 February 2020[8], which reported the view of some experts that if the *"Universal Definition"* was adopted for the definition of a heart attack, rather than the *"popular standard definition"* developed by the Society for Cardiovascular Angiography (SCAI) and Interventions used by the EXCEL authors, patients receiving a stent were at higher risk of heart attacks than those who underwent CABG.

The dispute over how to define a heart attack and the implications for the study's conclusions was reported to have prompted some European clinicians to question these findings. The EACTS, the body representing European cardiac surgeons, was reported to have withdrawn support for the updated European guidelines that reflected the recommendation of stenting or open heart surgery as equally effective, saying that it was *"a matter of serious concern"* that some patients may have received incorrect advice and that *"patients with left main coronary artery disease treated with stents were 35% more likely to die than those treated with conventional open heart surgery."*

Patients, particularly in the post-*Montgomery*[9] era, are of course entitled to be advised as to the options and the

7 https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7941379/

8 https://www.bbc.co.uk/news/health-50715156

9 *Montgomery v Lanarkshire Health Board [2015] SC 11 [2015] 1 AC 1430.*

comparative advantages and risks of each procedure as part of the consent process.

The ESC stood by its revised guidelines, stressing that they were based on wider evidence in addition to the results of the EXCEL study. The EXCEL authors responded that the Universal Definition *"was not suitable"* for comparing the two procedures. The Universal Definition requires a highly sensitive blood test to identify damage to the heart muscle, a test so sensitive it may detect minor damage caused by the procedure itself. Many doctors, they said, don't perform this test on patients undergoing stenting or CABG. The EXCEL authors argued the higher mortality rate in the stent group was largely due to causes that were not heart-related, particularly cancer and infections that appeared several years after stenting or surgery. They said there had been no attempt to hide meaningful data - the EACTS had withdrawn from the guidelines *"without so much as even asking the EXCEL study group for clarification."*

In order to restore public and patient trust in these findings, and good relations between the stenting and cardiothoracic communities the EXCEL trial is undergoing independent review.

Guidelines and their impact on women's health

Numerous studies in recent years have demonstrated that heart disease and the ways in which it can uniquely and specifically affect women has been under-researched and women continue to face a greater risk than men of having their heart conditions misdiagnosed, diagnosed late or not treated as intensively or as effectively when a diagnosis has been made. This potential for disparity in treatment options and outcomes for women reflects what is seen as a gender bias, whether conscious or implicit, and represents a health disadvantage for women who are losing out on treatments that may result in better management of their symptoms and improvements in their quality of life. The concern is that guideline-recommended tests and therapies have been based on studies and randomised controlled trials in which women have been under-represented as participants and therefore do not reflect the difference in presentation of women's symptoms. Higher representation of women as authors has also been associated with a higher recruitment of women to join studies. There has been an increase in research into sex differences in heart disease and there is likely to be a corresponding increase in the release of guidelines specific to women and gender-based revision of existing guidelines.

Conclusion

Inevitably guidelines will have implications for a Court's determination of the relevant standard of care in a particular case, but we are a long way from a Court finding that a failure to adhere to a relevant guideline automatically amounts to breach, or that compliance enables a Defendant to escape liability. Clinical negligence remains a field in which lawyers are heavily reliant on expert evidence in its traditional forms: written reports and oral evidence based on an expert's clinical experience of standards at the time when the treatment took place, supported by published sources including textbooks and journals.

As stated, guidelines are not a substitute for experience and informed clinical judgement, and it remains to be seen if guidelines will usurp the role of expert evidence. In the meantime, we are likely to see an increase in legal scrutiny of guideline development procedures and challenges to their validity in negligence claims coming before the courts.

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Medical Negligence Cases 2021 for AvMA

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When I started writing this article, I thought that I would gather together a dozen cases from this year, and use each of them to make a separate, practical point about good management of litigation.

What I've found, though, is that they all tell the same story; good team work leading to careful and effective selection of experts, both medico-legal and clinical, should produce a good outcome for the claimant and for the litigation. By definition, a good team working together should be able to pursue any realistic claim appropriately and vigorously – and vigour is certainly needed in many large clinical negligence claims.

The most outstanding of my recent clinical negligence cases is one that came to trial earlier this year, and settled on day two, after I had started to cross-examine the central midwife. It was notable for several reasons. First, we didn't get a positive midwifery opinion until our fifth expert – that really is extraordinary in the light of the eventual success of the claim. Secondly, we also failed with our first paediatrician on causation – he attributed the profound brain injury to near miss cot death, when in fact it was caused by a well-known and easily identifiable condition at birth. Thirdly, the NHSR cancelled our settlement meeting not long before trial, on the basis that they did not intend to make any offers – startlingly different from their rhetoric.

I was hugely helped in that case by a paediatrician, who I knew well, liked, and respected enormously – he had (sadly he's passed away) an analytical style which was invaluable in assessing the true strengths and weaknesses of cases, and he used to prepare advisory reports at an early stage, following which we would spend significant time thrashing out the issues. He was insistent that the relevant condition could not get worse following birth, and that therefore, when it was described as +++ some weeks later, that was clear proof that it was +++ following birth, and should have been identified and managed. Interestingly, because breach and causation were both allegedly in dispute, there were 13 separate issues for the judge to decide, any one of which would have been fatal to the claim.

A very different problem involved a huge baby, very slow labour, with decelerations starting about two hours before eventual delivery, by crash Caesarean, following severe bradycardia. The history sounds straightforward, leading to an easy finding by a judge of breach of duty, but the expert reports made it far more difficult. The obstetrician talked round the ante-natal management generally, and commented on various unimportant aspects of the care, but did not deal with the day of delivery at all – a remarkable omission. The midwife expert was similar, but did deal with the day of delivery, unfortunately using phrases like *"it would have been beneficial..."*, and criticising the failure to make proper notes. All very interesting, but probably not helpful in front of a demanding judge who wants to know about Bolam breaches. We saw both experts in consultation, and they inspired no confidence. As a result, we then spent an hour discussing breach and causation with our causation expert. He was extremely helpful, and guided us to the simple summary above. We now have to find new experts.

I had a similar experience in another case, where the care expert, not selected by me, seemed to use an inappropriate method to calculate future care, and it then turned out that he had never actually arranged or managed a care package. Careful discussion seemed to improve matters, but sadly the joint statement proved that the expert really hadn't understood the issues.

Oddly, that case also provided the reverse example, of an excellent expert being selected without discussion between the legal team – possibly just chance. Causation is said to be an issue, on the basis that the infection in a baby should have been treated on any one of a range of dates; our paediatric neurologist is very firm in his opinion, in a sensible reasoned way, and we have confidence that we will win that battle.

Another case recently, involving surgical negligence, provided the reverse experience. When we got the joint

statement from the lead experts, and then discussed it with ours, it was obvious that he was completely outgunned by the defence expert – so much so, that we had to assume that much of the argument would go against us. Fortunately, the areas of issue between them were not central to the amount of damages, so that we got a good result in the end.

There is no substitute for keeping a database, recording comments on your own and the defence experts, their reports, performance in consultation, giving evidence (very rare in my cases), and general usability. If and when appropriate, that information can be shared. In my Chambers, we frequently ask each other about individual experts, or who would be recommended for a particular type of case. Track record is really important; sometimes, research doesn't reveal the full range of knowledge and opinion about an expert. Web entries tend to be fulsome, and it can be hard to separate the rhetoric from fact.

