

Lawyers Service Newsletter

March 2018

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Editorial

It would be a mistake to think that because of the government's focus on Brexit, nothing else is happening. On the contrary, there have been developments which are likely to have a direct effect on the clinical negligence market.

Following on from this editorial, the Newsletter includes a separate section outlining some of those developments; from the DH response to fixed costs to the possibility that the coroner's jurisdiction may be extended to include investigations into late term stillbirths.

AvMA Online Mediation Questionnaire: The questionnaire is open to all clinical negligence practitioners. The questionnaire is designed to be quick and easy to complete and can be accessed by clicking on this link: <https://www.avma.org.uk/avma-questionnaires/>

Please complete your mediation questionnaire on line by **Monday 23rd April**; we would like to hear from all Lawyer Service members, particularly if you have some experience of mediation.

Montgomery v Lanarkshire Health Board [2015] continues to show the extent of its reach on the importance of a patient's right to be advised of relevant information. Chris Hough of Doughty Street Chambers article looks at the recent decisions in **Thefaut v Johnston (2017) and Hassell v Hillingdon Hospitals NHS Foundation Trust (2018)**. Both cases succeeded on the basis of consent, not on the basis of the treatment provided. Chris was counsel for the claimant in the case of Hassell and secured a significant award of damages in that case.

Richard Paige, barrister at Park Square Chambers, Leeds looks at the case of **Shaw v Kovak & Others [2017]**. Richard's article: **"Rights without recourse"** is a thought provoking contrast to Chris Hough's. Richard looks at how the Court of Appeal in Kovak found that a failure to obtain informed consent and the resulting infringement of personal autonomy, does not give rise to a claim for damages in its own right.

The introduction of Qualified One Way Costs shifting (QOCS) in 2013 has been key in protecting an unsuccessful claimant in a clinical negligence claim from exposure to liability for the defendant's costs. However, QOCS protection will be lost if the court finds the claimant was fundamentally



Lisa O'Dwyer
Director, Medico-Legal Services

dishonest. The High Court has recently looked at the meaning of “fundamental dishonesty” in the case of **London Organising Committee of the Olympic and Paralympic Games V Haydn Sinfield [2018]**. The issue was subsequently looked at again a short time later in the case of **Razumas v MoJ [2018]**. Leanne Woods of 1 Crown Office Row’s article: **“Fundamental Dishonesty – Two Cautionary Tales”** looks at the courts recent guidance on fundamental dishonesty and how this finding will affect a damages claim. Leanne also looks at the fact that the fundamental dishonesty provisions do not apply to defendant dishonesty claims!

As the law around vicarious liability and non-delegable duties has developed, so too has the interest in the effect of these developments on **“The liability of private clinics and hospitals”**. Dominic Ruck Keene practises as a barrister at 1 Crown Office Row, his article reflects his experience in these issues having been involved in representing Ian Paterson’s patients in their action against the Spire Healthcare.

There is little doubt that in recent years the case law on secondary victim claims has made it much harder, although not impossible, to argue these cases. Naomi Rees of Old Square Chambers article looks at the circumstances in which **claims for psychiatric damage** as a result of clinical negligence should be brought.

Rebecca Greenstreet of Hardwicke Chambers article on **“Wrongful conception and Wrongful Birth: A Practical Overview”** is published at a time when the case of **ARB v IVF Hammersmith and R [2017]** is awaiting appeal. In that case the court will be considering whether the restrictions on damages for maintenance costs that apply in tort will also apply to claims founded in contract.

The lack of equality in funding and representation between families and hospitals in the coroner’s court undoubtedly has an effect on the quality of the coroner’s investigation. In turn this may also create a loss of opportunity to improve the care, systems and training operating in the NHS. Jo Moore of 1 Crown Office Row instructed by Dr Ruth O’Sullivan of AvMA examines the inquest touching the death of **Baby O** which highlighted a catalogue of failings at St Mary’s Hospital on the Isle of Wight. The inquest which was originally expected to last 1 day ran to 6 days and Jo has set out the court’s essential findings in her case report.

Dr Charlotte Connor of AvMA instructed Rachel Marcus also of 1 Crown Office Row on **the inquest touching the death of James Phelan**; a father of two young children. The coroner in this case had originally expected to treat this as a paper inquest, with no hearing. In fact, due to the issues identified by Rachel and Charlotte the case ran into 8 days with at least 3 pre inquest hearings.

Rachel has written up the Phelan case for the Newsletter. During the course of the inquest weaknesses in the Manchester Triage System were identified; these are now subject to a Prevention of Future Death report. The inquest also drew attention to issues such as lack of training in triaging and that the medical notes had been tampered with.

AvMA is grateful to all members of the bar who give up their time to help us make a difference to bereaved families. By helping bereaved families we can also improve the healthcare offered to the public at large.

AvMA continues to develop its helpline to ensure we reach as wide a public audience as is possible. We are currently looking for two volunteers specifically for the purpose of calling back clients who are unable to get through on our helpline first time around. Please see the Newsletter for Gill’s item on seeking volunteers for this purpose.

All clinical negligence practitioners with **five years or less PQE** should take note. **The Rising Stars Award** is a new initiative introduced to recognise the work that junior lawyers do. It is being run by Daniel Lewis and PIC cost specialists in conjunction with AvMA – details of eligibility are contained in the advert for the Rising Stars Award. The closing date for receipt of applications is **25th MAY**.

On the subject of recognition, AvMA would like to take this opportunity to say thank you to **Russell Levy** for his tireless commitment to clinical negligence practice and his support for AvMA. As many of you will know, Russell has been a partner at Leigh Day for 26 years; a tenacious litigator who has fought, not just for his own clients but for all claimants to have the right to a level playing field, a thorough investigation when treatment has gone wrong and fair compensation.



Russell has not only been an outspoken proponent of the need for candour and swift resolution but has led the way in arguing for a reversal in the burden of proof in clinical negligence claims. As Russell heads off into the sunset to enjoy his much deserved retirement, his shout out to all clinical negligence professionals is to: **"Remain vigilant to maintaining access to justice for Claimants!"**

Best wishes

A handwritten signature in black ink, appearing to read 'L. Russell', with a long horizontal stroke extending to the right.

Volunteers wanted for our Helpline and Call Back Service

As part of our ongoing commitment to enabling the public to access justice and to delivering impartial and independent information on their rights and redress we continue to look for ways to increase our ability to reach people who need our help. One of the ways we do that is by constantly reviewing and improving the public's ability to access our helpline.

Call Back Volunteers Wanted: We are actively seeking two new helpline volunteers to deal solely with calling back clients who were not successful in getting through to an advisor during helpline hours. Training will be given and subject to experience remote working may be possible. If you are interested please contact Gill Savage by using the link below.

Helpline Volunteers Wanted: We are always looking for additional volunteers for our helpline. In particular we are looking for people who can commit to a 1 ½ - 2 hour session once a week. If you are unable to commit to a 1 ½ - 2 hour session each week but would like to help then again, please contact Gill for an informal discussion. Again, training will be given and remote working may be possible, subject to experience.

Please contact Gill in the first instance by clicking on the link below <https://www.avma.org.uk/get-involved/helpline-volunteer/>

AvMA's Outline of Recent Legal Developments

The DH response to Fixed Costs in Low Value Clinical Negligence Claims

The Department of Health (DH) published their response to the consultation on Fixed Recoverable Costs in Low Value Clinical Negligence Claims in February. That response was accompanied by a supplementary report by Professor Fenn, both documents can be found here:

<https://www.gov.uk/government/consultations/fixed-recoverable-costs-for-clinical-negligence-claims>

To be fair to the DH, they do describe their response as a "summary" and it really is no more than that. Some of the key points to note from that summary are:

- 58% of the respondents said fixed costs for low value clinical negligence claims should not be introduced on a mandatory basis. Perhaps unsurprisingly, of those who supported the move to a mandatory scheme some felt that the threshold of £25,000 was too low and that £250,000 was more appropriate.
- On the four options put forward in the consultation paper for how the rate should be set, none of them attracted overwhelming support. In fact, 44% supported an alternative to the four options, this included suggestions that the matter should be referred to a working party.
- 77% of respondents said there should not be a maximum cap of £1,200 applied to recoverable expert fees for claimant and defendant lawyers. The concerns around this included that such a move would risk reducing the pool of available experts.
- 79% said there should be no presumption of a single joint expert. The concerns expressed included the fact that parties needed to be properly and independently represented which included the opportunity for a party to speak to the expert alone.
- 66% of respondents did agree with the concept of early exchange of evidence. Support for this included the fact that such a move would promote learning and the opportunity to improve care at an early stage.
- 55% of respondents agreed that there should be exemptions from fixed costs. Some of the suggestions for exemptions include where the claimant is a person with a disability, those lacking mental capacity, cases involving stillbirths and fatal accident claims. Cases where more than two experts were required might also fall outside of a fixed costs scheme.

A particular feature of Professor Fenn's recent paper was his observation that there had been a marked increase in

the proportion of post issue settlements; up from 24% in 2012/13 to 39% in 2015/16.

The corollary to this is that the proportion of claims which had settled pre issue had fallen steadily. Fenn's conclusions were derived from a study of 6,000 settled claims valued up to £25,000 and settled over a 4 year period. Fenn said that he **"cannot speculate too much on what has caused this phenomenon"**

Civil Justice Council Working Party

As you may recall, AvMA, together with the Law Society and APIL submitted draft terms of reference for consideration by the DH and others at the end of November 2017. We are pleased that the Civil Justice Council (CJC) has announced that the working party has now convened. It is to be led by Andrew Parker of DAC Beachcroft with David Marshall of Anthony Gold as Vice-Chair although membership has yet to be confirmed.

The working party has confirmed its terms of reference, details of which can be found at: <https://www.judiciary.gov.uk/related-offices-and-bodies/advisory-bodies/cjc/clinical-negligence-fixed-costs-working-group/>

The DH summary shows an overwhelming lack of support for a cap on expert fees to the value of £1,200, and single joint experts. Despite this, the working party has been asked to look at the feasibility of both of these issues being introduced. However, AvMA is pleased to see that the CJC is to have regard to how any improved process or scheme of FRC might affect issues of patient safety, including the way in which case outcomes are reported back to healthcare providers. This is something that AvMA considers critical to the process and has been very vocal about.

The working party is expected to publish recommendations in September this year.

Stillbirths, HSIB and the Coroner's Court

The rate of stillbirth in the UK is noted to be too high with 3,122 stillbirths reported in 2016. A stillbirth is only recorded if the foetus has attained a gestational age of 24 weeks or more, where the gestational age is less than 24 weeks the loss is referred to as a mid-trimester miscarriage; there are no records for the number of mid-trimester miscarriages that occur.

Currently, coroners in England do not have the power to investigate stillbirths, the rationale for this is that if a baby dies during delivery it is not considered to have lived and the coroner does not have jurisdiction to investigate. This has been a controversial issue for many families and coroners alike, particularly where there the death may be

due to a mismanaged delivery. However, this situation may be about to change.

The Civil Partnerships, Marriages and Deaths (Registration etc) Bill had its second reading on 2nd February; the Bill proposes that the Coroners and Justice Act 2009 be amended to allow Coroners to investigate late term stillbirths. It has been suggested that a stillbirth that occurs after 36 weeks gestation would qualify as a late term stillbirth. AvMA would welcome such a change which we consider to be long overdue.

During the second reading various suggestions were made including the possibility of specialist coroners to deal with this particularly sensitive issue. AvMA would go further and say there should be specialist coroners to deal with all healthcare related deaths, not just stillbirths. Disappointingly, there is no indication that this step will be taken. During the course of the Bill's second reading, Lilian Greenwood MP (Lab) noted that ***"The role of coroners is incredibly important...there are a number of reasons why coroners are the right people to investigate such deaths...the coroner is an independent judicial office holder...the inquest will be truly independent and transparent...can address local issues at a particular hospital or unit"***. If the coroner's power is extended, it will be interesting to see how the coroner's investigative approach to stillbirths sits alongside the Healthcare Safety Investigation Branch's investigation (HSIB).

One of the hallmarks of a typical HSIB investigation is the concept of a safe space and as an extension of that, a prohibition on the disclosure of any documents obtained during the course of its investigations. Disclosure would be available with a High Court Order for disclosure. See link for more information: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/514217/HSIB_directions.pdf

However, AvMA has been assured by the DH that safe space will not apply to HSIB Maternity investigations. To AvMA's knowledge the directions have not yet been amended, however the DH have written to us and said: ***"We plan to amend the Directions to the NHS Trust Development Authority responsible for the establishment of HSIB and the change of emphasis for the maternity investigations towards providing families with relevant information and away from protecting certain information from disclosure."*** Practitioners should be clear that the DH has also stated that this move does NOT mark an acknowledgement that "safe space" is not appropriate for first level investigations such as serious incident investigations.

