SERJEANTS' INN

THE AVMA LEGAL UPDATE JUNE 2016 – JUNE 2017

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WITH SPECIAL THANKS TO THE MEDICAL LAW REPORTS

HERE'S A THOUGHT:

"…I recognise that Mr. Carder has been awarded a sum which is small when compared with the costs of this litigation. That is regrettable. But litigation of this kind is often necessarily factually complex. Defendants faced with claims whose costs are likely to be out of proportion to the damages likely to be awarded after a trial should try to settle them early."[1]

[1] This is Lord Dyson, Master of the Rolls, adding a postscript to his decision (in July 2016) in *Carder v The University of Exeter* where the Court of Appeal dismissed the Defendant's appeal against the liability finding pursuant to which the 87 year old Mr. Carder had been awarded *£1,552.50*!!!!!!!!!!!!!!!

BREACH OF DUTY

IS THERE A DUTY OF CARE?

Darnley v Croydon Health Services NHS Trust [2017] EWCA Civ 151

Claim fails

CA FINDS by a majority (Jackson and Sales LLJ, McCombe LJ dissenting): no general duty owed by A&E receptionists arising out of advice about waiting times given to patients waiting to be seen.

Claimant ("C") suffered a head injury. When he attended A&E the receptionist told him that he would be seen in 4-5 hours. That was untrue. The accurate information was that because he had a head injury, he would be seen by a triage nurse within 30 minutes. He left the hospital after 19 minutes before being seen. Had he realised that he would be seen by a triage nurse within 30 minutes, he would have stayed. At home he suffered a left hemiplegia causing long-term disabilities. His injuries would have been prevented had he remained in hospital.

Although a duty of care had been imposed on the ambulance service after errors by telephone staff in *Kent v Griffiths* (No.3) ([2001] Q.B. 36), there was an important distinction between an ambulance service telephonist and an A&E receptionist. The ambulance service telephonist often passed information to paramedics or patients for them to act on. Patients waiting for ambulances needed to decide whether to stay where they were or arrange their own transport to hospital. In contrast, the function of A&E receptionists was to record the details of new arrivals, tell them where to wait and pass on details to the triage nurses. It was not their function to give any wider advice or information to patients.

McCombe LJ dissenting: The functions of a hospital could not be divided up into those of receptionists and medical staff. If the hospital had a duty not to misinform patients, the duty was not removed by interposing non-medical reception staff as a first point of contact. The failure to inform the patient of the triage system was a breach of duty by the hospital.

It is not the function of reception staff to give wider advice or information in general to patients. However, it is the duty of the hospital not to provide patients with misinformation.

> *TWEET: CA says no duty of care owed by A&E hospital receptionists. So OK for receptionists to give misleading information causing injury!?! WRONG.*

ABC v St. George's Healthcare NHS Trust and others [2017] EWCA Civ 336

C's appeal against strike out succeeds

CA FINDS (Irwin LJ decision, Gloster and Underhill LLJ agreeing): arguably fair, just and reasonable to impose on clinicians treating a patient with Huntington's disease a duty of care to disclose his diagnosis to his daughter, the Claimant, given that the condition was inherited.

In 2007 Claimant's father shot and killed her mother. He was convicted of manslaughter on the grounds of diminished responsibility and was detained in a secure hospital. In 2009 he was diagnosed with Huntington's disease. This is an inherited condition which is incurable, irreversible, progressive and fatal. It causes personality change. The child of a parent with Huntingdon's has a 50% chance of developing the same condition.

He told his brother about it but not his children; he said he did not want them to know so that they were not additionally distressed. At an MDT meeting in September 2009, the clinicians considered whether they should override his wishes. They agreed not to do so. On the same day, the Claimant told her father she was pregnant.

Informing the children of the disease was discussed again with the father in November 2009 and January 2010. He said he did not want them to know "*as he felt they might get upset, kill themselves, or have an abortion.*"

The Claimant had a daughter in April 2010. In June a social worker's assessment was that the illness may have contributed to his metal state at the time of the killing and that in the SW's view he was unable to understand the implications of his illness both on himself and his family.

In August 2010 C was accidentally informed of her father's diagnosis. On testing, the Claimant was found to have Huntingdon's. Her child has an accepted risk of 50 per cent of contracting the disease (not yet possible to diagnose either way).

The Claimant brought claims for wrongful birth claim and breach of Art 8.

She argued that since, in 2009, she had attended family therapy facilitated by the Ds, she was a "patient" and owed a direct duty of care.

Further, she argued that on *Caparo v Dickman* principles, the duty of care should be extended to those not in a doctor/patient relationship who have a vital interest in the genetic information which the clinician possesses. She relied on Guidance from the Royal College of Physicians and Pathologists and the British Society of Human Genetics and GMC Guidance in 2009 on confidentiality.

Ds agreed for strike out purposes that the foreseeability of injury and proximity limbs were met, the issue was – was it fair just and reasonable to impose a duty of care on the Ds?

Ds advanced 9 policy reasons.[2] And you need to read the decision for those – it's an easy read and only 17 pages.

This is interesting on floodgates and other factual scenarios where an extended duty of care could come into play:

> "42. The real concern is a "floodgates" argument. In written submissions to us, the Defendants submit that such problems as these may arise in a variety of medical scenarios aside from those involving genetic conditions. The examples given include a patient suffering from a sexually transmitted disease who refuses to tell his or her previous sexual partners; a patient whose vasectomy has failed but who refuses to tell his sexual partner; a patient who is suffering from a contagious disease who refuses to tell family or friends; a patient dying from a long, distressing illness and who does not wish his family to be told for fear of psychiatric harm; and a terminally ill patient who refuses to allow his pregnant partner to be told, for fear she might choose to terminate the pregnancy. Here, I recognise that there is force in the Defendants' submissions. The examples given are no more than that, and I readily accept that further problematic examples might be given. As we shall see, some of these situations (or variations upon them) have given rise to some of the few reported authorities from other jurisdictions where the extension of the duty of care has been contemplated.
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> 43. To my way of thinking there is at least one important distinction between the situation of a geneticist and all the other examples given. However problematic, and whatever the implications for "third parties", the clinician usually only has knowledge of medical facts about the existing patient. It is only in the field of genetics that the clinician acquires definite, reliable and critical medical information about a third party, often meaning that the third party should become a patient.
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> 44. Although parallel duties and difficulties of disclosure arise in other areas of clinical practice, usually to do with risks posed to others by the condition of the existing patient (see below), the clinical geneticist is in a different position. He or she often comes to know of a health problem already present, or potentially present, in the third party, and which means the third party requires advice and, in conditions other than Huntington's Disease, may require treatment, potentially life saving in its effect. One example would be diagnosis of a