An unusual problem arose in a claim about the failure to diagnose and manage stroke in an adult. It is asserted in the Defence that a particular form of treatment would not have been offered to the Claimant because of a particular physiological problem that he had. It is now agreed by the claimant and defendant experts that that assertion is definitely wrong. For me, an interesting question arises – how did that misleading assertion find its way into the Defence? If it came from an involved doctor, was it not checked with the experts? After all, if it had been true, it would have defeated the claim, so it is really important that the NHSR and their solicitors should get it right. If it came from one of the experts we know about, it would discredit him or her completely. If it came from another expert, whom they have abandoned, why didn't the new expert(s) immediately point out the error, and why didn't the solicitor tell us? All interesting questions which the defence will doubtless refuse to answer. I think it is important to check the Defence carefully to see where the information has come from, and interrogate the defendant if necessary.

Oddly, I have two cases recently where genetics are important. I say *'oddly'* because I don't remember any others in over 25 years of brain injury clinical negligence. It seems to be an area where extra special care should be taken by the claimant team, because there is so much development going on, and it is comparatively easy for a defendant to cast doubt on the aetiology of the injury by agonizing about genetic possibilities. I had a consultation recently with the genetics expert in one of those cases and, after wading through treacle for quite some time (not his fault at all) we finally broke through to a nice, clear view of the reality, namely that the Defence suggestion was fanciful.

Incidentally, going back to experts, that was a case where we had a con with the two main medical experts before they wrote detailed reports, and clarified much of the detail, simplified the approach, and ended up with excellent reports. I'm a great fan of early discussions with experts, before we get a whole range of reports conflicting with each other, which we then have to try to reconcile.

A really interesting case involved failure to diagnose severe illness, in which the paediatric neurologist was very helpful in helping us to consider breach on different dates, some dates making causation easier than others. Guidance like that, even through it may be outside the expert's area of specialty, can be invaluable.

This case raised a really interesting question, which pops up from time to time; how do claimants' litigation teams manage the problem when the claimant cannot or will not be examined, either by their own experts or by defence ones. An extension of this is; what do you do when the effect of the brain injury is to make the claimant so difficult to manage that he or she cannot or will not engage with rehabilitation? There is no easy answer, and every case and every patient is different, but it is our job, with the guidance and help of medico-legal and clinical professionals, to support and guide the claimant in a way that he or she finds acceptable. Sometimes, questions such as *"what makes you want to get up in the morning?"* will reveal that there are carrots to induce co-operation. We recently had a consultation with the experts and the case manager to try to establish and confirm a good rehab approach, and it seemed to be very successful.

I think it's worth remembering that, following every successful liability settlement or trial, there will be a substantial quantum case; I feel that quantum is often under-estimated in clinical negligence litigation – it is very much a specialty of its own, and sub-standard management of quantum can result in millions of pounds not being recovered.

Possibly the most important aspect of quantum in major claims is rehabilitation. I've been lecturing and writing about brain injury rehabilitation for nearly 30 years, going back to the days when people genuinely asked whether rehabilitation worked. Part of the interest and enjoyment of the work I do is that lawyers can be partly instrumental in facilitating optimum rehabilitation for injured clients, knowing that it gives them the best possible chance of reducing dependence and improving quality of life. I regard this as an important function for good quantum lawyers.

In major litigation, care is always the main element, and care experts are hugely variable. The range of issues is wide, and knowledge of all the various possibilities is worth acquiring; it's definitely not enough to read your own expert's report and assume that he or she is correct. As with all experts, it's worth remembering that you should not use them unless your research reveals that they have a good track record. It's no accident that the well-known ones are well-known!

A thread that runs through all the points in this article is that teamwork is needed between solicitors, barristers, experts, and sometimes the claimant and family. The pooling of knowledge in order to select experts, either medico-legal or clinical, coupled with the input from those experts, really can help to maximise outcome for the claimant and to make litigation easier.

In conclusion, I think I would reduce my advice to a few major points. First, selection of experts on liability and quantum is vital. Secondly, teamwork between claimant and family, solicitor, barristers, and experts makes all the difference to the outcome. Thirdly, good claims need determined management and progression, because there are always hurdles along the route.

The *Scope of Duty* principle in light of *Khan V Meadows*

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Introduction

In June 2021, the Supreme Court handed down its much anticipated judgment in *Khan v Meadows* [2021] UKSC 21. This decision is one that clinical negligence practitioners need to read, digest and be ready to apply to their cases. This article focusses upon the key features of the decisions in this case from the High Court, Court of Appeal and Supreme Court and sets out some practical tips for those practitioners grappling with scope of duty arguments in future.

First, it is helpful to have a quick refresher of the basic principles in wrongful birth claims.

The *'healthy'* child

The law applicable to wrongful birth claims was considered in the context of a *'healthy child'* by the House of Lords in *McFarlane v Tayside Health Board* [2000] 2 A.C. 59. The House of Lords held that no duty of care was owed to the parents in respect of the financial cost of bringing up a healthy child following negligent advice about or negligent performance of a sterilisation operation.

The *'disabled'* child

In *Parkinson v St James and Seacroft University Hospital NHS Trust* [2002] QB 266 and *Groom v Selby* [2002] PIQR P18, the Court held that in cases of wrongful birth: (a) the parents were not able to recover the costs of the upbringing and caring for a normal healthy child (*McFarlane* followed); but (b) they were entitled to an award of compensation for the additional expenses associated with bringing up a child with significant disability.

In *Parkinson* and *Groom*, the disability was not caused directly by the negligence of the defendant. There was no direct link between negligence and the ensuing disability. In each case the doctor had undertaken the task of protecting the patient from an unwanted pregnancy. In *Parkinson*, the pregnancy itself. In *Groom*, the continuation of the pregnancy. In both, the disability arose from genetic causes or foreseeable events during the course of the pregnancy which were not due to a new intervening cause. This was deemed a sufficient causal link between the defendants' negligence and the disability of the child in each case and the claimants could recover the additional losses associated with the disability.

Khan V Meadows: The facts

The core facts can be summarised as follows:

(a) The Claimant consulted her GP with a view to establishing whether she was a carrier of the haemophilia gene because she wanted to avoid having a child with haemophilia.

(b) She was told that her blood test results were normal. Given the advice that she received, she was led to believe that any child she had would not have haemophilia.

(c) The Claimant subsequently became pregnant with Adejuwon. Shortly after his birth, Adejuwon was diagnosed with haemophilia. The Claimant was referred for genetic testing, which confirmed that she was in fact a carrier of the haemophilia gene.

(d) Had the Claimant been referred for genetic testing by the Defendant: (i) she would have known she was a carrier before she became pregnant; (ii) further testing would have revealed that the foetus was affected; and (iii) the Claimant would have chosen to terminate her pregnancy and Adejuwon would not have been born.

(e) Adejuwon's haemophilia is severe. He has also been diagnosed as having autism, which is unrelated to the haemophilia. However, the management of his haemophilia was made more complicated by his autism.

The issue

The parties agreed that the Defendant negligently caused Adejuwon to develop haemophilia by failing to determine that the Claimant was a carrier of the haemophilia gene. The Defendant agreed that the Claimant would have terminated her pregnancy (i.e. *'but for'* causation was made out). The Defendant agreed that she could recover the costs associated with Adejuwon's haemophilia. However, it was disputed that the Claimant could recover the costs associated with his autism which the Defendant argued was not related to the negligence.