HSIB is expected to start its investigations into stillbirths, neonatal deaths and brain injury at birth from April 2018. They aim to conduct investigations as soon as possible after the event and draft a report within 8 weeks of the incident. It is expected that once the maternity arm of HSIB is fully established they will be conducting a 1000 investigations each year.

The qualifying criteria for an HSIB investigation are largely based on guidelines set out by the Royal College of Obstetricians and Gynaecologists (RCOG). More details of HSIB criteria can be found here: <https://www.hsib.org.uk/maternity-information/>

Rapid Resolution and Redress (RRR)

In November 2017, the DH published its response to the consultation on RRR. That response made it clear that the DH would continue to work on the final scope of the RRR scheme and that this should be available by Spring 2018. This currently remains unavailable.

One of the key RRR proposals was in relation to early investigations; 92% of people responding to the RRR consultation supported this proposal. The Response document stated that ***"Respondents agreed that the scheme should include early investigations, but these should not replace trusts' own internal investigations, which should be instigated in line with the Serious Incident (SI) framework, irrespective of RRR."***

NHSR Early Notification Scheme

It has been compulsory since April 2017 for trusts to notify the NHSR of any maternity incidents which are likely to result in serious brain injury. The notification should be made using the NHSR Early Notification Standard Report Form.

NHSR are currently working on producing a leaflet on Early Notification for families. The leaflet seeks to stress the importance of learning lessons at an early stage, as well as transparency and openness in the NHS. NHSR want families to understand that NHSR will work with the hospital involved in the incident to ensure a full investigation. It also encourages families to take an active role in the review.

A leaflet for families is an important step in reaching out to those whose baby has or may have been injured by avoidable harm. However, AvMA has not approved the information that NHSR proposes to give families although we continue to work with them to try to get this right. We will update you when the leaflet has been published.

Whether it is at the time of the first duty of candour notification, at the commencement of an invitation to

RRR, mediation or as part of the Early Notification Scheme, it is imperative that families have the opportunity to be advised of their rights. Those rights include being aware of the possibility of litigation or seeking independent legal advice from AvMA or any other similar organisation that may exist. To omit to do so is contrary to the NHS commitment to transparency and openness.

Law Reform (Personal Injuries) Act 1948

Section 2(4) of this Act entitles an injured claimant to recover private care costs instead of having to rely on state funded care. Care and loss of earnings are two heads of damage that significantly contribute to the value of the overall damages awarded in cases of serious injury.

Defendant groups have for years been trying to have this Act amended or repealed, so far without success. However, while clinical negligence costs are rightly, under the spotlight the time has again come for defendant groups to relaunch their attack on this area of law.

The issue was discussed in the House of Lords earlier this year when on 30th and 31st January Lord Sharkey asked ***“Does the Minister agree that repealing Section 2(4) would save the NHS an enormous amount of money?”*** ***Lord O’Shaughnessy replied: “It is one of the issues we are looking at as part of a cross – government strategy that will report in September...”*** He also said that reform to tort law is another area under consideration.

AvMA recognises there is no easy answer to this question. From the claimant’s point of view, why should they have to worry about whether their local authority can and will continue to commit to their future care needs.

Is it even right that a claimant who has been injured through no fault of their own and often as a result of care provided by another public body should be faced with restrictions on where they live? The fact that one local authority can and will provide more care than another local authority in a different part of the country will inevitably mean that the injured party may be restricted in their choice of where to live.

In these times of austerity barely a day goes by without some commentary on the lamentable state of local authority finances. The National Audit Office report “Financial sustainability of Local Authorities 2018” was published on 8th March – see link: <https://www.nao.org.uk/press-release/financial-sustainability-of-local-authorities-2018/>

The report says that ***“if local authorities with social care responsibilities keep using their reserves at current rates, one in ten could have exhausted them within***

three years”. That can bring little or no comfort to any injured person.

The considerations around what the local authority can afford to provide, what it is statutorily obliged to provide, what the injured party wants and the extent to which the tortfeasor should be bound to contribute are complex. Needless to say, there is unlikely to be any resolution in the immediate future but there is growing enthusiasm from insurers and defendant organisations alike to bring this debate to the fore. Claimant practitioners should be aware of this, thinking about what is in their client’s best interest and how they will respond when the time comes.

Post LASPO Review

You may recall that in Jackson LJ’s supplementary report on civil legal costs published in July 2017 he advised that the different civil justice reform programmes under consideration should be co-ordinated. This included the MoJ’s post LASPO review so the effect of withdrawing legal aid could be considered. It is worth remembering that Jackson’s proposals for cost reform were on the basis that Legal Aid be retained.

The post LASPO Review consultation opened on 8th March, the terms of reference can be found here: <https://www.gov.uk/government/consultations/fixing-recoverable-costs-for-clinical-negligence-claims>

The aim of the post implementation review is to assess the impact of the set of policies introduced by and since LASPO. The government is keen to engage with interested parties who wish to contribute to the evidence gathering exercise of the review. The findings will be published later this year probably after the summer.

Alternative Dispute Resolution

The CJC published their interim report on ADR and Civil Justice in October 2017. This coincided with the NHSR Chief Executive, Helen Vernon telling the Public Accounts Committee that they have been ***“...increasingly pushing cases towards mediation as a way of resolving claims without formal court proceedings...we have found that quite difficult to get off the ground particularly because there has been some resistance from claimant lawyers whose preference is for the more formal route”***.

In January this year, the NHSR advised AvMA that between 5th December 2016 and 30th November 2017 there had been 99 completed mediations. The NHSR have not provided details of how many of those cases involved litigants in person. However, they have advised us that they are currently undertaking an evaluation of the feedback which they would be happy to share with AvMA;

we will be meeting with them after Easter to discuss in more detail.

AvMA has concerns that Litigants in Person (LiPs) are not aware of their rights and options prior to mediation. We are calling for a commitment that LiPs will be made aware of the existence of independent advice and information and are provided with the details of AvMA and any other organisations that can give an impartial view before they agree to enter into mediation.

Further, we believe there needs to be a more level playing field for patients acting as LiPs. Parity between the parties includes having access to relevant documentation prior to as well as support during the course of the mediation process.

AvMA are also concerned about the use of confidentiality clauses at mediation. We recognise that some confidentiality is required to prevent parties discussing issues raised during the course of the mediation and prior to settlement. However, we are aware that some confidentiality clauses go further than that, they extend to "the facts and terms of settlement". It is difficult to see why these far reaching confidentiality clauses are considered necessary in mediation; litigation moved away from this approach many years ago.

It also begs the question: How can a mediation scheme be properly evaluated without an independent review of the terms of settlement being made available? AvMA has set out these and other concerns in supplementary submissions to the CJC dated 14th March: click [here](#)

Litigation can leave a claimant with more questions than answers, but does mediation fare any better in practice? What is your experience of mediation? What did your client think of it? How routinely do NHR invite you to mediate? Can the mediation process be improved for low value clinical negligence claims?

Please take the time to complete the AvMA mediation feedback questionnaire. This is an opportunity to critique and evaluate the strengths and/or weaknesses of the mediation process. **Questionnaires should be completed by Monday 23rd April.** This link should take you straight to the questionnaire, it does not take long to complete: [Mediation Questionnaire](#)

Conduct

The conduct of the litigating parties, both pre and post issue is a significant factor which can cause settlement to be delayed; delay in itself increases the cost of litigation. Delay also causes patients/claimants to suffer additional and unnecessary stress as well as the clinical staff involved in the poor care provided. Conduct is an issue

which AvMA believes should be examined more closely; the issue had been included as part of the draft terms of reference submitted to the DH back in November 2017. It is therefore disappointing that the working parties current terms of reference do not include this significant factor as one requiring further consideration.

Upon receipt of the joint draft terms of reference, the Ministry of Justice responded to us: **"there has been recent analysis of the drivers of costs as outlined in the NAO report "Managing the cost of clinical negligence in trusts"...and the PAC report"**. AvMA takes a very different view and has replied to the MoJ's letter by pointing out that the NAO report specifically says: **"the report examines how clinical negligence claims against the trust are managed but does not cover how individual clinical negligence claims are handled"**.

We have also drawn attention to the fact that the Public Accounts Committee (PAC) report of 01.12.17 notes that the NHS culture is defensive when something goes wrong and that greater insight is required into why people bring claims. PAC has observed that there needs to be clarity around why it is that the NHS is taking longer to resolve claims and what is being done to address this.

We are told that the standard of investigation offered by the NHS at this early stage is poor, in particular the standard of serious incident reporting. Professor Fenn recognises that it is taking longer to settle cases; the National Audit Office report acknowledged that it is taking the NHS an extra 126 days to settle cases and at £40/day extra cost that is adding £5,040 per case. Even Jackson LJ in his report in July 2017 said that conduct was an issue that should be investigated.

A great deal of time and money could be spent changing the process. However, unless and until you identify and address the root cause of the problem/s with the current system you will simply allow those problems to follow any new process that may be introduced; the problem or problems will perpetuate unless they are identified and tackled.

One of AvMA's frustrations with the current system is that there are already processes and procedures in place which, if enforced, would make a huge difference to patients and their families. To make those processes effective legal advice should be made available to potential claimants at the outset. With a little help and assistance, many patients/their families would be able to achieve their primary aim of finding out what happened to their or their loved one's care. It will also enable them to identify what has been done to prevent the same thing happening again.

The NHS Constitution pledges that, when mistakes happen or if a patient has been harmed whilst receiving healthcare, an appropriate explanation will be provided, and they should know that lessons will be learned. There is already an existing right to compensation where a person has been harmed by negligent treatment. Why aren't the processes working?

The internal investigation process rarely results in compensation being offered at the earliest opportunity. The complaints process could and should be considerably more effective than it is; Duty of Candour notices should advise people of what has gone wrong, both at the outset and during the course of the investigation – this is another opportunity to settle early on which is not being used to its maximum potential. Even when it comes to the Pre Action Protocol, arguably the last ditch attempt at preventing litigation, trusts or the NHSR on their behalf all too often deny liability in their letter of response only to settle later on. By letter of response stage, the NHSR are expected to have obtained their own medical expert evidence; if that is being done properly why are cases going on to settle after issue?

General

I look forward to sharing the results of the questionnaire with you in the June edition of the Newsletter, if not before. Please be assured that all individual responses to the questionnaire will be treated in confidence although we will be reporting on the overall findings identified from all completed questionnaires. As ever, if you have any questions, queries or suggestions on how to improve our Lawyer Service newsletter please let me know by emailing Norika@avma.org.uk.

Best wishes

Lisa

Thefaut v Johnston and Consent

CHRISTOPHER HOUGH
DOUGHTY STREET



Two recent High Court decisions have illuminated the practical consequences (and benefits for Claimants) following the Supreme Court decision in *Montgomery v Lanarkshire Health Board* 2015 AC 1430.

The two cases are *Thefaut v Johnston* 2017 EWHC 497 per Green J and *Hassell v Hillingdon Hospitals NHS Foundation Trust* 2018 EWHC 164 per Dingemans J.

Both were rather similar on the facts: in each case, the Claimant underwent surgery which led to significant injuries. The issues in both cases related to the information given prior to surgery, and the conduct of the actual surgery.

In both cases, the Claimants won on the informed consent issue, but lost the claims based on negligent surgery. The outcome was that they recovered substantial damages where elective surgery led to a non-negligent complication. Historically, such cases were usually not pursued as pretty much unwinnable. As these two cases show, they can now be won on behalf of Claimants (or, from the Trusts' perspectives, lost). This is a significant development which gives many other claimants a new avenue of enquiry.

In Mrs Thefaut's case, she suffered nerve damage which left her with constant pain in her back, radiating into her leg. Unfortunately, in Mrs Hassell's case, she was left tetraplegic. Her damages had been agreed (subject to liability) at £4.4 million. Happily, this sum was enhanced by the additional £75,000 and interest which follow beating a Part 36 offer.

There were a number of common questions:

- What was said?
- What should have been said?
- When should it have been said?
- What would the patient have done if they were given the correct information?

In both cases, the criticisms made in relation to the conduct of the surgery failed. The claims succeeded solely on the basis of consent.