[2] Nicol J, who struck the claim out on the ground there was no reasonably arguable duty of care, found all 9 of them persuasive. The CA found…none of them persuasive. If at first you don't succeed…

strong genetic disposition to breast cancer. In such circumstances the third party is not a patient, but should become a patient. Moreover, in many of the other scenarios envisaged, the practicalities of addressing the implications preclude effective remedy. Some former sexual partners may be known, but they do not constitute a closed class of individuals whose risk is defined by the genetic link to the patient, and who, for the most part, will be contactable.

Contrast:

Connor Smith v University of Leicester NHS Trust [2016] EWHC 817 (QB), McKenna J

NB – at the time of this strike out decision, the claimants in *ABC v St. George's* had been granted permission to appeal but the appeal had not yet been heard.

Claims struck out

QB FINDS: no duty of care owed by a hospital to the relatives of a patient at the hospital

D's patient, Mr. Caven, had a genetic disease, AMN, which affects the brain's white matter. Claims were brought by 2 second cousins of Mr. Caven. Both had the childhood version of AMN. One died and claims were brought by his children under the FAA.

The claimant cousins alleged that Mr. Caven should have been diagnosed earlier and that had he been diagnosed earlier, others in the family would have been offered genetic testing and their conditions would have been detected earlier. With earlier diagnosis, they said, they would have had access to different treatment and a better outcome. As to Mr. Caven's diagnosis, there had been a failure on D's part to do tests when they were initially requested.

It would not be fair just and reasonable on policy grounds to impose a duty of care on D in respect of those who were not its patients.

Following the CA decision in *ABC*, these claims would not have been struck out.

Also Be Aware of:

Section 1 of The Children Act 1989

Welfare of the child.

When a court determines any question with respect to—

(a) the upbringing of a child; or

(b) the administration of a child's property or the application of any income arising from it,

the child's welfare shall be the court's paramount consideration.

UN Convention on the Rights of the Child, Article 3.1

In all actions concerning children, whether undertaken by public or private social welfare institutions, courts of law, administrative authorities or legislative bodies, the best interests of the child shall be a primary consideration.

Watch Out For:

CN and GN v Poole Borough Council [2016] EWHC 569 (QB), Slade J – CA's DECISION RESERVED

Another *Caparo* case.

Mother and 2 children, one (CN) severely disabled, all suffer abuse and horrible behaviour from a delinquent family living on same council estate. That family had been reported to LA before Cs moved to estate. Children bringing a common law, not statutory, action alleging negligent failures to protect them from harm and rehouse them. Children alleging physical and psychiatric harm. Children's claims brought by the Official Solicitor.

Master Eastman – strikes out all 3 claims relying on *X v Bedfordshire CC* [1995] 2 AC 633 – a local authority exercising its statutory powers does not owe any additional common law duty.

Slade J – reinstates children's claims.

CA – appeal by LA against the decision to reinstate the children's claims – heard in the CA on 8 June (Davis, King, Irwin LLJ) – judgment reserved.

*Why is **CN** important for clinical negligence?*

In ***ABC***, the Ds relied on *X v Beds* and *D v East Berkshire NHS Trust* (responsibility for children in care and clinicians with care of children suspected of being abused by their parents) in support of the argument that extending the doctor's duty of care was contrary to the incremental way in which the law of negligence ought to develop.

The decision in ***CN*** may make extensions to the duty of care in medical cases easier/harder depending which way it is decided.

And Check This Out:

CICA v Y [2017] EWCA Civ 139

Application fails

CA FINDS (Leveson P, McFarlane and Henderson LLJ): a child born as a result of an incestuous rape has no claim under the CICA Scheme (2008) because the child is not a victim of a crime of violence.

The applicant, Y, was the child of M, his mother, and KM his grandfather. From the age of 11, applicant's grandfather repeatedly raped his mother. Y was born with a serious genetic disorder probably caused by the incest – there was a 50% chance of such problems in those born of incest against a 2-3% chance in the general population.

The rape crime occurred before the child was conceived and existed. Therefore, the child had not suffered a personal injury.

The child's real claim was that he should never have been born at all and a claim for wrongful existence is not one that the law recognises *McKay v Essex Area Health Authority*.

BUT THERE'S THIS:

> "That M (and mothers in her position) should receive compensation to reflect the undeniable difficulties which she has experienced and continues to experience in carrying the responsibility for caring for a disabled child born as a result of the sexual crime of violence committed against her is another matter and one that should be addressed by the Secretary of State: for my part, it is difficult to see why, as a matter of fairness, the common law approach adopted in such cases as *Parkinson v St James and Seacroft University Hospital NHS Trust* should not be incorporated into the Scheme." Sir Brian Leeson P paragraph 26.

THE BOLAM TEST

Muller v King's College Hospital NHS Foundation Trust [2017] EWHC 128 (QB)

C's claim succeeds (quantum awarded in the total sum of £16,500, of which £12,000 was PSLA)

QB FINDS (Kerr J): negligently, D's histopathologist had failed to identify malignant melanoma on review of slides.

The test of breach of duty, in a pure diagnosis case involving alleged misreporting, is *Penney v East Kent Health Authority* [1999] EWCA Civ 3005. There are 2 questions one of fact and one of interpretation: i) what was there to be seen by the reasonable clinician, ii) how should any abnormality which it has been found as a fact was there to be seen, reasonably have been interpreted?