The issue at trial and on appeal can be summarised as follows: Whether, as a matter of law the Defendant's liability should be limited to losses associated with Adejuwon's haemophilia or whether she should be liable for the additional losses associated with both his haemophilia and autism?

The answer to this question resulted in the difference between a damages award of £1,400,000 (for the losses associated with his haemophilia) and £9,000,000 (for the losses associated with his haemophilia and autism).

The High Court

The Defendant relied on the principle established in *South Australia Management Corporation v York Montague* [1997] AC 191 (*'SAAMCO'*). In *SAAMCO*, it was held that where a defendant was under a duty to take reasonable care to provide information upon which someone else would decide on a course of action, if they were negligent they were only responsible for the consequences of the information being wrong if the particular risk fell within the scope of that duty (not for all the consequences of that course of action).

The Defendant argued that all the foreseeable risks of the pregnancy cannot be transferred to a doctor who has provided a service in relation only to one specific risk (the risk of haemophilia).

The case at first instance was heard by Yip J. She did not accept the Defendant's submissions. Yip J accepted that there is a distinction between a case where a parent does not want to have any child and one where a parent does not want to have a child with a particular disability. However, she was not persuaded that this was an appropriate starting point. She stated that, as a matter of simple *'but for'* causation, Adejuwon would not have been born but for the Defendant's negligence. The Claimant would not have had a child with the combined problems of haemophilia and autism. Had the Claimant known she was a carrier, she would have terminated her pregnancy. The other risks associated with that pregnancy would no longer have existed.

As to the *'scope of duty'* argument, Yip J held that the focus of the Defendant's duty and the very purpose of the service the Claimant sought was to provide her with the necessary information to allow her to terminate *any pregnancy* afflicted by haemophilia. The birth of Adejuwon resulted from a pregnancy which was afflicted by haemophilia. His autism was bad luck, in the same way as meningitis in *Groom* was bad luck. Equally, each condition was the natural consequence of a pregnancy that would not have continued if the doctor's duty had been performed correctly. The scope of the duty in this case extended to preventing the birth of Adejuwon and all the consequences that brought.

Therefore, Yip J found that the costs of the unrelated autism were recoverable and damages were assessed in the sum of £9,000,000. The Defendant appealed to the Court of Appeal.

The Court of Appeal

On appeal, the Defendant accepted that: (a) the *'but for'* test of causation was made out; (b) it was reasonably foreseeable that as a consequence of the Defendant's breach of duty that the Claimant could give birth to a child where the pregnancy would otherwise have been terminated; and (c) any such child could suffer from a condition such as autism.

However, the Defendant argued that in determining whether the costs relating to autism were recoverable Yip J was required to apply the *"scope of duty test"* as set out in *SAAMCO*. The rationale being to protect a defendant from liability for every foreseeable factual consequence of their negligence.

Nicola Davies LJ stated that the *SAAMCO 'scope of duty test'* was not only relevant but determinative. She accepted that there were three relevant questions and answered them as follows:

What was the purpose of the procedure, information or advice which is alleged to have been negligent? The purpose of the consultation was to put the Claimant in a position to enable her to make an informed decision in respect of any child which she conceived who was subsequently discovered to be carrying the haemophilia gene. It did not extend beyond that. Critically, the possibility of the Claimant giving birth to a child who would suffer from autism never formed part of any discussion or advice. Given the specific enquiry of the Claimant

(namely would any future child carry the haemophilia gene) it would be inappropriate and unnecessary for a doctor at such a consultation to volunteer to the person seeking specific information any information about other risks of pregnancy (including autism). This would require knowledge of a variety of factors of which the Defendant was unaware. The Claimant's wishes as to pregnancy generally was a decision for her to take having considered a number of factors.

What was the appropriate apportionment of risk taking account of the nature of the procedure, information or advice? The doctor would be liable for the risk of a mother giving birth to a child with haemophilia because there had been no foetal testing and consequent upon it no termination of the pregnancy. The mother would take the risks of all other potential difficulties of the pregnancy and birth both as to herself and to her child.

What losses would in any event have occurred if the Defendant's advice / information was correct or the procedure had been performed? The loss which would have been sustained if the correct information had been given and appropriate testing performed would have been that the child would have been born with autism.

The COA held that the scope of the Defendant's duty was not to protect the Claimant from *all* the risks associated with becoming pregnant and continuing with the pregnancy. Nicola Davies LJ stated that the *SAAMCO* test requires there to be an adequate link between the breach of duty and the particular type of loss claimed. It is insufficient for the court to find that there is a link between the breach and the stage in the chain of causation (i.e. the pregnancy itself) and thereafter to conclude that the Defendant is liable for all the reasonably foreseeable consequences of that pregnancy. In finding that the Claimant was deprived of the opportunity to terminate the pregnancy, Yip J was referring to one of the links in the chain of causation. Whereas, following *SAAMCO* the link must be between the scope of the duty and the damage sustained.

In the context of this case, it was held that the development of autism was a coincidental injury and not one within the scope of the Defendant's duty. Therefore, damages were limited to £1,400,000. The Defendant appealed to the Supreme Court.

The Supreme Court

The Supreme Court considered that the appeal raised questions of: (i) the role which factual *"but for"* causation, foreseeability and remoteness of damage perform in the analysis of a claim for clinical negligence; and (ii) how the question of the scope of a defendant's duty fits into this analysis (including the relevance of the *SAAMCO* judgment outside claims for pure economic loss). [23]

Lord Hodge and Lord Sales (in giving the majority judgment) stated that a helpful model for analysing the place of the scope of duty principle in the tort of negligence consists of asking six questions in sequence. They noted that it is not an exclusive or comprehensive analysis, but it may bring some clarity to the role of the scope of duty principle (highlighted by *SAAMCO*). [28] Those questions are:

(1) Is the harm (loss, injury and damage) which is the subject matter of the claim actionable in negligence? *(the actionability question)*

(2) What are the risks of harm to the claimant against which the law imposes on the defendant a duty to take care? *(the scope of duty question)*

(3) Did the defendant breach his or her duty by his or her act or omission? *(the breach question)*

(4) Is the loss for which the claimant seeks damages the consequence of the defendant's act or omission? *(the factual causation question)*

(5) Is there a sufficient nexus between a particular element of the harm for which the claimant seeks damages and the subject matter of the defendant's duty of care as analysed at stage 2 above? *(the duty nexus question)*

(6) Is a particular element of the harm for which the claimant seeks damages irrecoverable because it is too remote, or because there is a different effective cause (including novus actus interveniens) in relation to it or because the claimant has mitigated his or her loss or has failed to avoid loss which he or she could reasonably have been expected to avoid? *(the legal responsibility question)*

It is quite possible to consider these questions in a different order and to address more than one question at the same time. However, this analysis serves to demonstrate that the answers to the questions of factual (*'but for'*) causation and foreseeability cannot circumvent the questions which must be asked in relation to the scope of the defendant's duty. [29-30]

The key questions in this case were (2), (4) and (5).