The starting point for any consideration is *Montgomery* and, in particular, Paragraphs 87 and 90 of the speeches. As is well-known, the court reconsidered the relationship between doctor and patient, and shifted the balance in power from doctor to patient. This reflected the importance of patient autonomy. It was for the doctor to advise, and the patient to decide.

An adult person of sound mind is entitled to decide which, if any, of the available forms of treatment to undergo.... The doctor is therefore under a duty to take reasonable care to ensure that the patient is aware of any material risks involved in any recommended treatment, and of any reasonable alternative or variant treatments. The test of materiality is whether in the circumstances of the particular case, a reasonable person in the patient's position would be likely to attach significance to the risk or the doctor is or should reasonably be aware that the particular patient would be likely to attach significance to it

In *Thefaut* it was held:

- a) There needs to be adequate time and space for there to be a reasonable dialogue and time to consider. This was not satisfied by a short telephone conversation lasting some 4-5 minutes.
- b) It is not appropriate to give new information to the patient on the morning of surgery.
- c) Communication must be in comprehensible English: the doctor should not bombard the patient with complicated technical information.
- d) The doctor underestimated the risks of surgery, and over estimated the benefits.

In *Hassell*, it was conceded that the risk of paralysis had to be discussed. The statistical risk was put variously at between 1-500 and 1-10,000. The judge, Dingemans J, in a conspicuously clear judgment, referred to a risk of between 1-500 and 1-1000. This might have distinguished the statistical risk from the earlier decision by the same

judge in *A v East Kent University Hospitals Trust* 2015 EWHC 1038 that a risk of 1-1000 was not material.

Both cases strongly criticise providing information on the day of surgery. In *Thefaut*, the judge accepted the argument that Mrs Thefaut needed "adequate time and space". Mr Justice Green dismissed her signing the consent form.

.. the simple fact that Mrs Thefaut signed the hospital consent form is not taken as an indication of acceptance of risk. In my view the document is of no real significance on the present facts (it would have greater significance in emergency cases involving no prior contact between patient and clinician (para 77))

In *Hassell*, Mrs H was asked to sign a consent form just as she was taken into surgery. The consent form warned of the risk of cord injury (which the experts agreed was sufficient warning of the risk of paralysis) but the experts also agreed that, if this information was given first a few moments before surgery, it did not allow the patient an opportunity to reflect.

Pausing there, it is remarkable that both Claimants recovered damages where the damage was caused non-negligently, and the damage was caused by a risk which was referred to as one of the risks of the procedure and recorded on the consent form the patient had signed as accepting.

Turning to the substance of *Hassell*, the issues were very much factual. In considering what was said, the judge heard evidence from Mrs Hassell and the surgeon, Mr Ridgeway. The case really turned on what was said at a meeting on the 28th June 2011, although much time was spent reviewing Mrs Hassell's past medical history and her willingness to undergo surgical procedures in the past (explicitly arguing that she would have undergone surgery whatever was said).

The only contemporaneous record was a letter, dated 1st July but agreed to have been dictated at the time of the consultation. This letter failed to refer to the risk of paralysis.

The judge held that there was no warning of the risk of spinal cord injury and no advice given of alternative treatments. In preferring the evidence of Mrs Hassell, the judge referred to several aspects of the evidence:

- There was no discussion about the option of conservative treatment. In fact, Mrs Hassell had not had physiotherapy for her neck. That Mr Ridgeway thought she had indicated no discussion had taken place (Mrs Hassell would have corrected the mistake).
- Mr Ridgeway was not a very good communicator.

- He failed to refer to the risks of DVT and PE in his oral evidence.
- He failed to correct the failure of his contemporaneous letter to mention the risk of paralysis.
- His operation note was ambivalent and short.
- He failed to correct an obvious mistake in the Trust's Chief Executive's response to a letter of complaint.
- Mrs Hassell was an excellent witness who remembers discussing the risk of a hoarse voice (which would have affected her ability to work as head of year in a local school).
- In a letter dated April 2012, Mr Ridgeway said that the risks of the relevant surgery were similar to earlier lower back surgery. In fact, that earlier surgery did not carry with it a risk of paralysis.
- There was an inconsistency between his oral evidence and his WS in whether Mrs Hassell was offered steroid injections as an alternative to surgery.
- Mr Ridgeway's website did not refer to a risk of paralysis.
- The contemporaneous letter recording the result of the meeting on the 28th June 2011 did not refer to the risk of spinal cord injury or the risk of paralysis.

The judge accepted that, if Mrs Hassell had been told of the risk of paralysis, she would not have had the surgery (C5/6 decompression and disc replacement) on the 3rd October 2011. She would have tried conservative treatment (which she had had before). It was not open to the Trust to argue that Mrs Hassell would have ended up with surgery at another time, and might have suffered the same non negligent risk. In line with the *Chester v Afshar* principles, she established liability.

It might be thought that this is a case peculiar to these facts and is not of wider significance. The important points we feel should be made are:

Informed consent cannot be given on the day of surgery (subject of course to medical emergency). There needs to be a full discussion giving the patient adequate time and space to consider the options and advice. There are many cases of elective, non-emergency surgery where consent has been obtained hours, or even minutes, before theatre. *Montgomery* is retrospective in effect, and all practitioners should review the consent process. As a general observation, the NHS has tended not to offer multiple appointments before surgery, and this will require a change in management to allow a full discussion at a date which gives the patient the opportunity to reflect.

Hospitals would be well-advised to put more information in writing. And to avoid the mistake made by Mr Ridgway of ensuring that anything in writing includes a full list of the material risks.

Both Mrs Thefaut and Hassell succeeded, in part, because the surgeon had not offered "reasonable alternative treatments". When Montgomery was first decided, this seemed to be the area where the law had changed. Cases such as *A v East Kent*, and *Tasmin v Barts* suggested otherwise. Time may show that these cases were against the general tide allowing recovery.

As counsel in the Hassell case, there were a number of arguments which we were disappointed not to have won on:

A) The evidence from the experts was that the benefits of surgery were surprisingly small. Mr Jackowski (who advised the Trust) told the court that at 2 years 85% of those who had surgery were better, but exactly the same percentage were better with no surgery, and not even physiotherapy. All treatment did, whether surgical or non-surgical, was to accelerate the improvement. The judge remarked at the time - its not a great advertisement for either surgery or non-surgical treatment. None of this was explained to Mrs Hassell. In *Montgomery*, at para 90 the SC held.

the doctor's advisory role involves dialogue, the aim of which is to ensure that the patient understands the seriousness of her condition and the anticipated benefits and risks of the proposed treatment and any reasonable alternatives, so that she is then in a position to make an informed decision.

We argued that this "marginal benefit" of a short term acceleration should have been explained to Mrs Hassell. This was not accepted by the judge, and the statistical comparison not referred to in the judgment.

B) In *Thefaut*, Mr Justice Green considered the situation where the surgeon had warned of the risk of nerve damage, but had failed to refer to the risk in the letter. The court decided that the letter prevailed as the "official advice". At paragraph 72 Mr Justice Green said:

... oral advice had been given about the prospects of recovery .. the option of having no surgery was in this case was highly material .. however Mrs Thefaut was aware of this from oral conversations ... this was a critical part of the context to the advice and its omission [from the letter] risked confusing the patient into thinking that because it has not been mentioned as part of the formal advice, when everything else has been mentioned, it was of no real significance and/or has been overtaken and superseded by the formal written advice.

In *Hassell*, it was agreed that the letter written on the 1st July did not refer to the risk of paralysis. We argued that the omission of the risk of paralysis in the formal written advice was the end of the matter. It did not matter whether the fault was Mr Ridgway in not mentioning the risk of paralysis, or the fault of the secretarial team in not typing the latter correctly. The Trust were liable for both doctor and secretary. This argument was lost because the court held that the letter was not sent to Mrs Hassell (an argument which emerged at quite a late stage during trial).

C) The consent form referred to cord injury. It was the view of the experts that this was a reasonable description of the risks. But, in his evidence, Mr Jackowski agreed that, following *Montgomery*, the doctor has to give a much fuller explanation of what this means - making it clear that this could be paralysis from the neck down with some description of the functional consequences. Given that it was agreed not to be relevant if this was the first time that there was any reference to the risk of cord injury and paralysis (which was the judge's finding), any observation would have been obiter, but we had the impression that the judge thought that there should have been a fuller explanation.

D) The risk of paralysis was between 1-500 and 1-10,000. The Supreme Court said that risks should not be reduced to a matter of percentages, but in *A v East Kent* Mr Justice Dingemans held that a risk of 1-1000 was not material. This was followed by Jay J in *Tasmin v Barts Health*. The case of *Hassell* was an opportunity to accept that a risk of paralysis was so serious that even a risk of 1-1000 was material.

E) Finally, we were very disappointed to lose the argument about surgery. Mrs Hassell was under a general anaesthetic and completely at the mercy of the surgeon. She could not say what happened. We knew that she suffered spinal cord injury at exactly the same level of surgery, at exactly the time of the surgery. We argued that this could not be a coincidence. There is a line of CA authority that requires the Hospital to explain why. The judge accepted the (impressive) expert evidence that many cases can be of unknown cause.

These arguments live to fight another day. Mrs Hassell has recovered a life-changing sum of money which she would probably have lost had *Montgomery* not been decided. The reader can be assured that she does not care that some of the arguments were lost. She was a wonderful client and witness and those representing her wish her and her family the greatest happiness in spending this money as wisely or as frivolously as she feels fit.

Rights without recourse

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In the case of *Shaw v Kovac & others* [2017] EWCA Civ 1028 the Court of Appeal considered the question of whether a claimant could recover damages for “infringement of the [claimant’s] right of autonomy” as a free-standing head of loss, when they had been treated in the absence of informed consent.

Facts

The Claimant was the executor of the estate of Mr Ewan. Mr Ewan died at the age of 86 immediately following an operation for a trans-aortic valve implant. Mr Ewan did not regain consciousness between the operation and his death. The surgeon and Trust both admitted that Mr Ewan had not been properly informed of the risks of what was an experimental procedure and that had he been properly informed he would not have undergone the operation. The Claimant alleged that Mr Ewan would have survived for a further 5 years without the operation.

First instance

Before HHJ Platts at first instance the Claimant was awarded damages including interest of £15,591.83, of which £5,500 was made up of general damages for pain, suffering and loss of amenity. The general damages award was a reflection of (a) preparatory investigations (including an angiogram); (b) preparations for and the operation itself and its aftermath; and (c) the anxiety caused by the impending operation, none of which Mr Ewan would have suffered had he not consented to the operation.

The Claimant’s Schedule of Loss included a claim for “damages for loss of life of William Ewan without having given informed consent”. This head of loss was disallowed as being a claim for loss of expectation of life, and thus fell foul of s.1 of the Administration of Justice Act 1982. However, in closing submissions before the trial judge it was argued that the failure to obtain informed consent created a right to damages independent of any other loss being claimed or proved, i.e. was a freestanding claim, which was neither a claim for personal injury nor for loss of expectation of life. The judge refused to make such an

award and on appeal it was argued that the judge “should have acceded to the claimant’s arguments and should have made an additional award of damages to reflect the wrongful invasion of Mr Ewan’s personal autonomy”.

Appeal

The appeal was rejected. The leading judgment was given by Davis LJ who considered and dismissed the following arguments advanced on behalf of the Claimant:

a. The wrongful invasion of Mr Ewan’s personal autonomy represented a distinct cause of action from any claim in negligence. Such an argument ran contrary to previous authorities that, in the absence of fraud or bad faith, claims based upon a lack of informed consent were actionable in negligence;

b. Recent authorities, and especially *Chester v Afsar* [2004] UKHL 41 and *Montgomery v Lanarkshire Health Board* [2015] UKSC 11 either created or lent support for the proposition that a claimant was entitled to a freestanding award for infringement of the right to personal autonomy. These cases did not expressly provide for such an award and were distinguished on the basis that *Chester* concerned causation, which was conceded in the present case and *Montgomery* concerned the legal test to be applied when considering informed consent, which was also conceded in the present case;

c. The Claimant should be entitled to a “conventional award” in much the same way as a conventional award was made in *Rees v Darlington Memorial Hospital NHS Trust* [2003] UKHL 52, which was not designed to be compensatory, but a recognition of a right which had been infringed. Again, *Rees* was distinguished from the present case with Davis LJ suggesting that the award in *Rees* had been compensatory (despite Lord Bingham having expressly stated that it was not).