In this case, the experts agreed that signs of melanoma were present on the slides and there to be seen. They agreed that the slides showed 3 features not consistent with a diagnosis of a benign ulcer. A normally competent pathologist would not be acting reasonably if she missed those signs.

TWEET: In a data interpretation case, go to Penney.

FB v Princess Alexandra Hospital Trust [2017] EWCA Civ 334

C's appeal succeeds

CA FINDS (Thirlwall LJ lead decision, Jackson LJ short decision, King LJ agreeing): An SHO had breached her duty of care when she failed to ask a child's parents what symptoms had precipitated their bringing the child to A&E at 4am.

C was 13 months old when she became unwell. Her mother noted that she had a high temperature and her eyes were rolling. She was taken by ambulance to hospital at 4am. The SHO diagnosed a respiratory tract infection and discharged. In fact, C had pneumococcal meningitis. She was re-admitted later the same day and administered antibiotics but sustained permanent brain damage and deafness.

Causation was conceded: it was agreed that had C been admitted by the SHO, she would have had antibiotics and not suffered any injury.

The trial judge found that the SHO had not asked C's parents why they had brought C to A&E in the early morning, but concluded that only a more senior doctor would have noticed the appellant's symptoms during the examination or asked the parents about what had prompted the emergency visit, so it had not been substandard practice for the SHO to fail to elicit that history.

The CA disagreed. History-taking is a basic skill that hospital doctors at all levels are expected to possess. In taking history in A&E, it was a basic requirement, absent special features, to elicit the reason for a child being brought in the early hours. There is no difference in the standard of care required of an A&E SHO as compared to a more senior doctor in the context of taking a patient history in A&E.

Jackson LJ emphasised that in tortious claims the defendant has to exercise the skill and care of a reasonably competent member of their profession, in the post that they were fulfilling (i.e. in this case an SHO in an A&E Department). That involves leaving out of account the particular experience of the doctor or their length of service (citing *Wilsher v Essex AHA* [1987] Q.B. 730). The position is more nuanced in contractual claims, however.

TWEET: even the most junior doctor has to be able to take a history. Simples.

THE BURDEN OF PROOF

Barnett v Medway NHS Foundation Trust [2017] EWCA Civ 235

C's appeal dismissed

CA FINDS (Irwin LJ, Hallett and Hamblen LLJ agreeing): The Judge was entitled to dismiss the claim on the basis that C had not discharged the burden of proof.

C suffered from a rare congenital condition which made him prone to stress fractures. He was admitted to hospital with acute pain, given a 7-day course of antibiotics and a few weeks later, a spinal abscess was discovered. Despite surgery, the abscess left him with paraplegia.

C alleged that if blood cultures had been taken before antibiotics were prescribed, the results would have revealed an infection so that he would have had a longer course of antibiotics, closer monitoring of the infection, earlier detection of the abscess and effective treatment.

The judge heard oral expert evidence from two microbiologists. There was considerable uncertainty in the expert evidence about the onset and progression of the infection. He held that there was no evidential basis establishing to the required standard that blood cultures would have revealed an infection, or that further antibiotics and monitoring would have prevented the paraplegia.

CA considered that this was one of the rare cases where the judge had been justified in his inability to resolve an issue of fact consistent with the approach in *Stephens v Cannon* ('*Stephens*'; [2005] EWCA Civ 222) and *Verlander v Devon Waste Management* ([2007] EWCA Civ 835). In *Stephens* the CA had elaborated on the circumstances in which a court was entitled to despatch a disputed issue of fact by resort to the burden of proof:

a. The court should always strive to make a finding of fact, and should only rely on the burden of proof in an exceptional case as a matter of last resort.

b. A court which resorted to the burden of proof had to ensure that others could discern that it had striven to make a finding in relation to the disputed issue and could understand the reasons why it had concluded that it could not do so.

c. A court was more likely to resort to the burden of proof in certain types of case (e.g. the identity of the aggressor in an unwitnessed fight). However, as a matter of logic, a decision based upon the burden of proof could arise in relation to any type of disputed fact.

In this case not only was the medicine particularly difficult, but the expert evidence had been expressed in difficult and shifting terms. Taken as a whole C's expert evidence fell short of establishing the probability of infection.

TWEET: Litigation is a battle. Claimants gotta be better to win. Tough.

DECISIONS ABOUT EXPERT EVIDENCE

EXP v Barker [2017] EWCA Civ 63

D's appeal fails (appeal on breach of duty only, causation conceded)

CA FINDS (Irwin LJ with Black and Henderson LLJ agreeing): A judge had not erred in finding that a consultant neuroradiologist had been negligent when, in 1999, he failed to identify and report a brain aneurysm on reviewing a scan.

C (a barrister in court at the time) had visual disturbance and saw an orthopaedic surgeon privately who referred her for a spine and brain MRI. The scan was reported by D (identity known because C retained the MRI packaging!) D reported it as normal. In 2011, C (now a DJ) suffered a collapse as a result of brain haemorrhage which left her very seriously injured. Shortly before trial, D conceded causation (ie if identified in 1999 the brain aneurysm would have been successfully treated). The issue at trial was breach of duty. That issue turned on the evidence of experts in neuroradiology.

It emerged in cross examination that the connection between D and his expert, Dr. Molyneux, had been "*lengthy and extensive*": Dr. M had trained D, written at least one paper with him, helped him to get foreign placements and to become a consultant and they had sat together on a committee. There was a court direction requiring experts to give information about any possible conflict of interest. Dr. M breached that.

Further, D's orthopaedic expert had written reports relying on a study which Dr. M knew had been criticised and could not properly be relied on. Dr. M failed to draw that to anyone's attention.

At the end of the case, C's counsel submitted that Dr. M's evidence should be excluded. The judge did not exclude it (partly because D's case would then be bound to fail) but he found

that he could place little weight on it. The CA said it would have been a proper decision for the judge to have excluded it.