The scope of duty question: The Court stated that there is no principled basis for excluding clinical negligence from the ambit of the scope of duty principle [67]. It is necessary in every case to consider the nature of the service which the medical practitioner is providing in order to determine what are the risk or risks which the law imposes a duty on the medical practitioner to exercise reasonable care to

avoid [63]. In this case, the Court held that the scope of duty question was answered by addressing the purpose for which Ms Meadows obtained the service of her GP. She approached her GP for a specific purpose. She wished to know if she was the carrier of a haemophilia gene. Dr Khan owed her a duty to take reasonable care to give accurate information or advice when advising her whether or not she was a carrier of that gene. In this context it matters not whether one describes her task as the provision of information or of advice. The important point is that the service was concerned with a specific risk, that is the risk of giving birth to a child with haemophilia [67].

Factual causation: Ms Meadows lost the opportunity to terminate the pregnancy in which the child had both haemophilia and autism. There was thus a causal link between Dr Khan's mistake and the birth of Adejuwon. But the Court held that such a conclusion as to factual causation does not provide any answer to the question of the scope of Dr Khan's duty. [68]

The duty nexus question: The law did not impose any duty on Dr Khan in relation to unrelated risks which might arise in any pregnancy (given the factual differences with *Parkinson* and *Groom*). It follows that Dr Khan was held to be liable only for the costs associated with the care of Adejuwon insofar as they are caused by his haemophilia [68]. Further, the Court held that the *SAAMCO* counterfactual can be applied as an analytical tool. In other words, the following counterfactual question can be asked: What would the Claimant's loss have been if the information which the Defendant in fact gave had been correct? The question is not about whether the Claimant would have behaved differently if the advice provided by the Defendant had been correct. Rather, it assumes that the Claimant would behave as he did in fact behave and asks, whether, if the advice had been correct, the Claimant's actions would have resulted in the same loss. By this means, the Court can ascertain the loss which is attributable to that information being wrong [53]. In this case, the Court asked what the outcome would have been if Dr Khan's advice had been correct and Ms Meadows had not been a carrier of the haemophilia gene? They held that the undisputed answer is that Adejuwon would have been born with autism.

Therefore, the appeal was dismissed.

Practical Tips

The following practical tips can be derived from the decisions of the Supreme Court and Court of Appeal in this case:

Establishing *'but for'* causation and foreseeability are sometimes not enough: On first blush, this appears to be a strange result. The Claimant has satisfied *'but for'* causation. In other words, she would not have had her baby but for the Defendant's negligent advice. Therefore, how can she not recover the damages associated with all her child's disabilities? Well, it is easiest to see the *'scope of duty'* test as one that must be assessed *before 'but for'* causation. If a particular loss does not fall within the scope of the Defendant's duty, then it is irrelevant if *'but for'* causation is made out or not. As the Supreme Court stressed: answers to the questions of factual causation and foreseeability in the Claimant's favour cannot circumvent the need to satisfy the scope of the duty question.

Significance of *Khan v Meadows*: This is a highly significant decision. The Supreme Court was unanimous in its support of Nicola Davies LJ's judgment in the Court of Appeal that *SAAMCO* and the scope of duty test are to be applied in clinical negligence cases. There was a minority judgment given by Lord Burrows and Lord Leggatt, but only to the extent that they took issue with the *'novel'* approach of the six questions set out by the majority. Both were clear that the scope of duty principle is just as applicable to a medical practitioner as to anyone else who gives professional advice. Those representing defendants will no doubt wish to employ this argument in cases of *"coincidental"* or *"piggy-back"* causation. This is likely to have greatest significance in cases of a clinical failure to warn. In other words, a patient who is negligently not warned about risk X may be unable to successfully claim if risk Y materialises during surgery.

Does this spell the end for *Chester v Afshar* [2004 UKHL 4]? (i) In *Chester*, the defendant (a neurosurgeon) advised the claimant to undergo a surgical procedure on her spine. This procedure carried a small non-negligent risk of developing cauda equina syndrome (CES). The claimant underwent the procedure and developed CES. At first instance, the judge found that the defendant had negligently failed to warn the claimant of the risk of developing CES. The Court of Appeal held that since the risk which eventuated was likely to be the same no matter how skilfully and carefully it was carried out, the failure to warn neither affected the risk nor was it an effective cause of the claimant's injury. Therefore, on the conventional *'but for'* analysis, the claimant could not satisfy the test of causation. However, the House of Lords held that on policy grounds the test of causation was satisfied. The risk that eventuated was within the scope of the duty to warn so that the injury could be regarded as having been caused, in the legal sense, by the breach of that duty.

(ii) The judgment in *Chester* featured heavily in the decisions of the courts below, but was not to be found in the Supreme Court's analysis. Perhaps, this is because it is no longer sustainable. In *Chester*, the Defendant's duty was limited to the requirement to warn of a certain risk of surgery rather than to necessarily prevent inherent risks of the procedure. In circumstances where the claimant would have undergone the same procedure (just at a later date) and where the risk would have been the same in any event, it must be queried whether there is a sufficient nexus between the duty and the harm.

***Parkinson* & *Groom* are factually different to *Khan*:** Both the Court of Appeal and the Supreme Court were at pains to stress that it is necessary to consider the nature of the service provided in order to determine the risk(s) in respect of which the law imposes a duty to exercise reasonable care to avoid. In wrongful birth claims, be careful to recognise the difference where the purpose of the advice, information or procedure concerns the pregnancy generally (such as *Parkinson* & *Groom* where the purpose of service undertaken was prevent the birth of any child) and where it concerns something more narrow such as a particular disability the child might have (*Khan*). These cases can be distinguished from each other and can ultimately lead to a significant difference in outcome. On that basis, practitioners will need to be mindful of: (i) investigating the specific purpose of any consultation with clinicians / claimants when holding conferences or reviewing records; and (ii) being precise in pleading their statements of case.

The Application of Article 2 ECHR at Inquests

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Since the last AvMA newsletter in June this year, the Divisional Court has handed down two judgments which consider the engagement of Article 2 in inquests and more specifically, when the operational duty arises. These decisions do not fundamentally change the relevant principles, but they clarify them in a way which means that they are likely to be applied more restrictively than before.

Article 2 and inquests

Article 2 of the European Convention of Human Rights (ECHR) (the right to life) imposes two sets of substantive obligations on states: (i) a negative duty to refrain from taking life without justification; and (ii) a positive duty to protect life. The positive duty also contains two further sub-duties: (a) a systemic duty to ensure there are adequate systems in place to protect life; and (b) an operational duty to take positive steps to protect an individual's life in certain circumstances.[1]

It also imposes on the state an investigative duty to inquire into the circumstances of a death, including an *'enhanced duty'* to investigate a death which occurred in circumstances where the state arguably breached a substantive duty owed to the individual.[2] In England and Wales, this duty is commonly fulfilled by holding an inquest which is permitted to investigate not only the means by which but also the wider circumstances in which the deceased came by their death. This is known as an *'Article 2'* or *'Middleton'*[3] inquest.

The leading domestic authority on when the operational duty arises remains the decision of the Supreme Court in *Rabone*[4]. In that case, Lord Dyson set our four criteria[5] which courts should consider when determining whether the operational duty has arisen:

1. The existence of a real and immediate risk to life (glossed in the judgment as a risk which is *"present and continuing"*[6]);

2. An assumption of responsibility by the state for that individual's welfare and safety;

3. The victim must be sufficiently vulnerable; and

4. The risk must be exceptional, rather than one which the individual should reasonably be expected to take in the circumstances.