Davis LJ also questioned whether the Claimant was seeking a vindictory award and held that if she were such an award would be prohibited by *R (Lumba) v Secretary of State for the Home Department* [2011] UKSC 12.

Davis LJ raised concerns about the manner in which a freestanding award for infringement of personal autonomy might be quantified and the potential opening of the floodgates should such an award be made.

Wrong case?

Shaw raises a very important question about an individual's rights to personal autonomy, the extent of those rights and how the Courts can and should protect those rights. It is perhaps therefore a shame that it was this particular case that found its way to the Court of Appeal to consider these issues. There is an undertone running through the judgment that the Claimant's case was ill-prepared and the arguments advanced on her behalf were not properly thought out:

- a. The Claimant had pleaded her loss on the basis of loss of expectation of life, which clearly was irrecoverable. It was observed that at first instance Claimant's Counsel "had sought to put the claimed loss rather differently from that outlined in the pleaded case and Schedule of Loss."
- b. Davis LJ specifically commented that he found "the arguments advanced on behalf of the appellant to be somewhat unfocused" and that "they shifted during the course of argument";
- c. The initial argument that the invasion of personal autonomy created a freestanding cause of action was fatally flawed because "such a cause of action has never been pleaded";
- d. In relation to the quantification of such a claim it was observed that Claimant's Counsel "could identify no principled approach which the courts assessing damages might then adopt";
- e. When arguing for a conventional rather than compensatory award it was again noted that "Such an approach had not been put forward in the Grounds of Appeal or written argument".

In contrast, of the Defendant's Counsel it was said "as Mr Hutton pointed out in the course of his excellent submissions."

Criticisms

Davis LJ stated that "A claim in negligence of this kind requires proof of damage as a necessary part of the cause of action: it is not one of those torts which is actionable per se." He observed that damage had been proven by the Claimant and an award of damages had been made as a result.

However, the award made was to compensate the Claimant for the losses that she had suffered flowing from

the infringement of Mr Ewan's personal autonomy. She did not receive damages for the infringement of the personal autonomy. The amount of damages awarded would have been exactly the same had informed consent been obtained but the operation then performed negligently (with the same ultimate outcome), i.e. the infringement of the right (to personal autonomy) did not in itself sound in damages.

The recent cases of *Chester* and *Montgomery* have established beyond any doubt that patients have the right to make informed choices and that if consent is not informed then that right to personal autonomy is infringed. Indeed, Davis LJ stated that "the very existence of such rights... has always been the foundation of and rationale for the existence of a duty of care on doctors to provide proper information."

In *Chester* Lord Hope had stated "The function of the law is to enable rights to be vindicated and to provide remedies when duties have been breached. Unless this is done the duty is a hollow one, stripped of all practical force and devoid of all content. It will have lost its ability to protect the patient and thus to fulfil the only purpose which brought it into existence." It is suggested that the judgment in *Shaw* fails to follow this principle, and this is most clearly illustrated when Davis LJ noted that "if the claim to an additional award is well-founded it must be the case that an award would also in principle be recoverable, in the context of lack of informed consent, even if the operation performed on a patient was a complete success" and "damages would be payable... even if it were established that the patient still would have consented if he had been given the proper information. It is, however, impossible, in my opinion, to see the justification for such an outcome."

Although these latter points were raised as arguments against such an award, I would suggest that they in fact demonstrate the failings in the judgment. A patient's right to make an informed choice and their right to personal autonomy are not dependent upon the ultimate outcome. Those rights are infringed as soon as the procedure for which consent is required is performed. Whether the risks associated with that procedure (of which the patient has not been informed) materialise is immaterial to the infringement of those rights. Similarly, whether or not the patient would have consented is immaterial.

Of course, if the risks do not materialise or the patient would have consented in any event, then no damage can be said to have flowed from the breach of duty, but it still remains the case that those rights have been infringed and, if the judgment of Lord Hope in *Chester* is to be

applied then a remedy should be provided. If this means that the law should recognise a new cause of action then the law should do this.

Nor, in my opinion, is the argument about the difficulties of quantifying the claim any grounds for refusing such an award. Many awards made by the Courts are arbitrary; indeed all personal injury awards for pain, suffering and loss of amenity are arbitrary. Whilst the awards do increase with the severity of the injury in truth, the loss of an arm, for example, does not have a monetary value. Even clearer is the statutory bereavement award. Often ridiculed for its paltry amount, the same sum is arbitrarily awarded for the death of a much loved mother with multiple dependants as is awarded for the death of universally loathed loner with one dependant. It seems perverse that in the latter case the single dependant will receive a higher sum than the many dependants in the former case. The Courts have even illustrated a willingness to allow such novel awards for arbitrary sums in appropriate cases, as occurred in *Rees*.

It is unfortunate that such an important issue was presented to the Court of Appeal in the manner in which it was. Counsel for both parties accepted that no cases could be identified in which a distinct award was made for infringement of personal autonomy. However, in the case of *Gulati v MGN Ltd [2015] EWHC 1482 (Ch)* (which was a phone hacking case) Mann J ruled that "While the law is used to awarding damages for injured feelings, there is no reason in principle, in my view, why it should not also make an award to reflect infringements of the right itself, if the situation warrants it. The fact that the loss is not scientifically calculable is no more a bar to recovering damages for "loss of personal autonomy" or damage to standing than it is to a damages for distress. If one has lost "the right to control the dissemination of information about one's private life" then I fail to see why that, of itself, should not attract a degree of compensation, in an appropriate case". This was itself derived from the decision in *Campbell v MGN Ltd [2004] 2 AC 457* in which Lords Nicholls stated that "Instead of the cause of action being based upon the duty of good faith applicable to confidential personal information and trade secrets alike, it focuses upon the protection of human autonomy and dignity - the right to control the dissemination of information about one's private life and the right to the esteem and respect of other people." For my part, I can see no reason why, in the context of personal autonomy, the right to control the dissemination of information should be considered any differently to the right to make informed choices. If anything, the right to determine what happens to your own bodies is a right more worthy of

protection than the right to determine what happens to information about your own bodies.

Furthermore, no reference was made by either Counsel to any reported cases in jurisdictions other than our own, which commonly occurs when no local case law of applicability can be identified.

Public policy

Towards the end of his judgment Davis LJ did state that even if the Court of Appeal could make such an award "I can see strong reasons of policy for not doing so." Undoubtedly, in limited classes of cases the Courts will refuse to make awards which would ordinarily be made, on grounds of public policy. Wrongful birth cases is one such example. Davis LJ noted of *Rees* (one such wrongful birth case) that "As Mr Hutton pointed out, the claimant – as in *McFarlane* – was in effect being deprived on policy grounds of damages to which otherwise, on a conventional "but for" approach, she might well have been entitled."

Undoubtedly, there are strong public policy grounds for denying a patient damages for the infringement of their rights to personal autonomy without proof of actual damage. Reference was made in the judgment to "claims farming" and it can easily be envisaged that patients that have undergone successful procedures could be encouraged to put forward spurious claims on the basis that they were not properly informed of all the material risks. However, if that is to be the case, then the Courts should recognise that patients do have such a right which, if infringed, would have entitled them to damages, but for policy reasons.

Footnote

As a final footnote, Davis LJ did leave open the door, albeit only a crack, to such a claim succeeding in the future (provided it was properly formulated), when he stated that "if, in any particular case, an individual's suffering is increased by his or her knowing that his or her "personal autonomy" has been invaded through want of informed consent... then that can itself be reflected in the award of general damages." It will be interesting to see in the future whether mere "suffering" will be sufficient or whether the conventional requirement of a physical injury or recognisable psychiatric disorder will be a prerequisite. However, given that most medical procedures do involve some form of physical intervention (such as cutting with a scalpel) could this be argued to be a physical injury upon which an individual's suffering could then be pinned?

Richard Paige specialises in clinical negligence and acts on behalf of Claimants and Defendants. He has a particular interest in issues relating to consent to treatment.

Fundamental Dishonesty - Two Cautionary Tales

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All claimant practitioners know that the overwhelming majority of clinical negligence claimants are honest and straightforward. They have suffered avoidable, often life changing injuries and each element of their claim is properly considered and properly evidenced. But there will be rare occasions when a claimant's honesty in pursuing all or part of a claim is questioned. In *London Organising Committee of the Olympic and Paralympic Games v Haydn Sinfield* [2018] EWHC 51 (QB) the High Court recently gave guidance on (1) the meaning of "fundamental dishonesty" under s57 of the Criminal Justice and Courts Act 2015 (the '2015 Act') and (2) how such a finding should affect a damages claim. This is an important case because it will apply to clinical negligence claims and it clarifies the circumstances in which a dishonest part will taint the whole and lead to the whole claim being dismissed. *Sinfield* has been quickly followed by a (obiter) High Court decision in a clinical negligence case, *Razumas v Ministry of Justice* [2018] EWHC 215 QB.

Background to 'Fundamental Dishonesty' Provisions

Before April 2015, if a defendant suspected that part of a personal injury claim was fraudulent, then the remedy was a strike out application for abuse of process. However, it was difficult for a defendant to succeed on such an application. The Supreme Court in *Summers v Fairclough Homes* [2012] 1 WLR 2004 held that, although a Court had the power to strike out a dishonestly exaggerated claim as an abuse of process, this was only to be exercised in exceptional circumstances.

However, s57 of the 2015 Act has provided defendants (and defendants only) with the means of having a personal injury claim dismissed on the basis of 'fundamental dishonesty'. s57 operates as follows:

- a. A claimant brings a claim for damages in respect of personal injury;
- b. The court finds that the claimant is entitled to damages;

c. The defendant applies to have the claim dismissed under s57 of the 2015 Act because of fundamental dishonesty;

d. The court is satisfied on the balance of probabilities that the claimant has been fundamentally dishonest in relation to the primary claim or a related claim;

e. The court must then dismiss the primary claim unless it is satisfied that this would cause the claimant substantial injustice;

f. The duty to dismiss the primary claim includes dismissing elements of the claim in respect of which the claimant has not been dishonest.

The QOCS provisions have made the concept of fundamental dishonesty familiar to all clinical negligence lawyers. *Sinfield* will no doubt find itself being applied in QOCS cases.

Facts of Sinfield

Mr Sinfield had been a volunteer, a 'Games-maker', at the London 2012 Olympics. He fell and sustained a fairly nasty wrist fracture with some long term functional consequences. Liability was admitted.

The whole issue in this case arose from Mr Sinfield's two acre garden. He served a Preliminary Schedule, signed by him, claiming nearly £14,000 for past and future commercial gardening costs. This was framed on the basis that, before the injury, he and his wife did the gardening but, after the injury, they had to employ a gardener. £14,000 amounted to 42% of the special damages claim and 28% of the total damages claim. The Preliminary Schedule was followed by a signed list of documents. This included invoices from named gardeners. The Claimant also served a signed witness statement in which he said "[p]re-accident [my wife] and I did all the gardening...[My wife] still does some of the garden but it is impossible for her to do it alone and so we now employ a gardener."

However, Mr Sinfield had 'massaged' the truth. He did have a gardener tend the two acres but that had been going on since 2005 and so had not changed since the

accident. It turned out he had prepared the invoices himself. The Defendant prepared an amended defence alleging fundamental dishonesty. The Claimant served a supplementary witness statement saying he had worded his first statement badly and accepting he had gardening help before his accident. He also admitted preparing the invoices himself but claimed this was a legitimate 'self-billing' practice. At first instance the judge (perhaps charitably) found that:

a. The Claimant had been "*muddled, confused and careless*" but not dishonest in his Preliminary Schedule.

b. However, the false invoices and parts of his witness statement were dishonest. They had been motivated by attempts to conceal the muddle he had created.

c. His dishonesty was fundamental to the gardening claim but "*did not contaminate the entire claim*".

d. Accordingly, the Claimant had not been fundamentally dishonest but the judge went on to find that, even if he was wrong about that, it would be substantially unjust for the entire claim to be dismissed.

The Defendant appealed. In the High Court it was successful on all grounds.

The High Court's Decision

The High Court gave useful general guidance on the meaning of fundamental dishonesty and how to approach s57 of the 2015 Act, before applying this to the facts.