The judge had been entitled to find that the independence and objectivity of D's expert witness were so compromised that he could place little weight on his evidence. Further, there were good reasons for doubting the expert's approach to the two breach of duty issues (was an aneurysm present and, applying the Bolam test, should it have been identified).

TWEET: experts MUST be independent. End of.

See also the GMC's Guidance (April 2013) – Acting as a Witness in Legal Proceedings

Baynham v Royal Wolverhampton Hospitals NHS Trust [2016] EWCA Civ 1249

C's appeal fails

CA FINDS (Jackson LJ deciding and Black and Gloster LJJ agreeing): the appellant had misunderstood the CA's function. Trial judges, not appeal court judges, hear evidence and appraise the quality of experts.

Cerebral palsy case. C challenged the dismissal of her claim on the basis that the trial judge had erred in his assessment of the expert evidence.

C alleged that a 30-minute delay by hospital staff in performing a Caesarean section, caused or materially contributed to her cerebral palsy, learning difficulties and epilepsy.

C lost because the Judge (Goss J) preferred D's expert evidence. C appealed saying her witnesses had been "*more consistent, authoritative, reliable and independent*" than D's ie. the result wasn't fair.

On appeal C also sought to introduce new evidence about drug taking two months after the trial by one of D's experts (Dr. Ferrie).

The CA said an appellant can argue that the judge had misunderstood expert evidence or made findings which were not open to the court on that evidence. But appraising the quality of the witnesses was within the province of the trial judge.

All of the judge's findings were open to him on the evidence.

The attempt to adduce new evidence on appeal failed. The expert's misconduct was irrelevant to his evidence and to any issue in the appeal.

TWEET: the CA deals with errors of law and procedural irregularity. It doesn't determine evidence. No change.

Watts v The Secretary of State for Health [2016] EWHC 2835 (QB)

C's claim failed

QB Judge FINDS: D's expert evidence was to be preferred – C's brachial plexus injury occurred naturally as a result of her posterior shoulder being caught. The birth was in 1993, 23 years before trial.

C's serious criticisms of D's expert (Mrs. Chaliha, Consultant O&G) were justified – she had not appreciated the importance of applying 1993 standards and based her report on one text book only (she said it was the only one she had to hand).

TWEET: C's expert was ignorant. Don't let your experts be ignorant. Bad.

Harris v Johnston [2016] EWHC 3193 (QB)

The Mr. Kirkpatrick case. Enough said. BUT – see *Thefaut v Johnston* [2017] EWHC 497 (QB) where Mr. K's evidence was accepted.

CONSENT CASES

See separate table.

INDUSTRIAL INJURIES

What Physical Injury is Required to Complete the Tort of Negligence?

Greenway v Johnson Matthey PLC [2016] EWCA Civ 408

Cs' appeals fail

Workplace exposure to platinum salts. Workers already paid enhancement and collective agreement providing some payment if job lost due to sensitisation. Testing indicated Cs were sensitised. Sensitisation symptomless but created susceptibility to developing a platinum allergy if exposure continued. D removing Cs from contact with platinum and therefore removing them from their jobs. Cs claiming loss of earnings in tort and contract. Breach of duty admitted. Issue - is sensitisation an injury?

Claims dismissed:

Negligence - No personal injury. Sensitisation, like pleural plaques in *Rothwell* [2007] UKHL 39 is not a hidden impairment (like lung scarring from pneumoconiosis in *Cartledge*) and does not itself give rise to detrimental physical effects in ordinary life. Physical injury cannot be watered down to include "*mere physiological changes which happen to have financial consequences*" (para 53).

Contract claim – no duty owed. The employer's duty was to protect from physical injury not economic harm. And the contract of employment already provided for job loss. Not fair, just and reasonable to hold D liable in contract.

Pure economic loss in tort – Cs' analogy with *Spring v Guardian Assurance* rejected. Tort could not impose a duty more extensive than the contractual duty agreed between the parties.

TWEET: Negligence requires a physical injury. No change.

How Much Injury Is Enough?

Carder v The University of Exeter [2016] EWCA Civ 790

D's appeal fails

CA FINDS (Dyson MR deciding, Gross and Clarke LLJ agreeing): a 2.3% contribution to asbestosis is enough to make a material contribution even if the extent to which that 2.3% increases the severity of the disease is small and non-measurable.

C was 87. He had been exposed to asbestos dust in 4 employments. He suffered asbestosis (fibrosis of the lungs) which is a divisible disease. 2.3% of the total exposure was caused by D's negligence.

Crucially, D admitted that 2.3% was a material contribution to the whole exposure and to C's asbestosis. And further crucially, D admitted that the increase in disease caused by the 2.3% was not de minimis.

C was awarded £1,552.50 (2.3% of full liability at £67,500).

NOTE: The 2.3% could be helpful in a provisional damages claim.

> *TWEET: in a divisible injury, being 2.3% worse off, even if the difference in condition is not measurable, is enough to complete the tort of negligence.*
>
> ***See MLR Commentary – Adrian Hopkins QC***

PSYCHIATRIC INJURY – WORKING AROUND RONAYNE

RE and Others v Calderdale and Huddersfield NHS Foundation Trust [2017] EWHC 824 (QB), Goss J

Cs' secondary victim psychiatric claims succeed

QB FINDS: claims by: i) the child, RE, for catastrophic personal injury, ii) her mother for physical and psychiatric injury (PTSD) and iii) her grandmother (present at birth) for nervous shock (PTSD) all succeeded.

There was a negligent failure by the midwife to diagnose shoulder dystocia and summon emergency assistance. RE should have been born 11 minutes earlier. Had that happened, she would have avoided all damage.

The birth was awful. RE's head was "out" for 15 minutes while her body was stuck. When the head emerged, the mother was on all fours on the floor. She was then asked to get off the floor onto the bed. The mother was worried the baby's neck would break while she did so.