However, Lord Dyson stressed that whilst all of these factors were relevant, they were not *"a sure guide as to whether an operational duty will be found by the ECtHR to exist in circumstances which have not yet been considered by the court."*[7] It is also worth noting that the four criteria are also referred to in some judgements as Lord Dyson's *'three indicia'*, where criteria 1 and 4 are combined under the heading of the *'nature of the risk'*.

Case 1: *R (Morahan) v Assistant Coroner for West London*[8]

Facts

Tanya Morahan was 34 years old. She had a history of paranoid schizophrenia and cocaine use and previous admissions to hospital. She had been held under section 3 of the Mental Health Act 1983 at a community-based rehabilitation unit operated by the local NHS Trust, but around two weeks before her death her section was rescinded and she remained at the unit as a voluntary patient. On 30 June 2018 she left the unit with permission

1 *See e.g. Savage v South Essex Partnership NHS Foundation Trust [2008] UKHL 74 at paras 50, 68-69 and 72*
2 *See R (Smith) v Oxfordshire Assistant Deputy Coroner [2011] 1 AC [paras 70 and 84]; R (Long) v Secretary of State for Defence [2015] 1 WLR 5006 [para 5]*
3 *Following the decision in R (Middleton) v Coroner for the Western District of Somerset [2004] UKHL 10*
4 *Rabone & Anor v Pennine Care NHS Trust [2012] UKSC 2*
5 *Ibid [para 21-24]*
6 *Ibid [para 39]*
7 *Ibid [para 25]*
8 *[2021] EWHC 1603 (Admin)*

but failed to return as required that evening and did not return until the next day. On 3 July 2018, she again left the unit with permission but again did not return. At the request of the Trust, the police visited her flat the next day but she did not answer the door. On 9 July 2018 she was found dead at her flat. The pathologist concluded that she had died of cocaine and morphine toxicity. It appears to have been common ground that Tanya had died by *accidental* drug overdose.[9]

The Coroner ruled at the pre-inquest reviews that Article 2 was not engaged. The family challenged this by way of judicial review, arguing that the circumstances of the death triggered an automatic duty to hold an Article 2 inquest, or alternatively that on the facts of the case there were arguable breaches of the operational duty owing to alleged failures to detain Tanya on her return to the unit on 1 July 2018, to take more active steps to locate her after she failed to return on 3 July 2018, and to put in place an after care plan when her section 3 detention came to an end on 25 June 2018.

The Divisional Court's Judgment

The claim was dismissed. Giving the only reasoned judgment, Popplewell LJ undertook a very thorough analysis of both the domestic and Strasbourg jurisprudence on Article 2 and provided further guidance. This included noting that it had been an important feature of previous cases on similar facts that the individual was particularly vulnerable to a risk of suicide (for which the individual was receiving treatment)[10], and that for the operational duty to be engaged there must be a relationship between the control of the state and that specific risk which eventuated. To illustrate this, it was stated that, in contrast, a *"psychiatric hospital owes no duty to protect a patient, whether voluntary or detained, from the risk of accidental death from a road traffic accident whilst on unescorted leave."*[11]

As to automatic engagement of Article 2, it was held that there were certain categories in which the engagement of Article 2 would be automatic, but the key ingredient remained a *"real evidential basis which makes the suggestion of a breach of a substantive obligation by the state a credible one."*[12] Even in such automatic cases (e.g. the suicide of a prisoner in custody), where positive evidence of a breach would not be required, an arguable breach of Article 2 remained the touchstone – but in such cases there would always be a legitimate suspicion of a breach owing to the factual circumstances.[13] Such automatic cases would include killings by state agents, suicides or attempted suicides and unlawful killings in custody, suicides of conscripts, and suicides of involuntary mental health detainees. But the category was not closed.[14]

On the facts of this case, however, it was held that none of the factors identified in Rabone were fulfilled, as: (a) there was no history to suggest a real risk of suicide or drug overdose; (b) there was no relevant assumption of responsibility, as although Tanya was receiving treatment for paranoid schizophrenia and potentially exacerbating effects of substance misuse, her condition was not linked to a foreseeable risk of accidental death from a recreational drug overdose; (c) Tanya was not especially vulnerable in connection to a risk of accidental overdose; and (d) this risk was not exceptional, as it was one to which Tanya was exposed in the same way as any other recreational drug user irrespective of her status as a patient.[15]

As there was no arguable breach, there would be no automatic engagement of Article 2.[16] In any event, it was held that this was not an automatic case, as there was a need for a fact-specific consideration of cases concerning voluntary patients to determine where on the spectrum they lay between genuinely voluntary patients and patients who were voluntary in name only. Further, there was no justification from the case law for extending the automatic duty to cases of accidental death.[17]

Case 2: *Dove v HM Assistant Coroner for Teeside & Hartlepool & Others*[18]

Facts

Jodey Whiting was 42 years old. She suffered from spinal conditions, together with a history of depression, drug dependence and emotionally unstable personality disorder. She had been in receipt of employment support allowance, but this had been withdrawn by the Department for Work and Pensions (DWP) on the basis that she was considered not to have shown good cause for not attending a face-to-face assessment. This decision would be criticised by the Independent Case Examiner,

9 *Not stated expressly but this seems to be the firm implication of [paras 3, 36 and 124]*
10 *Ibid [paras 46 and 59], analysing Rabone and Strasbourg decision in Fernandes de Oliveira v Portugal (2019) 69 EHRR 8*
11 *Ibid [para 67], drawing on reasoning in R (Maguire) v Blackpool and Fylde Senior Coroner [2020] 3 WLR 1268*
12 *Ibid [para 75]*
13 *Ibid [para 122; see also paras 75, 89, 94, 96, 100 and 103]*
14 *Ibid [para 122]*
15 *Ibid [paras 123 and 127-130]*
16 *Ibid [para 135]*
17 *Ibid [paras 136-138]*
18 *[2021] EWHC 2511 (Admin)*

which subsequently found there to have been *"significant failings"* by the DWP.[19] On 21 February 2017, Jodey was found dead in her flat. The medical cause of death was recorded as being the synergistic effects of morphine, amitriptyline and pregabalin together with cirrhosis. She had left notes which suggested that she intended to take her own life.

The Coroner, holding a *Jameison*[20] (i.e. non-Article 2) inquest, provided a short-form conclusion that Jodey died by suicide. The family applied for an order to quash the conclusion on a number of grounds, including that there had been an arguable breach of a substantive duty under Article 2 by the DWP.

The Divisional Court's Judgment

The Court dismissed all four grounds of appeal. As to Article 2, Farbey J held that in relation to the operational duty: (a) there was no authority to support the proposition that by providing welfare benefits the DWP assumed responsibility for preventing the suicide of those in receipt of it, with the policy requirement that the DWP conduct a *'safeguarding'* visit for a person who did not attend an assessment conveying practical guidance to rather than a legal assumption of responsibility; (b) although Jodey was vulnerable, there was no general obligation to prevent suicide in the absence of the assumption of responsibility; and (c) the risk posed by the withdrawal of benefits did not arise from an inherently dangerous situation of specific threat to life, such that it was not *"exceptional"* in the sense deployed by Lord Dyson in *Rabone*.[21]

As to the systemic duty, it was held that there was a comprehensive framework for decision-making by the DWP and that the evidence demonstrated individual failings attributable to mistakes or bad judgment rather than failings which were systemic or structural in nature.[22]

Comment

Neither of these two decisions displace the *Rabone* criteria from their place as key indicators as to whether the operational duty arises in a particular case. However, the interpretation given to the criteria in these decisions is part of, and furthers, a recent trend of restricting the circumstances of when the operational duty may be held to arise.