According to Knowles J:

a. A claimant should be found to be fundamentally dishonest within s57:

- i. If the defendant proves on the balance of probabilities that the claimant has acted dishonestly in relation to the primary or related claim; and
- ii. Has thus substantially affected the presentation of the case, either on liability or quantum, in a way which potentially adversely affects the defendant in a significant way. The formulation "*substantially affects*" is intended to convey the same idea as going to the root or to the heart of the claim.

b. Whether the effect is significant or not will be judged in the context of the particular facts and circumstances of the litigation. The judge gave the (extreme) example of a dishonest claim for £9000 out of a claim worth £10,000. That would significantly affect the defendant's interests even if the defendant was a multi-billion pound insurer.

c. If the judge is satisfied the claimant has been fundamentally dishonest then the claim must be dismissed, including those elements of the claim that the claimant has not been dishonest about.

d. The only exception is if the judge is satisfied the claimant would suffer substantial injustice if the claim was dismissed. This must mean more than the mere fact the claimant will lose his damages for the untainted heads of loss.

There was no doubt where Knowles J stood on the facts. First, he found that the Preliminary Schedule had been dishonest rather than "*muddled, confused and careless*". Thus, this was a successful appeal to the trial judge's findings of fact. Secondly, he overturned the trial judge's finding that the Claimant had been fundamentally dishonest in relation to the gardening claim but not the whole claim. The gardening claim was the largest head of loss in the Schedule and had been evidenced by a dishonest witness statement and false invoices. Both were premeditated and maintained over many months. Thirdly, there was no basis to find it would be substantially unjust to dismiss the entire claim. That the Claimant would lose his damages on the other heads of loss was not enough.

Razumas – Dishonesty Going to Breach of Duty

It seems s57 fundamental dishonesty cases are like buses – two have come along at once. In *Razumas* the High Court again made a finding of fundamental dishonesty. The Claimant was a prisoner suing the MOJ for negligent medical treatment in prison. He alleged a negligent failure to diagnose cancer resulting in an above knee amputation. The Court found that he had lied about having surgery while out of prison and on the run. He had sought to base one of the breach of duty allegations on this false factual assertion.

Because the Claimant's clinical negligence claim was dismissed the Court's decision was obiter - s57 only applies where the Claimant has an entitlement to damages. Nevertheless it is worth noting for two reasons. First, because Cockerill J approved the approach in *Sinfield*. In particular she agreed that something more than the Claimant 'just' losing his damages is required to amount to a substantial injustice. Secondly, the fundamental dishonesty in *Razumas* went only to a single allegation of breach of duty. But, the Court found that this allegation would have been one route for the Claimant to succeed entirely on his claim. Accordingly, the Claimant was found to be dishonest in relation to the primary claim.

Dishonesty of Defendants

The fundamental dishonesty provisions of the 2015 Act only apply to claimants (which includes claimants in counter-claims). They have no application when a defendant is dishonest. Of course, in some cases, a defendant's dishonesty will lead to the claim being successful. But if that does not happen then a claimant will have to turn to a patchwork of more general CPR provisions or, in extreme cases, to contempt of court or even criminal proceedings. A defence might be struck out for abuse of process but, as stated above, that will only happen in exceptional circumstances. Costs-related orders are more common, *for example*:

- CPR r44.4(3): the usual rules for assessing costs include considering the conduct of the parties;
- CPR r36.17(3): where the claimant has made a Part 36 offer that the defendant fails to beat at trial, the claimant will be able to rely on any dishonesty by the defendant to argue for a significantly enhanced interest rate on the damages and for interest on costs. In *OMV Petrom SA v Glencore International AG* [2017] EWCA 195 the Court of Appeal ordered the Defendant to pay interest on the Claimant's costs at 10% above the base rate. This included a non-compensatory element reflecting the Defendant's conduct in pursuing a dishonest and unreasonable defence in the face of a reasonable settlement offer.

Clearly, the impact of these provisions will usually pale into insignificance for defendants in clinical negligence claims, not least because the defendant is usually an NHS Trust or a practitioner backed by a medical defence organisation. From a claimant perspective there seems to be an asymmetry in the impact of the Court's treatment of serious dishonesty.

A Cautionary Tale

This piece started by saying that the overwhelming majority of clinical negligence claimants are honest. But, for the small number who contemplate exaggeration or dishonesty in relation to even one head of loss or one breach of duty allegation, Sinfield and Razumas are cautionary tales. Claimant solicitors can also expect defendants to seek out and pursue s57 arguments with increased vigour. Of course, the facts of every case will need to be considered, but claimants will need to know that dishonesty in relation to one part of the claim may well taint the whole. If a claim is dismissed entirely then the consequences may be extreme and themselves life-changing.

The liability of private clinics and hospitals

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Due to the settlement of the claims late last year brought by private patients against Spire Healthcare for negligent treatment given by Ian Paterson, the issue of the circumstances in which private healthcare providers may be liable to patients treated by clinicians operating under their aegis has still yet to be considered by the courts. The two potential routes to ground a tortious duty is vicarious liability through there being a relationship akin to employment between provider and doctor, or that they had a direct non delegable duty to ensure the safety of their patients.

As a brief reminder of the relevant case law: -

In order to find vicarious liability on the grounds of a relationship akin to employment, the test summarised in *Various Claimants v Barclays Bank PLC* [2017] EWHC 1929 (QB) are that (1); the defendant is more likely to have the means to compensate the victim than the tortfeasor and can be expected to have insured against that liability; (2) the tort will have been committed as a result of activity being taken by the employee on behalf of the employer; (3) the employee's activity is likely to be part in reality of the business activity of the employer; (4) the employer, by employing the employee to carry on the activity will have created the risk of the tort committed by the employee; and (5) the employee will, to a greater or lesser degree, have been under the control of the employer. In essence, the court will focus on the practical realities of the relationship between the employer and person claimed to be akin to being an employee. Once there is a relationship akin to employment, then there is a separate question as to whether the allegedly tortious act was sufficiently connected to that relationship to ground liability.

The test for a non delegable duty as summarised in *Woodland v Swimming Teachers Association and others* [2014] A.C. 537 is that: (1) The claimant is a patient or a child, or for some other reason is especially vulnerable or dependent on the protection of the defendant against the risk of injury; (2) there is an antecedent relationship between the claimant and the defendant, independent of the negligent act or omission itself, (i) which places

the claimant in the actual custody, charge or care of the defendant, and (ii) from which it is possible to impute to the defendant the assumption of a positive duty to protect the claimant from harm, and not just a duty to refrain from conduct which will foreseeably damage the claimant; (3) the claimant has no control over how the defendant chooses to perform those obligations, ie whether personally or through employees or through third parties; (4) the defendant has delegated to a third party some function which is an integral part of the positive duty which he has assumed towards the claimant; and the third party is exercising, for the purpose of the function thus delegated to him, the defendant's custody or care of the claimant and the element of control that goes with it; and (5) the third party has been negligent not in some collateral respect but in the performance of the very function assumed by the defendant and delegated by the defendant to him.

With regards to the liability of private hospitals and clinics, whether vicarious liability is found to exist in a particular case for the negligence of a particular clinician is a fact specific question, likely to depend on the extent to which the following factors in particular were held to apply:-

- Policy considerations, e.g. that there should be no distinction between private and public healthcare when ensuring that someone is liable for negligent care to patients and can compensate someone injured by the tort, e.g. if doctor's insurance is absent or insufficient.
- The relevant risks to patients are likely to be seen to be those inherent in the nature of the clinic or hospital's business.
- Whether the doctor in question is seen as 'integrated' into the clinic due to the central importance and role of doctors within clinics.
- Whether and how the clinic or hospital enables patients to be treated by the private doctor, provides them with the opportunity and potentially facilities, including the assistance of employees of the clinic, to

perform negligent treatment and hence place the doctor in a special position with respect to the patient.

- The contractual and commercial relationship between the clinic or hospital and the doctor, in particular: whether there was joint marketing/ joint business development discussions and activity; whether the clinic or hospital's profit was directly related/proportional to what work the doctor did or whether a doctor in effect only paid 'rent' to the clinic regardless of whether any patients were treated or not. A doctor may be seen as effectively entrepreneurs, with e.g. their own profit and loss separate from that of the clinics, even if the clinic or hospital's profit and loss is necessarily (in) directly related to the business activities of the doctors. This relationship is critical to the question of the degree to which the private doctor's activities are part of, and in accordance with the purpose of the clinic's business, and should therefore be liable for damage caused by such activities.

- The extent of any practical independence of the private doctor's working arrangements from control by the clinic or hospital. E.g. whether a clinic or hospital could give instructions to the doctor regarding quantity and/or quality of work, or who they should treat; and whether patients were assigned by the clinic or hospital to the particular doctor, or they have a degree of choice in decisions over their care generally and specifically who treats them. This factor is connected to whether the private doctor is seen as 'integrated' into the organisational structure of clinic's enterprise.

- The degree of oversight of a particular private doctor's practice by the clinic or hospital. This includes e.g. any role in selecting and training the doctor; any granting and renewal of practising privileges; any assessment of the doctor's qualifications and experience to perform particular procedures; and any appraisals and monitoring of the untoward incidents and the individual doctor's performance. This includes consideration as to whether the hospital or clinic would have any ability to take action to prevent future negligence; e.g. if negligence on the part of the doctor came to its attention whether the clinic could suspend the doctor from working at the clinic.

- Whether the clinic would be classed as a private hospital under the legislative and statutory framework applying to private hospitals, e.g. The National Minimum Standards and Regulations for Independent Healthcare, February 2002. This overlaps again with the extent to which there is a non delegable duty of care.

If a relationship akin to employment is found between a clinic and a doctor, it is highly likely that the doctor treating a patient in the clinic would be seen to performing

activities that were directly connected to the relationship between the doctor and the clinic.

With regard to non delegable duty, it should be noted that there has been a number of obiter judicial comments as to the lack of a difference between private and public hospitals with regards to the existence of such a duty, for example Dyson LJ in *Farraj* and another v *King's Healthcare NHS Trust* and another [2009] EWCA Civ 1203 at [88]. Dyson LJ stated that " I shall assume that a hospital generally owes a non-delegable duty to its patients to ensure that they are treated with skill and care regardless of the employment status of the person who is treating them... the rationale for this is that the hospital undertakes the care, supervision and control of its patients who are in special need of care. Patients are a vulnerable class of persons who place themselves in the care and under the control of a hospital and, as a result, the hospital assumes a particular responsibility for their well-being and safety.

The factors likely to be taken into consideration in a particular case are: -

- That patients requiring medical treatment are inherently vulnerable and dependent to some degree on clinic to protect them against risk or injury.

- The relationship between patients and the clinic or hospital pre-exists and is independent of negligence of the doctor, which places the patient in the care of the clinic.

- The alleged negligence is likely to be seen to be related to the performance of the core function of a clinic or hospital to care for patients.

- The legislative and regulatory schemes suggest that clinics and hospitals have a non delegable duty

- The degree of control over doctors and who it is exercised by. Potentially there is a difference between clinic which only provides consulting rooms to doctors vs. one that provides operating facilities and/or assisting medical staff: i.e. the degree to which the patient is in the care/ charge of the clinic or in reality only that of the doctor. The critical question may well be whether the clinic or hospital is only be seen to be liable for arranging for the provision of care, rather than for its actual performance.

Lizanne Gumbel QC, Robert Kellar and Dominic Ruck Keene from 1 Crown Office Row represented Ian Paterson's patients in their actions against Spire Healthcare.

Psychiatric damage in clinical negligence claims

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Bringing a secondary victim claim can seem an uphill struggle; that is very purposely so because of the control mechanisms set down in *White v Chief Constable of South Yorkshire*, and later *Alcock v Chief Constable of South Yorkshire* [1992] 1 A.C. 310 which still serve as the starting point and lay down criteria for assessing such claims. However, it is the particular circumstances of secondary victim claims which arise from clinical negligence actions that, at first blush, can seem almost impossible to pursue. By looking at the established principles and analysing the relevant case law, this article seeks to determine what circumstances are likely to be sufficient for those who suffer psychiatric damage as a result of clinical negligence to another to bring a claim and just how high the bar is set in the test for recovery of damages.

The test arising from *Alcock* has four parts:

1. The Claimant must have a close tie of love and affection with the victim
2. Must be close in time and space, "the immediate aftermath" criteria
3. There must be a direct perception of harm to the primary victim rather than hearing about it at a later time and,
4. It must be a sudden and shocking event (this is an objective standard by reference to persons of ordinary susceptibility).
5. Must suffer a frank psychiatric illness as opposed to grief, sorrow or deprivation which can be considered as ordinary and inevitable incidents of life.

Each of the strands of the test could well form the subject of its own article, but for the purposes of this it is assumed that the first and last strands of the test are the least contentious.