RE was born at term, flat, silent and apnoeic with a white body and a purple, swollen head. RE's mother thought she was dead. RE had to be resuscitated.

Was the mother a primary victim? Yes. Negligence occurred when RE's head had crowned but her body was stuck in the birth canal. And the hypoxia started when she was still in utero. So damage to baby RE started when the she was still legally treated as being one with her mother (and before RE became a separate legal entity). So the mother was a primary victim and *Page v Smith* not *Alcock* applied.

If the primary victim finding was wrong, the mother would have been a secondary victim. There was no conditioning for what happened and no warning of a materialising risk that RE would be born lifeless. For the mother, this was a shocking, exceptional, horrifying experience judged objectively. It was not "part and parcel" of childbirth.

Was the grandmother a secondary victim? Yes. She was present throughout. She was also convinced RE was dead. The psychiatric experts agreed she had suffered PTSD. The judge found that was caused by her first-hand observation of RE's first 15 minutes of life. D argued that the event was not sufficiently horrifying to establish a claim. The judge found it was.

BUT – the judge gave no reasons. It is highly likely that Defendants will attack the decision.

Medical Records: It's an understatement to say that D's defence was not helped by D negligently (as the judge found) digitising the records and destroying the originals *after* the claim had been intimated. Inability to scrutinise the original records caused real difficulty. The judge proceeded on the rebuttable assumption that his reading of the notes should be the most favourable to the Cs and D did not disagree with that approach.

> *TWEET: Defendant destroys records. Judge not pleased. Claimants all win. Destroying records is stupid. 1/2*
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> *TWEET: The secondary victim reasoning is lacking. But the fight back against Ronayne starts here. 2/2*

Damages in Contract for Mental Distress

Shaw v Leigh Day [2017] EWHC 825 (QB), Andrews J – *See Blog*

C's appeal against strike out succeeded

QB FINDS: a client's claim against her solicitors for damages for mental distress allegedly suffered as a result of the solicitors' allegedly negligent representation at the inquest into her father's death was arguable.

Mrs. Shaw is claiming mental distress damages of £5,000.

Yearworth and 9 Others v North Bristol NHS Trust [2009] EWCA Civ 37

CA FINDS (Judge LCJ, Sir Anthony Clarke MR, Wilson LJ): men whose sperm had been banked and then negligently destroyed by D had good claims under the law of bailment for non-pecuniary benefits including damages for mental distress.

Less and Carter v Hussain [2012] EWHC 3513 (QB), HHJ Cotter QC

QB FINDS: pre-conception advice given privately by D, a consultant gynaecologist, to C1 (a woman who suffered from fibroids and a thrombo-embolic condition). The advice was given to the prospective mother, C1, face to face and then relayed by her to the prospective father, C2 (couple not married). D negligently advised it was safe to conceive when in fact there were risks of which C1 should have been warned. Relying on the negligent advice, couple conceive. The pregnancy very difficult and C1 suffered a huge amount of fibroid related pain and the baby was stillborn. The parties agreed that the cause of the stillbirth was a naturally occurring even wholly unconnected with risks of which the couple had not been warned.

Both claims failed on factual causation – judge found that Cs were desperate to have a baby and would have conceived even if given competent advice.

As to the father's claim for mental distress damages, the Court found that the contract was one for peace of mind that could give rise to such damages but that D was unaware of the father's identity and he was a third party to the contract and any claim would have failed for that additional reason.

QUANTUM

Accommodation

Manna v Central Manchester University Hospitals NHS Foundation Trust [2017] EWCA (Civ) 12

Quantum only appeal – C winning on all issues

CA FINDS (Tomlinson LJ deciding, Ryder LJ agreeing): C had catastrophic injuries as a result of negligent obstetric injury. Award of costs of an additional, suitable home for father to enable overnight stays there upheld. Decision to calculate costs using C's lifetime multiplier not father's also upheld.

Cerebral palsy case. C's parents had divorced. D challenged trial judge's award of compensation for a second adapted home so that C could visit father. Whilst considered generous, award was upheld. D had not objected to use of C's lifetime multiplier at trial and it was too late to do so on appeal.

NB: the decision predates the negative discount rate. In Manna, the *CA called Roberts v Johnstone* formula "*imperfect but pragmatic*". Now, it's not so much imperfect as useless.

> *TWEET: Important case on additional homes for separated parents of seriously injured children.*
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> ***See MLR Commentary – Katie Gollop QC***

JR v Sheffield Teaching Hospitals NHS Foundation Trust [2017] EWHC 1245 (QB), William Davies J

Liability admitted, quantum only. Obstetric injury. Very severe injuries: moderately severe spastic cerebral palsy and significant cognitive impairment. Negative discount rate decision. Capitalised value of claim over £23.5 million.

On *R v J* – the judge considered he was bound by *R v J* and awarded nil.

Lost years – see paragraphs 20 to 39.

The Judge found that though C's injuries were devastating, he was not as catastrophically injured as was the claimant in *Croke v Wiseman*: he could engage with others. Further, unlike

the claimants in *Croke* and *Iqbal*, C was a 24 year old man not a child. The supposed lack of dependants did not prevent a lost years claim arising. Lost years claim succeeded.

C granted permission to appeal the accommodation decision.

D granted permission to appeal the lost years claim decision.

Both appeals will be listed together and an expedited decision from the CA is anticipated.

> *TWEET: C gets nil for RvJ. C awarded lost years though injured when a child. C and D get leave to appeal. Watch this space.*

LAT v East Somerset NHS Trust [2016] EWHC 1610 (QB), HHJ Reddihough

Interim payment. An injured C is not expected to reside in rented accommodation pending final determination of quantum. It is reasonable to take the accommodation claim for purchase costs into consideration at an IP hearing. C does not have to give credit at the IP stage for a parent's living costs.

NB – this is a pre negative DR case.

Damages v Public Funding Cases

Harman (A child by his mother and litigation friend) v East Kent Hospitals NHS Foundation Trust [2015] EWHC 1662 (QB), Turner J

QB FINDS: C can choose whether to pursue the tortfeasor for a future loss or whether to rely upon the statutory obligations of a public body.