Automatic Article 2 Inquests

In *Morahan*, it was affirmed that the rationale for imposing the Article 2 duty automatically was the same as that for non-automatic cases. In automatic cases, the circumstances of the death would be enough to raise a legitimate suspicion of such a breach (meaning that positive evidence was not needed), but on a strict legal analysis the category derived from the same fountainhead as non-automatic cases: an arguable breach of Article 2. The list of automatic cases provided in the judgment also offers helpful clarification for practitioners.[23]

An assumption of responsibility in relation to the particular risk must be demonstrated

Both cases reaffirmed the reasoning of the Court of Appeal in *Maguire*[24] that, of the *Rabone* factors, the assumption of responsibility is the *'unifying feature'*[25] of the application of the operational duty. Whilst it was held in *Rabone* that there is a general obligation to take certain routine steps to try to prevent prisoners and detainees from committing suicide because incarceration heightens the risk of self-harm,[26] *Morahan* highlights that this general obligation does not apply to all other risks to the individuals life, such as an accidental overdose. It was clarified that *"the Article 2 substantive obligation is tailored to harms from which the authorities have a responsibility to protect those under its care."*[27]

This therefore demonstrates a restriction in the scope of the operational duty. In *Rabone*, the Supreme Court listed the second factor as *"an assumption of responsibility by the state for the individual's welfare and safety"*.[28] Whilst this is phrased in quite general terms, the decision in Morahan closely links the question of whether an operational duty is owed to the responsibility to protect a person from the particular type of harm.[29] If there is no link or connection between the state's control over the person and type of harm which eventuated, then the operational duty will not arise.[30] This is because it was held that it would otherwise be contrary to the underlying justification of the operational duty and would risk

19 *Ibid [para 33]*
20 *Following ex parte Jamieson [1994] 3. WLR 82*
21 *Dove [paras 78-86]*
22 *Ibid [paras 87-77]*
23 *Morahan [para 122 (5)]*
24 *R (Maguire) v HM Senior Coroner for Blackpool Fylde [2020] EWCA Civ 738*
25 *Dove v HM Assistant Coroner for Teeside & Hartlepool & Others [2021] EWHC 2511 (Admin) [para 83] and R (Morahan) v Assistant Coroner for West London [2021] EWHC 1603 (Admin) [para 65]*
26 *Rabone & Anor v Pennine Care NHS Trust [2012] UKSC 2 [para 101]*
27 *R (Morahan) v Assistant Coroner for West London [2021] EWHC 1603 (Admin) [para 73]*
28 *Ibid [para 22]*
29 *R (Morahan) v Assistant Coroner for West London [2021] EWHC 1603 (Admin) [para 67]*
30 *Ibid*

imposing a disproportionate burden on state authorities[31] (something that the ECtHR has ruled should not occur[32]).

It could be argued that this brings the law on Article 2 more in line with the duty of care principles familiar to negligence practitioners. Whilst the principles differ,[33] the issue of control being linked to the risk seems analogous to the remoteness of damage principle in negligence claims: that the damage must fall within the scope of the duty of care. For example, in the context of consent cases, it has been established that there must be a close link between the injury suffered and the duty to warn of the risk of that injury.[34] This somewhat resembles Popplewell LJ's reasoning that the existence of the operational duty must be analysed with *"reference to the type of harm which the individual is foreseeably at real and immediate risk"*[35] and that *"[i]t is not all risks to life, or even all risks to life within limited categories, which attract the duty, but only real and immediate risks to life in those categories of which the state agent is or ought to be aware."*[36]

Facts will matter

These decisions clarify the relevant principles that will apply, but facts matter too. In Dove, the contention that the DWP bears responsibility for the risk that a person in receipt of benefits may take their own life takes this case outside the factual circumstances likely to apply in clinical scenarios. In *Morahan*, Tanya's death was by accidental overdose in circumstances where there was no history to suggest a risk of this, a matter which received emphasis in the judgment.[37] It is also noted that Tanya was an informal patient. In this regard, in *Rabone* it was stated that a *"[t]he paradigm example of assumption of responsibility is where the state has detained an individual, whether in prison, in a psychiatric hospital, in an immigration detention centre or otherwise"*.[38] In view of the reasoning in *Morahan* that there must be a link shown between the state's responsibility to a person and the risk which eventuates, it may well be for a future case to consider the extent of the responsibilities of a hospital to a detained patient who has not taken their own life[39] in relation to the engagement of Article 2.

Conclusion

These two decisions form part of a series of cases in which the application of the operational duty has been restricted. They will make it more difficult to show that Article 2 in engaged than it has been previously. That being said, the threshold test remains that of an *arguable* breach, reaffirmed in *Dove* to be a *"low threshold"*.[40] It is suggested that practitioners seeking to contend that Article 2 is engaged would be well-advised to ensure that their submissions include focused consideration of the link between the state's responsibility to the individual and a foreseeable outcome which eventuated, and also pay close attention to the factual similarities and differences between their case and the authorities. Finally, it is important to keep an eye on further developments in an area of law which has seen detailed judicial consideration in recent months – there may well be more cases to come.

31 *R (Morahan) v Assistant Coroner for West London [2021] EWHC 1603 (Admin) [para 67]*
32 *Osman v UK (87/1997/871/1083) [para 116]*
33 *Ibid [para 38], Rabone & Anor v Pennine Care NHS Trust [2012] UKSC 2 [para 36 and 37]*
34 *See e.g. Correia [2017] EWCA Civ 356; Duce [2018] EWCA Civ 1307; Khan [2019] EWCA Civ 152*
35 *R (Morahan) v Assistant Coroner for West London [2021] EWHC 1603 (Admin) [para 65]*
36 *Ibid [para 48]*
37 *E.g. Morahan [paras 128-129]*
38 *Rabone [para 22]*
39 *A detained patient who has taken their own life will automatically engage Article 2: Morahan [para 122 (5)]*
40 *Dove [para 86]*

Case comment: *Dove v HM Assistant Coroner for Teeside & Hartlepool & Others* [2021] EWHC 2511 (Admin)

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This article seeks to comment on the recent High Court decision in *Dove v HM Assistant Coroner for Teeside & Hartlepool & Others [2021]* EWHC 2511 (Admin). Although the Court considered multiple grounds of appeal this comment will focus on the Court's ruling in relation to Article 2 and, in particular, as to the applicability of the positive operational duty.

The factual background

The deceased died from an overdose of prescription medication in 2017 whilst in the community. It was the family's contention that the deceased had been suffering from severe stress prior to her death and that a recent decision by the DWP to stop paying her ESA contributed to this.

HMAC held a *Jamieson* style inquest (i.e. HMAC held that the enhanced investigative duty under Article 2 (the right to life) was not engaged in the deceased's case) and concluded that the deceased died from suicide.

The family of the deceased sought, by appeal, for the Coroner to hold a fresh investigation under section 13 Coroners Act 1988.