The difficulty in secondary victim claims arising from clinical negligence is that most cases would necessarily arise from events that happen in hospital and hospitals are places where a visitor is "to a certain degree conditioned as to what to expect"; the starting point is therefore that

when we enter with or to visit a loved one, we do so on the basis that there is an expectation that things we encounter may well be shocking and distressing. The fourth criterion of the test is therefore set against this background.

In North Glamorgan NHS Trust v Walters [2002] EWCA Civ 1792 the concept of what could be considered a horrifying event and its immediate aftermath was discussed. In that matter there was a failure to diagnose a child as suffering with acute hepatitis. Action was brought by the child's Mother for the psychiatric injuries that she sustained in the 36 hours between the child suffering a fit and his death. The real question on appeal was whether the 36 hour period was one which could be properly characterised as a single horrifying event which could be considered sudden, or whether this was a gradual series of events over that period. This case was made all the more complex because throughout the 36 hour period after the Mother had awoken to find her son fitting, she was then negligently given assurances about his condition and hope that when he was moved from South Wales to Kings College Hospital that he could be given a transplant, only to discover on arrival he was acutely unwell, and ultimately could not be saved.

Rather than consider each episode throughout the period in turn, Ward LJ found that there was an "inexorable progression" and that the event was a tale with "an obvious beginning and an equally obvious end". He found that after the assault on the Mother's nervous system had begun, she "reeled under successive blows, as each was delivered". In that way the horrifying event, taken as a whole, was founded¹.

In *Shorter v Surrey and Sussex Healthcare NHS Trust* no such horrifying event was found to have arisen over a two-day period of time where the Claimant had learned about the initial events giving rise to negligence relating to her sister over the telephone. Later, when she saw her

¹ Referenced and followed in the unreported case of *Farnworth v Wrightington Wigan and Leigh NHS Foundation Trust*, Manchester County Court 21 December 2016.

sister on the hospital trolley, she was not in a condition which could be described as horrifying, on an objective basis, and was then kept up to date with deterioration over the telephone until she later came back to the hospital to find her sister on life support. That was found not to be shocking, but to be a realisation and not a single horrifying event, but was determined as a series of events over a period of time.

The circumstances from where a secondary victim may arise in the clinical negligence setting will be limited in any event; in hospitals one of the most likely places to witness a horrifying event would, of course, be in theatre, where the patient is likely to be unaccompanied (except by medical staff, who are unlikely to satisfy the close tie test). Furthermore, as the case law has determined, it is much more difficult to ever establish liability as a secondary victim for clinical negligence cases where the effects of the acts or omissions may manifest possibly years after the initial negligence. This is very different from, for example, a road traffic accident where the events play out right in front of the secondary victim.

An obvious, and therefore relatively more common situation where such circumstances may exist arising out of clinical negligence is during and in the aftermath of birth, given the likelihood of the presence of loved ones supporting the birth.

The case of *Wild v Southend University Hospital NHS Foundation Trust* [2014] EWHC 4053 shows though the limitations even in such cases. Here a Father was denied recovery in a case where his baby was stillborn. It was found that although he experienced growing and acute anxiety when a heartbeat could not be found, which developed to a realisation that the baby had died and indeed the necessity for a stillbirth the next day, that was not enough to equate to actually witnessing horrific events leading to a death or serious injury and Walters was therefore distinguished.

The Mother in this case was a primary victim (given that the negligence occurred when Mother and Baby were still one) and recovered. There were calls in submissions that this decision could lead to a gender bias, meaning that it would be almost impossible for Fathers in stillborn cases to recover, but Michael Kent QC, sitting as a Judge of the High Court, did not consider that was any ground for extending or modifying the control mechanisms in nervous shock cases.

A similar result was found in *Wells v University Hospitals NHS FT* [2015] EWHC 2376 where, even though liability for the clinical negligence was not established the court nevertheless went on to determine whether the claims

for psychiatric injury on behalf of the Mother and Father would have succeeded. Again, the Mother recovered as a primary victim, but the Father did not succeed. In that matter the baby was born by emergency C-section in circumstances where it was alleged that decision should have been taken sooner. Following resuscitation efforts the baby died. The Court found that those circumstances did not amount to a shocking event. It is not clear from the transcript of this matter whether the Father saw the baby after delivery. The baby was noted to be blue and with poor muscle tone and no respiratory effort and therefore it may be the case that seeing the newborn would have had an impact on the decision in this case.

The result in *RE (A Child) v Calderdale and Huddersfield NHS Foundation Trust* [2017] EWHC 824 does appear, at first glance, to be less restrictive than Wells. In that matter the baby suffered acute profound hypoxic ischaemic insult prior and following delivery. The baby had become stuck in the birth canal during delivery. Given that the Court found that the negligence had occurred when the baby's head had crowned, but body was in the birth canal, the Court considered that the Mother recovered as a primary victim, but nevertheless went on to consider whether, if that were incorrect, she may recover as a secondary victim.

There was very real evidence in that case, referred to in the judgment, that both the Mother and the Grandmother (who had been present for the entirety of the birth and also made a claim as a secondary victim) had very direct visual appreciation of the baby immediately after birth. They described the baby as being completely white and lifeless with a swollen, bruised and purple head.

Goss J determined that there was no conditioning for what came and no warning of the materializing risk that the baby would be born lifeless and require resuscitation – it was an outwardly shocking event that could not be described as “part and parcel” of childbirth.

Whilst one can only surmise that perhaps in the aftermath of the delivery in Wells that the baby may have been taken out of sight of the Father and therefore that he may not have encountered the assault on his senses in the immediate aftermath of the baby's birth, if he did, it would be difficult not to draw a direct comparison between the cases. Furthermore, there does not appear to be any conditioning regarding the Father's appreciation of what he was about to encounter, as present in many of the “gradual realisation” decisions - the decision in Wells therefore does appear a particularly harsh application of law to the facts of that case.

There is no real shift change brought about by RE (A Child) – on any view, the events were shocking and horrifying to witness and the plethora of cases which do not succeed (Wells included) only continue to impress upon us the high hurdles of really shocking circumstances that must be present to succeed.

Consideration can be given to events in other healthcare settings, where perhaps there is less of an expectation of witnessing difficult events, for example, at a GP Surgery, or during a home GP consultation, though the temporal connection may be a further bar to recovery. In the unreported case of *Tanner v Sacker* HHJ Buckingham sitting at the Great Grimsby County Court considered the case of a GP failure to refer a child patient which it was asserted led to his sister, also a child, suffering psychiatric injury. The relevant event was determined as the GP appointment, which was unremarkable and the consequences of the negligence, which were deterioration in the condition, including his sister having accompanied him on the ambulance journey to hospital, could not be considered part of that event because they lacked proximity in time and space.

Paramedic cases are unlikely to succeed where the events themselves may already be or arise from traumatic events.

For cases in the clinical negligence setting potential claims will not succeed in cases where there is either conditioning or counseling as to a patient's condition or gradual deterioration (without more) and it appears that the case law soundly establishes that to control cases in this sphere, there has to be level of expectation that people in hospital will be very unwell and will outwardly exhibit such signs and symptoms that are unlikely, except in the most grave and exceptional of cases, to give rise to events so shocking that a secondary victim can succeed. Lord Ackner's definition in *Alcock* that requires a "horrifying event, which violently agitates the mind" appears to be as sound and as steadfast today as ever.

Wrongful conception and wrongful birth: a practical overview

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At a time where there is increased media interest and judicial attention surrounding wrongful conception and wrongful birth claims it is important for practitioners to be aware about, and up to date on, these types of claim¹.

Running the Claims

An introduction to the claims

At the outset it is essential to understand the differences between the three different types of claim which exist in this area of law:

- **Wrongful life:** This type of claim is brought by a child who is alleging that but for the defendant's negligence they would never have been born and that that would have been a better outcome. English law does not currently recognise this type of case as a viable claim, per *McKay v Essex Area Health Authority and Another*².
- **Wrongful conception:** This is a claim brought where the negligence has resulted in a conception which the claimant had sought to avoid and normally arises out of a negligent sterilisation (whether it is a failed sterilisation operation or the incorrect provision of information regarding that operation).
- **Wrongful birth:** Such cases are different to wrongful conception cases as here the claimant did not seek to avoid conception itself but instead the negligence has caused them to lose the opportunity to terminate a pregnancy (for example through negligent pre-natal screening). Interestingly such claims will often have the exact same factual matrix as wrongful life claims, despite the fact that, as above, English law does not currently recognise wrongful life claims as having a viable cause of action.

Limitation

Of great importance in all claims is awareness of the limitation period. A claim for damages arising out of wrongful conception or wrongful birth amounts to damages in respect of personal injury for the purposes of the *Limitation Act 1980*. As such, one limitation period will apply across all of the heads of damage (including any claim for maintenance costs, i.e. the costs of rearing a child, which do not amount to a separate claim for pure economic loss but arise out of the same cause of action as the other heads of loss).³

Identifying the parties

It is also crucial to ensure that all possible parties to an action are identified at an early stage. There are often more claimants than simply the individual who was provided with the negligent treatment and there can be more than one defendant involved in the provision of treatment or advice.⁴

In cases where the father is the one who was sterilised or provided with advice, the mother's claim will usually be straightforward, as she has herself suffered a physical injury as well as a financial loss. However, there are still restrictions on when mothers are able to bring a claim, usually in circumstances where they only became a partner of the father sometime after the negligence occurred. This issue was addressed in *Goodwill v British Pregnancy Advisory Service*.⁵ In *Goodwill* a claim, brought by a mother who had become pregnant following the spontaneous reversal of a vasectomy which had been undertaken by her partner c.3 years earlier, was struck out on appeal as an abuse of process. The claimant was found to be "merely ... a member of an indeterminately large class of females who might have sexual relations" with the father during his lifetime and as such the defendant could not be held to have voluntarily assumed responsibility towards the claimant, nor was the

¹ Further practical guidance on these claims can be found in my recent book entitled 'A Practical Guide to Wrongful Conception, Wrongful Birth and Wrongful Life Claims' available at <http://www.lawbriefpublishing.com/wrongfulbirthclaims/>

² [1982] Q.B. 1166

³ Per *Walkin v South Manchester Health Authority* [1995] 1 WLR 1543.

⁴ See for example *Farraj v (1) Kings Healthcare NHS Trust and (2) Cytogenic DNA Services* [2006] EWHC 1228.

⁵ [1996] 1 WLR 1397.

defendant in a sufficient or special relationship with her so as to give rise to a duty of care.⁶

Where the mother is the one who was sterilised or provided with advice then the father's position is also less clear cut. He will need to establish a relationship of proximity to be able to bring a claim; as the loss he has suffered is purely financial such loss must have been within the contemplation of the defendant at the time the negligence occurred. It is also worth noting that the right of a father to bring a stand-alone cause of action (i.e. not in conjunction with the mother) is not certain, following *Whitehead v Searle* (where it was suggested that whether or not there was such right had yet to be finally determined by the courts).⁷

It is therefore important to examine the proximity of the relationship between all potential defendants and all potential claimants, whether the mother or the father, in these claims.

Establishing the existence of a duty of care

As with any clinical negligence action evidence will need to be collated, whether factual or expert, to establish the necessary elements of a negligence claim; this includes identifying the existence of a duty of care (some examples include sterilisation operations, fertility treatment, pre-natal testing and genetic counselling).

There may also be a contractual cause of action, where for example the treatment is carried out in the private sector. Usually there will be an implied duty in a contract to exercise reasonable care and skill, which mirrors the duty which would be owed under tort, unless the contractual terms themselves impose a higher standard of care. *Thake v Maurice*⁸ and the recent case of *ARB V IVF Hammersmith and R*⁹ provide examples of claims brought in contract.

There is also the possibility of bringing a product liability based wrongful conception claim following the failure of contraceptive methods, see for example *Richardson v LRC*.¹⁰

Establishing a breach of duty and causation

When considering whether there has been a breach of duty regard should be had in applicable cases to the changes brought about by *Montgomery v Lanarkshire Health Board*.¹¹ *A v East Kent Hospitals University NHS*

*Foundation Trust*¹² is an example of a post-*Montgomery* wrongful birth case in which the court found that there had been no breach of duty. The claimant alleged that the defendant had been negligent in failing to warn her of the risk that her child would have chromosomal abnormalities: the court held that such a risk was no more than a background one.¹³ It was held that *Montgomery* was not "authority for the proposition that medical practitioners need to warn about risks which are theoretical and not material."¹⁴

Finally, causation needs to be established on the evidence. For wrongful birth cases this will usually turn on the evidence of the mother as to her intention to undergo a termination were she to have been provided with adequate information.¹⁵ *A v East Kent Hospitals University NHS Foundation Trust* also provides an example of a case which failed on causation, as it was held that even if the claimant had been aware of the risks and undergone investigations she still would not have elected to undergo a termination.