This is an important case not least because it neatly and clearly illustrates the application of the ratio in *Peters v East Midlands SHA* [2010] QB 48, and summarises the relevant parts of the relevant cases in this difficult and complex area of law (paragraphs 17-20).

C was a 14 year old by with severe autism and cognitive impairment seeking damages from D. He sought specialist private school fees to the age of 25 from D. His parents had had a long battle with the LEA to get funding to cover those fees.

D argued that since the funding was not a "potential" entitlement but an actual one, C could not ask the Court to order D to pay. Turner J did not agree. He found that:

- C's parents unequivocally wanted to pay for the fees out of C's damages, which *Peters* entitled them to do (paragraphs 23 and 24);
- It had been a long battle to obtain public funding for the educational establishment, which demonstrated a settled intention (paragraph 25);
- An indemnity from C's advisors was sufficient to prevent a double recovery (paragraph 26).

TWEET: Peters applies to educational fees. No change.

See MLR Commentary - Sir Robert Francis QC

Tinsley (By his litigation friend and property and affairs deputy) v Manchester City Council and South Manchester CCG (Interested Party) [2016] EWHC Admin, HHJ Stephen Davies (sitting as a HCJ)

QB FINDS: s 117 has to be provided free of charge by the State regardless of personal injury damages, even if awarded specifically for the purpose of funding future care.

C had a personality disorder following an RTA. He was a compulsorily detained mental health patient. On discharge, he spent time in a mental health nursing home funded pursuant to section 117 of the Mental Health Act 1983 which says that the state must provide after care until the patient is no longer in need. It is unlawful for the state to charge for s 117 care. He was awarded damages of £3.5m of which £2.89m was for future care.

C had been living in accommodation he paid for himself but a new deputy considered that was not financially sustainable. D's position was that C had enough money to pay for his own care and it was under no s 117 duty to provide after care.

D argued C was claiming double recovery which *Peters* did not allow.

The Judge found that s 117 after care had to be provided free of charge regardless of resources per *Crofton v NHS Litigation Authority* [2007] EWCA Civ 71. Damages should be disregarded.

Cash strapped local authorities would be frustrated if deputies made claims for full state funding which the LA could not refuse where those in need had sufficient resources from a

damages action including sums for future care. But that was a matter for Parliament (which had not changed this aspect of s 117 in the Care Act 2014). The deputy owed a duty to the person lacking capacity, not the state or the defendant in a damages action. The deputy should not be prevented from making a claim.

See MLR Commentary – Michael Horne QC

INVESTMENT - PI Trust or CoP Deputy?

Louise Ursula Watt v ABC & OS [2016] EWCOP 2532 (November 2016), Charles J

Guidance to parties and the COP on how awards of damages for personal injuries should be held and administered.

ABC was vulnerable and lacked financial capacity for 'big' financial matters but had financial capacity for day to day matters. He had suffered a brain injury which had left him with "fixed thinking" and an inability to consider or accept advice.

The risks of breakdown of his relationship with a deputy together with permanent vulnerability could make a trust preferable. A trust would recognise ABC's capacity / autonomy and might mitigate the risks of breakdown / future vulnerability. This had not been sufficiently considered, as it had been presumed that a deputy would be appointed.

Key points:

- The management regime of a substantial award should be considered as soon as possible (paragraph 92);
- In QB and COP proceedings the parties should provide reasoned comparisons between rival options to the Court (paragraph 65);
- there is no presumption that a deputy should be appointed (paragraph 69);
- a short list with general guidance is at paragraph 92. This is essential reading in analogous cases.

OH v Craven and AKB v Willerton [2016] EWHC 3146 (QB), Norris J (December 2016)

Further guidance on the procedure that the parties should follow before asking the Court to release funds from the CFO into a PI Trust.

Two cases with similar issues.

One C had financial capacity but the other did not because he was under 18 though approaching majority. Both applied for an order for the sums held by the CFO to be paid into PI Trusts to be administered by the solicitors who had acted for them in their litigation.

Norris J gave guidance on the Court's duty where its safeguarding role ended and money was to be released to a PI Trust. He expressed concern as to the potential conflict of interest presented by a firm of solicitors benefitting by their ongoing involvement in acting as trustees, balanced against the "one-stop-shop" advantage for the Claimant. The Judge was satisfied in one case, but not the other and required further steps to be taken to assure himself that the funds should be released.

By way of general guidance Norris J suggested that where the solicitors acting for the Claimant were to act as trustees in funds valued over £1M (see paragraph 31):

- a separate partner in the firm should instruct Chancery Counsel of more than 5 years' standing to advise the Claimant / litigation friend of the advantages / disadvantages of the PI Trust;
- this should be undertaken at the expense of the firm;
- the instructions and the opinion should be put in evidence when a compromise incorporating this proposal.

Where a fund was valued at over £3M (see paragraph 32):

- serious thought should be given to the appointment of a suitably qualified family member or independent professional to consider:
    - the trustee remuneration rates;
    - the engagement of any investment advisers or managers and their remuneration;
    - the exercise of any power which would deprive the beneficiary of income / capital.

FAA Claims

Rupasinghe v West Hertfordshire Hospitals NHS Trust [2016] EWHC 2848 (QB), Jay J

Intellectually brilliant Sri Lankan couple living in UK with 2 children. Father dies aged 33. Wife, C, a junior doctor looking forward to making consultant. Range of unpalatable work/childcare options. C's parents could not come to the UK and C chose to return to Sri Lanka, forgo career and earn less. Dependency claims for gratuitous care from relatives and commercial childcare, a driver and a cleaner were all settled for £335,000.

Issue for Court: Was C additionally entitled to damages for giving up her career and thus "*loss of income that has necessarily arisen in order to access that gratuitous care*"? Damages claimed at over £1.8 million.