The appellant's position on Article 2

The appellant's position was that the original inquest had been insufficient for the purposes of Article 2– i.e. that HMAC was under a duty to hold an enhanced investigation (more commonly known as a *Middleton* style inquest) due to an arguable breach of a substantive duty under Article 2.

It was submitted that there was an arguable breach in relation to certain substantive duties under Article 2: the positive operational duty; and the systems duty. It was not the appellant's contention that this was a case where the circumstances were such that Article 2 was automatically engaged.

The Court's review as to the reach of the positive operational duty:

The Court noted the leading case of *Rabone v Pennine Care NHS Trust* [2012] UKSC 2 and the dicta of Lord Dyson from that case where he set out three factors which were of guidance in determining whether the operational duty exists in any given circumstances:

i. the assumption of responsibility by the state for the individual's welfare and safety (including by the exercise of control);

ii. the vulnerability of the victim (for example, children to whom local authorities owe duties); and

iii. the nature of the risk – common risks present in everyday activities or professional obligations would not give rise to an operational duty.

The Court emphasised the key factor was the assumption of responsibility by the state. For example, the Court noted the case of *R (Maguire) v Blackpool and Fylde Senior Coroner* [2020] EWCA Civ 738, where it was held that the positive operational duty did not arise due to failures by individual personnel involved with the care of a vulnerable resident of a care home.

In the context of this case the Court observed at [56] that there was a duty to respect the rights of others and that *'any consideration of article 2 obligations in the context of social security must recognise the core demand on the Department to operate a system that takes account of the statutory rights of the very many people whose physical or mental health may raise a pressing need for benefits such as ESA.'*

The Court's ruling on Article 2

The Court dismissed this ground of appeal. The Court held that there was no assumption of responsibility. It was not supported by case law and the decision of the DWP to allocate funds, or not to do so, was based only on the eligibility criteria: it *'had nothing to do with*

article 2'. The safeguarding mentioned within the DWP's guidance for visiting applicants who had not attended a mandatory interview was merely *'practical'* guidance to decision-makers and was not sufficient to demonstrate the assumption of state responsibility for an individual's welfare.

The Court further held that the deceased's vulnerability, as someone who suffered with significant physical and mental health problems, was insufficient in this case to engage the operational duty: *'the unifying feature of the application of the operational duty is state responsibility... [and] there is no general obligation to prevent suicide in the absence of the assumption of responsibility.'*

As to the third factor, the Court considered that the nature of the risk in the deceased's case was not exceptional: the risk to her from the withdrawal of ESA *'did not arise from an inherently dangerous situation of specific threat to life such as risks posed by hazards which a person would not ordinarily assume.'*

The Court further rejected any submission that there had been an arguable breach of the systems duty. It was observed that there was a *'comprehensive framework'* for decision-making as to ESA and that the reports on previous cases were only evidence as to *'individual failings'* as to opposed to any *'systematic or structural'* issue.

In line with the Court's ruling that there was no arguable breach of any substantive duty under Article 2, the Court could not find that the enhanced investigative duty arose.

Comment

The case provides a significant example of the Court's consideration regarding the application of Article 2 in a *'non-traditional'* setting. It is pertinent that the appellant's submissions sought to rely on other inquests where it had been deemed that Article 2 was engaged in an apparently analogous situation. The most important feature, therefore, of the Court's decision is the emphasis placed on the first factor - the presence of an assumption of responsibility by the state - for the application of the positive operational duty.

Whilst the Court in *Rabone* (at [23]) noted that the ECtHR has found a breach of the operational duty in a case where there had been no assumption of responsibility by the state, it appears that the scope for such a finding is very limited.

It is perhaps also significant that this case follows the High Court decision in *R (Morahan) v HM Assistant Coroner for West London* [2021] EWHC 1603. In that case the Court refused to extend the scope of the application of cases in which the enhanced investigative duty automatically arises (i.e. where the circumstances are such that the enhanced duty will necessarily arise in every case). When taken together both cases tend to show a reluctance by the Courts to expand the scope of Article 2 from those cases which are already well recognised in law.

Nathan has a developing inquest practice and has experience in both jury and article 2 inquests.

A new compensation fund for victims of Ian Paterson

LINDA MILLBAND, NATIONAL PRACTICE LEAD FOR CLINICAL NEGLIGENCE, THOMPSONS SOLICITORS
EMMA DOUGHTY, HEAD OF MEDICAL NEGLIGENCE - LONDON, SLATER AND GORDON LAWYERS

Spire Healthcare have set up a new compensation fund for victims of Ian Paterson. Lead Solicitors, Slater and Gordon and Thompsons have been nominated to manage the fund.

In 2020, an independent inquiry found that Spire Healthcare's previous recall of Mr Paterson's patients had been insufficient and called for Spire to recall all of his patients. In December 2020, Spire wrote to at least 5,500 patients who were treated by Paterson at their centres. As a result, Spire Healthcare have set up a second compensation fund to compensate any further victims.

If you are approached by a former patient of Ian Paterson who has been recalled by Spire Healthcare and did not apply for compensation from the initial fund for the same injury, they may be eligible to claim from the second compensation fund. If your firm has been approached or instructed by any patients, please contact Emma Doughty on **Emma.Doughty@slatergordon.co.uk** or Linda Millband on **LindaMillband@Thompsons.law.co.uk** in order to register your client's claim and obtain the Application Form required to apply for compensation from the fund.

Slater Gordon Lawyers

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Forthcoming conferences and events from AvMA

For full programme and registration details, go to www.avma.org.uk/events or email conferences@avma.org.uk

AvMA Specialist Clinical Negligence Panel Meeting

1 December 2021, RSA House, London

The annual meeting for AvMA Specialist Clinical Negligence Panel members provides the opportunity to meet, network and discuss the latest key developments and issues facing clinical negligence law. This year's meeting will take place on the afternoon of Wednesday 1st December. Registration and a networking lunch will commence at 12.30, with the meeting starting at 13.30 and closing at 17.15. Booking now open! AvMA's Christmas Drinks Reception, which is also open to non-panel members, will take place immediately after the meeting. The event provides an excellent opportunity to catch up with friends, contacts and colleagues for some festive cheer! Booking now open!

Medico-Legal Issues in Diabetes

15 December 2021, 7BR Barristers Chambers, London

Many people with diabetes have multiple and complex health problems and, with this significant risk in mind, the potential delay or missed diagnosis of the patient can have serious consequences. This conference looks at the condition in detail, with top medical experts covering the GP's perspective on diabetes, endocrinology, renal complications, diabetes and the elderly, peripheral vascular complications, diabetes in obstetrics and there will also be the legal view on how to run a case arising from negligent management of diabetes. Booking now open!

Clinical Negligence: Law Practice & Procedure

27-28 January 2022, Birmingham

This is the course for those who are new to the specialist field of clinical negligence. The event is especially suitable for trainee and newly qualified solicitors, paralegals, legal executives and medico-legal advisors, and will provide the fundamental knowledge necessary to develop a career in clinical negligence. Expert speakers with a wealth of experience will cover all stages of the investigative and litigation process relating to clinical negligence claims from the claimants' perspective. Full details available soon.