In wrongful conception cases it is important to establish exactly when the claimant's knowledge of the failed sterilisation arose. It will obviously amount to a break in the chain in causation if the claimant knew of the fact of a failure (or the risk of one) and nevertheless continued to engage in unprotected sexual intercourse. *Sabri-Tabrizi v Lothian Health Board* is a case which failed on causation in such circumstances.¹⁶

Quantum

For wrongful conception and wrongful birth claims the recoverability of damages has proven controversial in English law. The progression of the three key authorities was as follows:

- *McFarlane v Tayside Health Board*: The claimants decided they did not want any more children and so the husband underwent a vasectomy. Unfortunately following negligent advice as to the success of the operation the couple became parents to a healthy child. The House of Lords held that, although damages for the pain and suffering of pregnancy and childbirth could be awarded, the costs of rearing the child were irrecoverable.
- *Parkinson v St James and Seacroft NHS Trust*: This case presented a factual variation to *McFarlane*, where a child had been conceived and born due to negligent

6 *Ibid* at 1404 – 1405.

7 [2008] EWCA Civ 285.

8 [1986] QB 644.

9 [2017] EWHC 2438.

10 [2000] PIQR 164.

11 [2015] UKSC 12.

12 [2015] EWHC 1038 (QB).

13 *Ibid* at [1].

14 *Ibid* at [90].

15 This might make a stand-alone claim brought by the father more difficult if he is not able to lead evidence from the mother directly.

16 1998 S.C. 373.

sterilisation but was not healthy as in *McFarlane* and instead was born with disabilities (such disabilities were not connected to the negligence). The Court of Appeal reiterated that the costs of rearing a healthy child must fail but here allowed recovery of the extra costs associated with rearing a child with disabilities.

- *Rees v Darlington NHS Trust*: The House of Lords was once again presented with a factual variation on the preceding cases, where here the claimant was a disabled woman who had elected to have a sterilisation operation because of the difficulties her disability would cause her in raising children. The sterilisation was performed negligently and resulted in the birth of a healthy child. The House of Lords determined that Rees was more in line with *McFarlane* than *Parkinson* and so the costs of rearing the child were irrecoverable, though a lump sum 'conventional award' of £15,000 was permitted to reflect the legal wrong suffered by the claimant.

The recent case of *ARB v IVF Hammersmith and R* held that the same restrictions on damages for maintenance costs that have been established in tort also apply to claims in contract, although that decision is awaiting appeal.

Notwithstanding the restrictions on damages there are still a number of recoverable heads of loss. A claim for damages in such cases will typically include:

- Any losses directly related to the pregnancy and childbirth:
 - ♦ General damages to reflect the pain, suffering and loss of amenity (PSLA) caused by an unwanted pregnancy and childbirth, which can include psychiatric injury. The usual principles governing the assessment of PSLA will apply here, though there are very few reported damages awards on which to rely: awards appear to range from £5,000 - £40,000 depending on the particular facts.
 - ♦ Financial losses caused by the pregnancy and childbirth directly, such as maternity clothes, loss of earnings of the mother (where these are due to time off to recover etc. and not due to time off to look after the child) and medical expenses including treatment, equipment and medicines.
- The conventional award of £15,000.

All of the losses claimed will need to be properly evidenced, by both witness evidence and documentary evidence where possible.

For those cases where the child is born with a disability there will also need to be a careful calculation of the

additional maintenance costs which arise as a result of the disability, over and above those maintenance costs which would be incurred in the event that a healthy child had been born. A damages claim for these extra maintenance costs is often large (amounting to sums in the millions) and can be expected to include losses incurred in the care and treatment of the disabled child, including equipment and accommodation needs.

The recent case of *Meadows v Khan*¹⁷ even suggests that such a claim can include not only the specific disability which the parents sought to avoid (and which the negligence relates to) but also any other disability which occurs as a natural consequence of the birth.

Procedure

Wrongful conception and wrongful birth claims include unique features which may demand additional procedural steps to be taken during the course of a claim. These include:

- Anonymity orders: Given the necessary legal arguments and terminology used towards the child who is the subject of these cases an application for an anonymity order ought to be considered. Although it will generally not be a persuasive argument that such an order is required to ensure that the parents and child do not receive different medical treatment because of the existence of the claim, there may be other factors relating to the impact on the child which warrant the making of an anonymity order.¹⁸
- Periodical payment orders: Particularly in cases concerning severely disabled children with long term care needs periodical payment orders should be considered. It is however unclear whether a claim for wrongful birth or wrongful conception falls within the scope of the *Damages Act 1996* so as to enable a periodical payment order (PPO) to be made by a court in respect of any damages claimed for the extra maintenance costs associated with a child's disability.¹⁹ As above the approach of the Court of Appeal when addressing limitation issues was to categorise the whole of the damages claim, including maintenance costs, as a personal injury claim. If that approach was taken in relation to PPOs then an order would be possible, subject to usual considerations, but this is an issue on which there has not been a final determination. It is however open to

¹⁷ [2017] EWHC 2990 (QB).

¹⁸ See for example *ARB v IVF Hammersmith and R* [2017] EWHC 2338 (QB) and *A v East Kent Hospitals University NHS Foundation Trust* [2015] EWHC 1038 (QB).

¹⁹ See discussion of this issue in two applications in *FP v Taunton and Somerset NHS Trust* [2009] EWHC 1965 at [6] and [2011] EWHC 3380 at [24].

the parties to an action to seek to compromise the claim on the basis of periodical payments.²⁰

- Interim payments: If liability has been admitted then whether or not a substantial interim payment should be requested requires consideration. This is most likely to be the case where the action involves a severely disabled child or a child who requires immediate alternative accommodation, necessitating the release of funds prior to the conclusion of their claim. Although the funds would strictly be for the benefit of the claimants (i.e. the parents) in these cases, previous case law has demonstrated that it may be a concern of the court that there is no Court of Protection involvement (given that a large proportion of any damages award would be made on the basis of the medical needs of a child). Such a concern will not be fatal to an application for an interim payment if alternative protection is in place, such as where the claimant's solicitors are prepared to provide an undertaking; whether or not this would be appropriate or possible should also be considered when making an application for an interim payment.

Wrongful conception and wrongful birth claims have particular sensitivities of which all practitioners should be aware. There has been very little judicial activity in these types of case in the last 15 years. However, at a time where there has been increased legal and public interest in these types of claim (with at least one Court of Appeal case expected) practitioners should be alive to the potential for a change, or at the very least a clarification, of the law surrounding wrongful conception and wrongful birth claims.

²⁰ See the suggestion in *FP v Taunton and Somerset NHS Trust* [2009] EWHC 1965 at [6].

Inquest touching of the death of Baby O

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In November last year in the Winchester Coroner's Court, Assistant Coroner Sarah Whitby concluded a 6-day inquest touching on the death of Baby O, who tragically died only a day after his birth at St Mary's Hospital on the Isle of Wight. The inquest considered not only the narrow circumstances of his death, but also interrogated staffing structures, training, and emergency transfers from the island to the mainland. AvMA instructed Jo Moore of 1 Crown Office Row Chambers to represent the family.

The facts

Baby O was born just after midnight on 30 May 2016. He was full-term and a healthy weight. Initial observations were encouraging, although meconium was noted at birth and he was placed in ambient oxygen with mild breathing difficulties.

His observations deteriorated overnight. At the inquest, the Trust's witnesses accepted that if those observations had been plotted onto a 'Newborn Early Warning System' chart, immediate review by a doctor would have been repeatedly indicated.

A paediatric consultant told the inquest that she conducted a ward round of the Neonatal Intensive Care Unit (NICU) and reviewed Baby O at 9am, but this was strongly contested by various members of the nursing team. While the Coroner eventually found that the round probably did take place, no notes or plan were documented. A senior advanced neonatal practitioner (SANNP) who attended the NICU for a short shift in an allegedly clinical role made incomplete notes and did not appear to recognise the seriousness of Baby O's condition. Baby O's breathing continued to deteriorate throughout the day and no review was sought. He was seen again by the same paediatric consultant at around 14.00. This review was also undocumented, and the only follow-up plan was that he should be nil by mouth, which was later unheeded. A serious incident investigation report following Baby O's death found that at this point,

a plan for follow-up review should have been made and discussions should have begun with a tertiary unit. In the event, no such discussions took place until much later.

Baby O's condition worsened. A junior doctor was called to attend the NICU at 18.00 and escalated care to the paediatric registrar, who arrived, intubated Baby O and commenced treatment at around 19.20. Tertiary advice was finally sought at 21.00. However, the protocol for the region was not followed and the wrong hospital was called. The first documented contact with the designated retrieval team was at 21.54. By then, it was suspected that Baby O was suffering from either persistent pulmonary hypertension of the newborn (PPHN) or a cardiac anomaly. A junior doctor present during resuscitation claimed to have raised the alarm that noradrenaline was erroneously running at 100 times the prescribed dose.

While Baby O was being resuscitated, his parents were left in a separate room for five hours with no news. His mother told the inquest of her "agonising wait... If they had said to me [Baby O] was really poorly, I would have spent more time with him."

Attempting to organise transfer, the Southampton Oxford Retrieval Team (SORT) considered air transport, but no helicopter was available. They boarded the next available ferry to the Isle of Wight to retrieve Baby O and arrived at 01.00 to find him in a very poor condition. Despite their efforts, little could be done to revive him. Baby O was taken to Southampton General Hospital by ferry and ambulance. He died at 05.50 in his mother's arms and his parents made the journey back to the island at 8am, alone.

Conclusions

The Coroner heard live evidence from 14 witnesses over the course of the inquest and six interested persons were separately represented. The family submitted both before and during the inquest that Article 2 of the ECHR was engaged, but the Coroner held that it was not. The Coroner also resisted the family's request for independent

medical evidence, and its submission that Baby O's death was caused, or contributed to, by neglect.

Noting that Baby O died of natural causes as a result of undiagnosed PPHN, the Coroner recorded a narrative conclusion. She found that the severity of Baby O's condition was not recognised early enough, and contact with a retrieval unit was not made soon enough, particularly considering the hospital's location. As PPHN was diagnosed at a late stage, "it could not be resolved". A formal investigation by the Trust into the alleged noradrenaline error did not take place until August 2017 and Baby O's family knew nothing of the allegation until it was raised at a pre-inquest review hearing the following month. The Coroner noted in her factual summary that this should have been investigated sooner and that the family should have been informed.

The cause of death was recorded as 1a: Acute Intraventricular Haemorrhage and 1b: Persistent Pulmonary Hypertension of the Newborn and Meconium Aspiration.

The Coroner also made a Regulation 28 Report to Prevent Future Deaths, identifying seven primary matters of concern. Three related to staffing levels and roles, and two to documentation and staff handovers. The report noted that nursing staff did not appear able to escalate concerns, possibly due to poor training, a lack of empowerment, or poor escalation and care plans. The Coroner raised concern over the transfer policy from the Isle of Wight, particularly where emergency retrieval is required overnight. In an unusual move, the Coroner will consider visiting St Mary's Hospital personally, to check that the changes reported by the Trust have taken effect.

Following the Coroner's conclusion, Dr Barbara Stuttle CBE, Chief Nurse at the Trust, said "the inquest heard that the care [Baby O] and his family received in May 2016 was completely unacceptable, and we are very sorry that we did not provide them with better care".

The Trust responded to the Regulation 28 Report on March 2018, stating that since the inquest it has completely replaced the documentation used in neonatal care, sent NICU staff on training courses, and abolished the role of the SANNP entirely. Just five months before Baby O's death, another baby had tragically died at St Mary's Hospital. An inquest held on the island concluded that "systemic gross neglect" had led to his "totally avoidable" death. An independent investigation into both deaths, led by Mike Bewick, Deputy Medical Director at NHS England, is ongoing. AvMA has also reported the results of the inquest to the Care Quality Commission.

Initially, the inquest was listed for only one day. Baby O's parents contacted AvMA for help when the inquest was relisted for a longer period and the family was faced with large volumes of disclosed medical records, witness statements and internal policies which left them feeling "overwhelmed". With the assistance of the pro bono team, Baby O's parents were able to participate fully and have at least some of their concerns acknowledged and addressed.