QB FINDS: Claim failed. The comprehensive services claim had been settled and there was no room for supplementation. C had not given up work to provide care herself so her earnings were not being used as a measure of the deceased's services. Rather, C was seeking compensation for her own loss of earnings.

> *TWEET: under the FAA, dependency on deceased's services, including childcare, can be awarded but there is no claim for the survivor's loss of earnings. No change.*

Co-habitees and the Bereavement Award

Smith v Lancashire Teaching Hospitals NHS Trust [2016] EWHC 2208 (QB), Edis J

QB FINDS: cohabitees of 2+ years are not entitled to the bereavement award.

This is a detailed judgment, an interesting read and a practical example of HR law in action.

Art 8 was not directly engaged. So the claim failed.

But if Articles 8 and 14 (prohibition against discrimination) had been engaged, the Secretary of State had not established that the difference in treatment between a widow and a bereaved cohabitee of more than 2 years was justified. The law requires reform.

Of interest was the fact that the 2012 Criminal Injuries Compensation Authority Scheme does provide for "bereavement payments" to cohabitees. So, asked the judge, rhetorically: "*Why should the state's resources be expended on providing a form of compensation for victims of crime which insurers of tortfeasors are not required to provide, in these times of austerity?*" (para 32)

And for once, there are figures: the cost to the insurance industry of the extension of the bereavement award to cohabitees was £1.43m and to the NHS a little over £1m per year. The judge considered this modest and the Government's position "incoherent".

Had the claim succeeded, the remedy would have been a declaration of incompatibility. The bereavement award provisions could not be read down.

TWEET: Still no bereavement award for cohabitees. Latest ECHR based challenge fails.

Autonomy and Pregnancy, Surrogacy and IVF

Clare Watson instructed by Irwin Mitchell has just concluded a hearing in which the Claimant argues for the commercial costs of a surrogacy.

Watch Out For:

XXX v Whittington Health NHS Trust, Sir Robert Nelson sitting as a HCJ, June 2017

Decision Awaited.

Quantum only trial. Of interest is that fact that C was granted an anonymity order in view of her psychological vulnerability and the exceptionally personal nature of her injuries.

C had been irradiated and was incapable of carrying a child. Two of the questions to be decided are: Have we moved on from ***Briody*** and if so, to what extent?

Briody v St Helen's & Knowsley Area Health Authority [2001] EWCA Civ 1010

Surrogacy costs disallowed.

Negligently, C deprived of womb. At first instance, C wanted D to fund a commercial US surrogacy using her own eggs and partner's sperm. Chances of success failed: i) chances of success so tiny and ii) paid surrogacy illegal here. At CA, eggs had been retrieved and fertilised by partner's sperm. Chances of successful pregnancy and birth still only 1%. UK surrogate found. As to use of donor eggs: neither the child nor the pregnancy would be the Claimant's. Conclusion: expenditure on surrogacy is not reasonable.

Intermediate cases not requiring a decision: pregnancy not C's but child hers (surrogacy using C's eggs) and pregnancy C's but child not C's (IVF with another woman's eggs). "*My tentative view is that each of these cases is a step too far.*"

Other remarks: D should not have to pay for fertility treatment caused by the partner's poor quality sperm and thus unrelated to D's negligence. Unthinkable a J would award damages for the costs of inter-country adoption.

> *TWEET: 2001, Hale LJ, surrogacy, legality, IVF, own child/another's child all discussed.*
>
> *C loses. But old decision. Good for Cs on GDs. Things have moved on.*

NB – Baroness Hale (Hale LJ at the time) said this: "*In the case of a woman who has always wanted children, to be deprived forever of the chance of having and bringing up those children is a very serious loss of amenity quite separate from the pain and suffering caused by the injury. The level of awards for young childless women should reflect an understanding of how grave a detriment this is."* (Para 18).

CHECK – are you claiming enough for fertility injury GDs?

Wilhelmson v Dumma *2017 BCSC 616 (Can LII) – Supreme Court of British Columbia*

Through injury, C fertile but unable to carry a child (previously pregnant and could have carried to term). She should be put back in the same position. Surrogacy fees the only way to do that. Illegal to pay a surrogate in Canada, so C claimed the costs of travel to US and the costs of paying a surrogate there. D opposing on ground of illegality. Judge finding for C – no illegality in a Canadian woman paying a surrogate in the US – Canadian law did not apply outside Canada's borders. C's desire to use a surrogate was real and not speculative and damages awarded. Costs estimated at $50,000 to $100,000. Judge said an award at the low end was appropriate and awarded $100,000 for 2 pregnancies. NB – that award was in addition for non-pecuniary damages for PSLA.

> *TWEET: 2017 Canadian case. Costs of travel to US to use a surrogate awarded: illegality of paid surrogacy in Canada irrelevant since surrogacy lawful in US. C wins. $100,000 for 2 pregnancies.*

R (on the application of A and B) v Secretary of State for Health [2017] UKSC 41

This is the Northern Ireland abortion case.

Note Baroness Hale's ringing endorsement (she was in the minority but that ought not to reduce the decibels) of a woman's right to autonomy and respect for her dignity in pregnancy whatever lawful choices she makes (paragraphs 93 to 96) and the reference to *Montgomery*, *Rees v Darlington* and *Parkinson v St James and Seacroft*.

These passages should help reinforce a claim in **stillbirth cases** for a sum of money that is at least equal to the bereavement award or the *Rees* award.

UK Costs of Surrogacy

F and G v X and 5 Others [2016] EWFC 33

Family Division case. Same sex couple granted parental orders in relation to 3 children born to different surrogates over 6 months. Court authorising payments made for reasonable expenses in the sums of: £13,192.80, £12,477.61 and £15,000.

IVF

XP v Compensa Towarzystwo SA [2016] EWHC 1728 (QB), Whipple J

Factually complicated. C suffered injuries in an RTA in Poland – liability admitted. That accident caused a miscarriage. On return to the UK C was abused by her partner. She was then involved in a second RTA on the M4. Liability admitted.

Polish law governed the claim arising out of the first RTA but the principles seem similar to those applicable in England and Wales.