32nd Annual Clinical Negligence Conference

24-25 March 2022 (Golf Day & Welcome Event 23rd March), Royal Armouries Museum, Leeds

Early bird booking now open! Join us in Leeds on 24-25 March 2022 as we finally get to welcome you to the 32nd AvMA Annual Clinical Negligence Conference (ACNC), the event for clinical negligence specialists! It will be the first ACNC since June 2019 and we can't wait to welcome you back! The very best medical and legal experts will ensure that you stay up to date with all the key issues, developments and policies in clinical negligence and medical law. The programme this year will have a focus on orthopaedics, whilst also covering many other key medico-legal topics at such an important time for clinical negligence practitioners. The full conference programme will be available in December 2021.

Networking is also a big part of the ACNC experience. On the evening of Wednesday 23rd March we will be holding the conference Welcome Event at the SkyLounge at the Doubletree by Hilton Hotel in Leeds, and the Mid-Conference Dinner will take place on the Thursday evening at the Royal Armouries Museum. We will also be holding our AvMA Charity Golf Day on 23rd March at Howley Hall Golf Club, Morley, Leeds, a short drive from the ACNC conference venue.

Look out for details on more AvMA events coming soon! For further information on our events:

www.avma.org.uk/events

e-mail conferences@avma.org.uk

AvMA Medico-Legal Webinars

For full programme and registration details, go to www.avma.org.uk/events or email conferences@avma.org.uk

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Forthcoming titles

Medical problems in pregnancy: what goes wrong?

Professor David Williams, Consultant Obstetric Physician, University College London

Recorded for the (Not) The ACNC online conference.

On-demand webinar from 10 November 2021

Live webinar: Dermatology for Lawyers

9 December 2021, 10:30-11:30am The session will cover:

- Delay in diagnosing
- Skin tumours
- Inflammatory conditions such as pyoderma gangrenosum
- Occupational dermatitis issues.
- Impact of Covid-19 in dermatology care

Dr John English,
Consultant Dermatologist,
Nottingham University
Hospitals NHS Trust

Dr English is a Consultant Dermatologist at Nottingham University Hospitals NHS Trust. He has over 40 years of experience as a dermatologist, including more than 3 decades of preparing medico-legal reports. Dr English was past Editor in Chief of the British Journal of Dermatology and Clinical and Experimental Dermatology. His main clinical interest now is teledermatology. For the past three years, Dr English has developed teledermatology in the East Midlands, with over 2500 referrals per year, of which over 50% are managed in primary care.

Recent titles added to the on-demand webinar library:

~ Breach of duty and response standards in ambulance practice

~ Anaesthesia: Medico-legal issues arising

~ Laparoscopic Surgery in Gynaecology: Medico-legal issues arising

~ Respiratory Medicine: Medico-legal issues arising

~ Injury, Pain and Anxiety

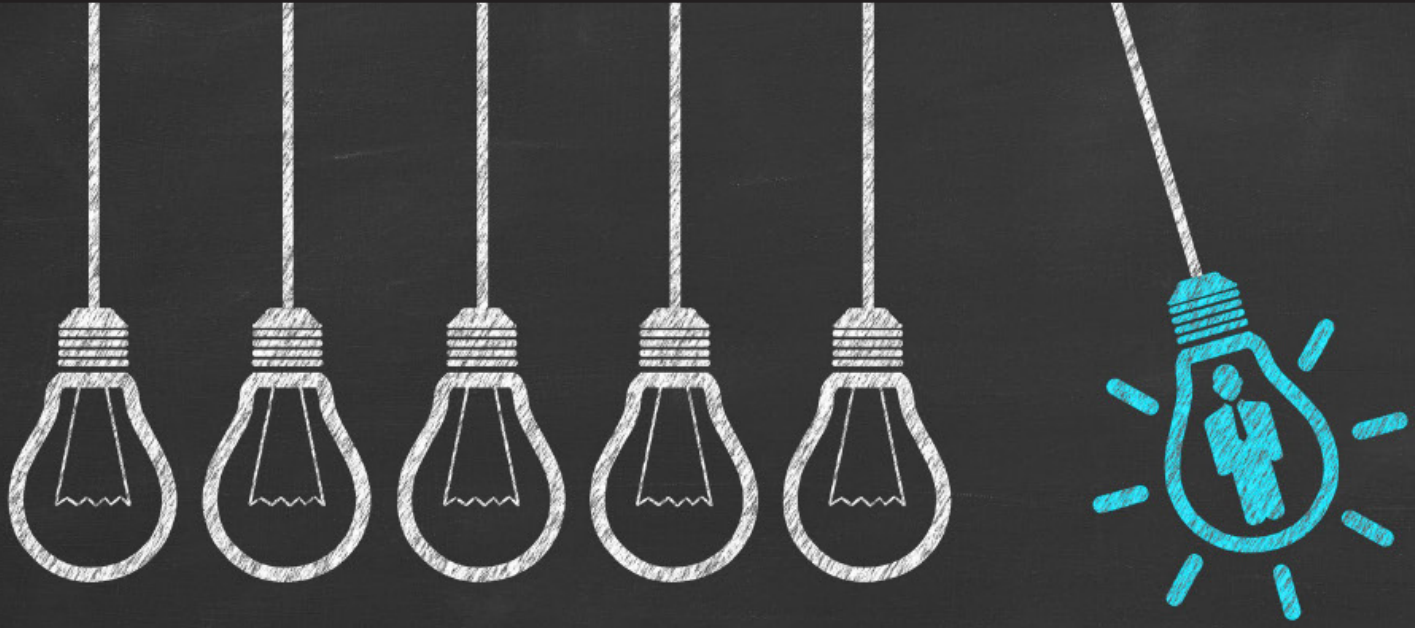
Journal of Patient Safety and Risk Management

The Journal of Patient Safety and Risk Management, published in association with AvMA, is an international journal considering patient safety and risk at all levels of the healthcare system, starting with the patient and including practitioners, managers, organisations and policy makers. It publishes peer-reviewed research papers on topics including innovative ideas and interventions, strategies and policies for improving safety in healthcare, commentaries on patient safety issues and articles on current medico-legal issues and recently settled clinical negligence cases from around the world.

AvMA members can benefit from discount of over 50% when subscribing to the Journal, with an institutional print and online subscription at £227.10 (+ VAT), and a combined individual print and online subscription at £177.22 (+ VAT).

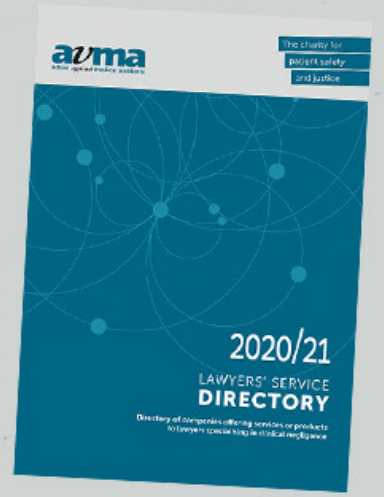
If you would like more information about the journal, or are interested in subscribing, please contact Sophie North, Publishing Editor on

sophie.north@sagepub.co.uk



THE EASIEST AND MOST RELIABLE WAY TO FIND SERVICE PROVIDERS SUPPORTING CLINICAL NEGLIGENCE SOLICITORS

The AvMA Lawyers' Service Directory provides listings of key service providers geared to the clinical negligence solicitor, including:



- Costs consultants
- Disability property specialists
- Rehabilitation consultants
- Nursing experts
- Counselling
- Mediators
- Court of Protection deputyship and personal injury trusts
- Medical records pagination, collation and review
- Investment managers

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