C said that but for the first accident, she would have had a child and she wanted a child. At the date of hearing, C was 40, fertile and there was no obstacle to her carrying a child. But she was single and not able – "*she feels depressed and she has no money*" (para 121). The Judge awarded the costs of 3 cycles of IVF in the total sum of £18,150 in the Polish case. With that treatment C was likely to conceive. The Judge said this (para 124):

> "*The claimant's loss of fertility is not absolute. Rather, her fertility is diminishing with time and age. She is now 40, and she is significantly less fertile than she was in 2011*

when she lost the baby. She will continue to lose fertility year on year. Her reducing fertility is the reason she needs IVF. Time is pressing and she cannot afford to wait for a partner, or for better circumstances of health, before trying to become pregnant naturally….Quite simply, IVF treatment is necessary to restore the position."

MISCELLANEOUS

LIMITATION

Lewin v Glaxo Operations UK Ltd [2016] EWHC 3331 (QB), Goss J

Claim not statute barred

C has arachnoiditis and is severely disabled as a result of Myodil used in a diagnostic procedure in 1973. Claim issued in 2015. Liability denied. Preliminary limitation hearing ordered.

It was for D to establish when the cause of action accrued. The damage was probably caused shortly before or in 2007. Damage was not caused prior to 1995.

On constructive knowledge D's arguments failed.

C did not have actual knowledge until 2012 and the claim was brought in time.

If wrong about that, the judge would have exercised his discretion under s. 33. Documentary evidence was preserved and the main prejudice to D was financial.

TWEET: cause of action accrues when injury is sustained, not at date of breach.

CONCURRENT TORTFEASORS

Wright v Barts Health NHS Trust [2016] EWHC 1834 (QB), Edis J

D's application to strike out failed

C sustained multiple injuries including spinal fractures falling through a skylight at work as a sub-contractor. At hospital, by the end of treatment, he was paraplegic.

He compromised his PI claim for £400,000 with £150,000 costs on the basis of an 80% reduction for contrib. He then issued proceedings against D. D applied for strike out on the ground that the settlement had extinguished C's loss.

The PI defendant and D were concurrent tortfeasors ie parties committing separate tortious acts which separate acts contributed to the same damage. (Not to be confused with joint tortfeasors ie parties jointly and severally liable for the same negligent act). The release of one did not operate as a release for all unless the settlement was clearly intended to have that effect or unless payment satisfied the whole claim.

There was no abuse of process in C settling his PI claim before bringing a separate action against D.

The £400,000 did not fully compensate C for his loss. The PI defendant was not liable for the whole of the part of C's loss for which both defendants were liable because of the con neg discount. And the PI defendant had not paid or purported to pay the whole of the loss allegedly caused by the hospital.

VIDEO SURVEILLANCE EVIDENCE

Hayden v Maidstone &Tunbridge Wells NHS Trust [2016] EWHC 1121 QB, Foskett J

Useful summary of law and practice in relation to video evidence.

DEFENDANTS RESILING FROM ADMISSIONS

Wood v 1) Days Health UK Ltd, Secretary of State for Health, Shropshire Community Health Service, Balle, Berwick Care Equipment Limited [2016] EWHC 1079 (QB), Laing J

This is a case about the world's most complicated chair.

The interesting part relates to D1's application to resile from its admission of liability.

C was paraplegic but then suffered a shoulder injury when her riser chair went wrong and threw her out of it.

The NHS defendants had supplied the chair. The NHS had ordered it from Berwick who obtained it from Days Health. The riser unit was supplied by Balle. The NHS then modified it.

C succeeded in obtaining summary judgment against the NHS defendants.

D1 sought to resile from its admission of liability. The Judge said no.

There had been no change in circumstances since the admission was made. D1 had inspected the chair before making the admission and had professional advice, it should have realised that there was a defence at that stage.

The real reason for wanting to resile was the increase in the claim's value since the admission was made: "*But that is a risk which is inherent in any personal injuries claim, and is a reason why it can sometimes be commercially advantageous to try and settle a claim at an early stage.*" (para 60)

Summary judgment against the NHS defendants was not a reason to allow D1 to resile from its admission. D1 could issue contribution proceedings if it wanted to.

Other defendants and C had relied on the admission to their detriments.

Finally, C's claim against Berwick was struck out.

Blake v Croasdale and Esure [2017] EWHC 1336 (QB) HHJ Purle QC

D permitted to resile from admission of liability.

RTA. C was a passenger in a car driven by D1 who sustained brain injury in the collision, another passenger died. D1 was convicted and imprisoned for causing death by dangerous driving. C submitted a claim via the MOJ Portal for a claim with a value of not more than £25,000.

D2, the insurer, wrote asking saying that primary liability was admitted but raised contributory negligence for not wearing a seatbelt and queried the low valuation of the claim.

Proceedings were served with a Schedule indicating a value of £3-5 million.

D2 served a Defence alleging *ex turpi causa* (at the time of the collision, C was part of a joint criminal enterprise with C1 to deal drugs).

D2's admission was binding and the Court's permission was required to withdraw it.

Permission would be granted because there was a real prospect of the *ex turpi* defence succeeding so that it should not be struck out. So far as the balance of prejudice was concerned, it was reasonable for D2 to take a pragmatic view on what was initially presented as a low value claim and then to take a different view on a claim for £3+ million. Not to grant permission would be to discourage defendants from acting proportionately.

JUDICIAL BIAS

Willmott v Rotherham NHS Foundation Trust [2017] EWCA Civ 181

C's appeal failed.

CA FINDS (Sales LJ, Jackson and McCombe LLJ agreeing): The trial judge was right not to recuse himself. No objective appearance of bias by referring to his own knee treatment and background research on the subject when finding that C's knee surgery had been non-negligent.

It was unwise for the judge to refer so extensively to his own experience of knee treatment and his background reading on the subject. But nothing the judge said or did gave an objective appearance of bias or predetermination of the matters addressed in evidence.