Inquest touching of the death of James Phelan

Represented by: Rachel Marcus of

One Crown Office Row and Dr Charlotte Connor,

Medico-Legal Advisor at AvMA



BACKGROUND

James Phelan was a high-flying, outgoing and gregarious City banker and father of two who, following the financial crisis in 2011, lost his job and his self-confidence. He became increasingly dependent on alcohol.

In August 2014, James decided, with immense willpower, that he was going to detox from alcohol while his family was away visiting relatives. He began to suffer increasingly severe withdrawal symptoms, including hallucinations. Despite this, he refused to start drinking again. Eventually, after 5 days, and frightened by his presentation, his partner Sian insisted on calling an ambulance. He was taken to A&E at St Peters Hospital, Chertsey, where he was triaged and sat in the trolley area awaiting assessment. An hour and a half after arriving at A&E, James spoke to the A&E nurse in charge saying he wanted to leave. She let him do so.

James walked out of the A&E department in shorts and t-shirt into an evening of torrential rain, with no phone, money or means of transport.

An hour or so later (although the timescale was disputed by the Trust's witness at the inquest), following discussion with James' increasingly frantic family, the A&E nurse in charge rang the police.

There followed a large-scale police search and media campaign (how large-scale, and why, was a matter for inquiry at the inquest). James' body was eventually found a week later, by the side of the dual carriageway leading away from the hospital.

His partner and mother of his children, Sian, could not understand why he was allowed to leave the hospital given the state he had been in when taken there. Her initial letter to the hospital raising her concerns was sent even before James was found. No reply was received. After James' death, Sian once more wrote to the Trust. Again, no substantive response was received. It was at this point that Sian made contact with AvMA. With AvMA's assistance, she requested a formal SUI.

RACHEL MARCUS 1 CROWN OFFICE ROW

The SUI, which was completed in December 2014, concluded in essence that the Manchester Triage System (in use in A&E departments across the UK) was not very good at managing 'mental health' presentations and this led to him being awarded a triage category less urgent than he might have been. It did not find any failings by individual members of staff.

The concerns of the family were manifold but they coalesced around the following themes:

1. Should the GP who spoke to him in the middle of the week have prescribed medication over the phone without seeing him? Was the medication she prescribed appropriate?
2. Was James' family given appropriate advice by the paramedics? Was there appropriate handover from the paramedics to the hospital?
3. Was James triaged appropriately? Why not? Was the triage system fit for purpose? Did anyone take seriously the physiological risks to someone of acute alcohol withdrawal? (Even in the SUI, the focus was on "mental health" presentation).
4. Was James counselled appropriately before leaving A&E? What might have been done to stop him? Again, did anyone take seriously the physiological risks to his health?
5. Once James left A&E, was the response adequate? Were the risks to him taken seriously and were these adequately conveyed to the police?
6. Was the police search adequate? What information did it rely on? Could James have been found earlier?

THE INQUEST

The investigation was opened shortly after James' death by HMC Darren Stewart. I am told that on receipt of the post-mortem report the coroner was minded to enter a

conclusion of natural causes and close the investigation. It was the family's insistence that there were still questions left unanswered which led eventually to the coroner calling a PIR.

The first PIR was held in January 2016; there were further PIRs in May and September 2016. Over the course of those PIRs the coroner was persuaded (not without some initial resistance) to call evidence from an A&E expert.

The inquest was eventually listed for three days in May 2017; it went part-heard, sitting for a further five days in total over August, September and December 2017. The coroner gave his conclusions in January 2018.

Evidence

On careful questioning, the pathologist came to the opinion that James was likely to have died within 24 hours of leaving A&E. The cause of death was alcoholic ketoacidosis.

Despite the focus on the triage process in the SUI, the Trust had not interviewed the nurse who had carried out the triage of James when he arrived at A&E. Despite the coroner making it perfectly clear at the PIRs that the Trust had not made enough effort to find her, it was only shortly before the inquest that we were notified that the triage nurse had provided a statement and would be giving evidence after all. In the event her evidence was vital. It became clear that not only had she had no training in conducting triage, nurses were given no training in the presentation of acute alcohol withdrawal: she had "no idea" how to judge the severity of someone with alcohol withdrawal and didn't know seizures were a feature of that condition.

The police evidence threw up a great deal of further information: the police investigation documents had not been disclosed to anyone but were relied on in detail by police witnesses in the witness box. Most pertinently, so was the record of the phone call made by the nurse in charge to the police. We requested a copy which proved what the family had been saying all along: the phone call to the police was not made until almost an hour after James had left A&E. It became clear that James' original medical records had been tampered with since they were first copied to the family after his death: someone (the nurse in charge conceded it looked like her own handwriting) had added the time "19.30" to the note relating to the call to police.

The record also confirmed the family's suspicions regarding what the police were told or not told: despite the nurse in charge professing in the witness box that she recognised James as vulnerable and knew he was

suffering from acute alcohol withdrawal, neither of these pieces of information were passed on to the police. The Police Search Advisor (PoISA) gave evidence that if he had been given that information, he would have classified the risk to James as "high" rather than "medium" and this would have triggered the involvement of search and rescue support earlier. He thought that James would have been found by the day after he left A&E instead of a week later.

The A&E expert for whom we had asked at the PIRs also proved central: he was absolutely clear that the triaging had been inadequate and that James should have been better counselled when he expressed the wish to leave A&E.

Coroner's Findings

The coroner found that there was an arguable breach of Article 2 on the basis of the general systemic duty given the problems with the MTS; but also, interestingly, on the basis of James' vulnerability (this was based on our submissions; those familiar with the state of the law regarding inquests, Article 2 and non-detained patients will recognise that this was a bold step) - and that there was arguably a breach of the operational duty on the basis of a real and immediate risk to his life of which the Trust ought to have been aware and was in a position to prevent.

The coroner found that the A&E cas card made no reference to the hallucinations which were observed by the ambulance crew, and was scant in detail compared to the patient clinical records ("PCR") that the ambulance crew completed. He noted the evidence from a number of witnesses that the PCR is not provided to ambulance staff until after been written up by the crew and that can be either during or after the triage process was completed. It was unclear in this case whether or not that detailed note made by ambulance crew formed any part of the handover to the A&E pitstop staff. It did not seem to have been accorded any significance in the subsequent triage consultation by the pitstop nurse and then the nurse who completed the triage.

The nurse who conducted the triage was an agency or bank nurse who had only worked in pitstop on 2 or 3 occasions. She was not familiar with the symptoms of acute alcohol withdrawal. The coroner found her evidence unconvincing regarding her assessment and involvement in decision-making regarding observations and James' MEWS scores. On the basis of the expert evidence, the "unwell adult" triage category used was inappropriate and there was a failure of care to triage James properly; the

nurse was inexperienced and selected an inappropriate flowchart as her starting point.

The coroner recognised that staff were operating in circumstances of stress and pressure at the time – this nurse in charge said that pitstop needed reinforcing and the A&E department was under pressure with the number and volume of patients presenting. However it was the clear evidence from the expert, the author of the SUI and the permanent nurses that experienced and capable staff should be appointed to pitstop and conduct the triage process. The expert was clear: getting triage right at the start was one of the critical functions of the treatment of patients in A& E, and those who carry it out should be senior staff who can conduct it correctly. That was not the case with the nurse allocated to triage on this occasion, who was an inexperienced agency staff member who had only worked in pitstop twice before. She was not familiar with the triage system and her selection of the wrong flowchart meant that a triage category which was more urgent than “green” could never have occurred.

Little or no (the coroner found that it was likely to have been no) reference was had by A&E staff to the PCR produced by the ambulance service – it contained key information which would have been part of the handover in terms of hallucinations, anxiety and odd behaviour, which were not referred to as part of the triage process.

Had it been referred to, there would have been a different outcome in terms of prioritisation. James would have been given a yellow or possibly orange category. Overall there was a failure by A&E staff adequately to apply the triage system to James in his circumstances, the result of which was that James was accorded an inappropriate triage category and was not seen by a doctor within an hour, which should have been the outcome had the MTS system been applied correctly. It was possible that this failure contributed to the ultimate outcome of him leaving the hospital before being seen by a doctor and subsequently collapsing and dying in some brambles off St Peter’s Way.

As for the nurse in charge who spoke to James before he left, it was more likely than not that she didn’t provide a detailed explanation to James of the risks of him leaving and not receiving treatment and assessment by doctor for acute alcohol withdrawal, and especially the risks to him. On balance, James had capacity and therefore would have been able to process and receive information associated with the risk relating to the decisions he was taking; the risk was not sufficiently explained to him.

When the nurse in charge did call police (and the coroner noted with some concern that there seemed to have

been an amendment in the hospital records about the timing of that contact, and observed that if not an honest mistake it would give significant cause for concern that a public authority like a hospital amended documents in such a way) the coroner found that critically certain information regarding James’ history of hallucinations and acute alcohol withdrawal was not passed on. The detective sergeant identified the process whereby the assessment of risk was made by the duty inspector based on the information provided by the reporting agency, in this instance the hospital. The following day, following information about James’ alcohol withdrawal and other surrounding circumstances, the duty inspector increased the risk assessment to high. That was an important decision because it activated the appointment of a PoSA and the ability to make use of Surrey Search and Rescue to conduct detailed ground searches. The coroner found it difficult to understand why the concerns that the nurse in charge said she had regarding James’ acute alcohol withdrawal and risk were not better communicated to the police; given that those were the reasons which she said were central to her concern it is difficult to understand why this was not communicated effectively to police in such a way as to shape the police search. There was no clear policy in terms of the requirement to report patients who had left hospital to the police; a phone call was made in this case because of a concern over and above that which would normally exist for a patient who denied the offer of medical treatment. The coroner found this difficult to square in terms of the information provided to the police. That was a failing on behalf of the staff of St Peter’s Accident and Emergency department.

It is possible that had that information been passed on, a different risk assessment would have been made by police; it is possible that James may have been found earlier than he was.

The coroner decided to write PFD reports to

1. The Royal College of Emergency Medicine/NHSE, whichever body he considered best placed to consider amendments to the use of the Manchester Triage System across the NHS, inviting them to consider amendments to clearly accommodate presentations such as James’ where there was a combination of physical and mental elements particularly in acute alcohol withdrawal (but there could be others).
2. The NHS Trust, in relation to
 - a) the competencies to be expected of staff in pitstop and triage

- b) guidance to staff as to what information should be passed to police. The standards should be higher than a member of the public ringing 999 or 101. The coroner was unconvinced that discussions between the police and the hospital in the past had produced anything of utility.
3. The Chief Constable, considering the way in which assessments were made of risk of missing persons to ensure that the relevant decision maker (the duty inspector) had the widest amount of effective information and support to make those decisions.

We made submissions that the coroner should also consider including in his PFD report to the Trust recommendations regarding

- a.) clearer guidance to staff on stratifying not only the risk that a patient might leave A&E without receiving treatment, but also the risk to the patient if he were to do so;
- b.) a "ready reckoner" be provided to staff in their consideration of whether patients have capacity or may be vulnerable, and the actions to be taken in either of those scenarios;
- c.) ensuring ongoing training in recognising alcohol-related presentations, and in particular acute alcohol withdrawal.

At the time of writing, the PFD reports had not yet been issued.

CONCLUSIONS

This inquest was an object lesson in what can be achieved with perseverance, commitment and AvMA support. It is very unlikely that this case would have looked like a good prospect for any solicitor at the outset: I am told that the coroner was minded to enter a conclusion of natural causes and close the investigation at a very early stage. Whilst the question whether a triage system in use across the country was fit for purpose was an interesting one for coronial inquiry, it would not have been enough to found a claim in negligence against a specific Trust. I certainly could not, at first glance at the papers, have advised that a claim had more than a 50% likelihood of success for the purposes of a CFA. The coroner was initially resistant to the idea that this inquest might engage Article 2. Accordingly the only option for representation was via AvMA.

Through an insistence through several PIRs on widening the scope and obtaining expert evidence, and through dogged questioning of the Trust and police witnesses, that position has changed. Eventually the coroner found several serious failings on the part of the NHS Trust, of

both systemic and an individual nature. Most importantly, Sian and the Phelan family have seen James' death being taken seriously.

I am told that AvMA has never had a barrister giving up so much of their unpaid time on a case. Of course at the outset no-one could have predicted how successfully we would expand the scope of the inquiry. I am immensely proud of what we achieved for James and his grieving family. AvMA's support and dedication were vital. Keep up the good work.

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Journal of Patient Safety and Risk Management

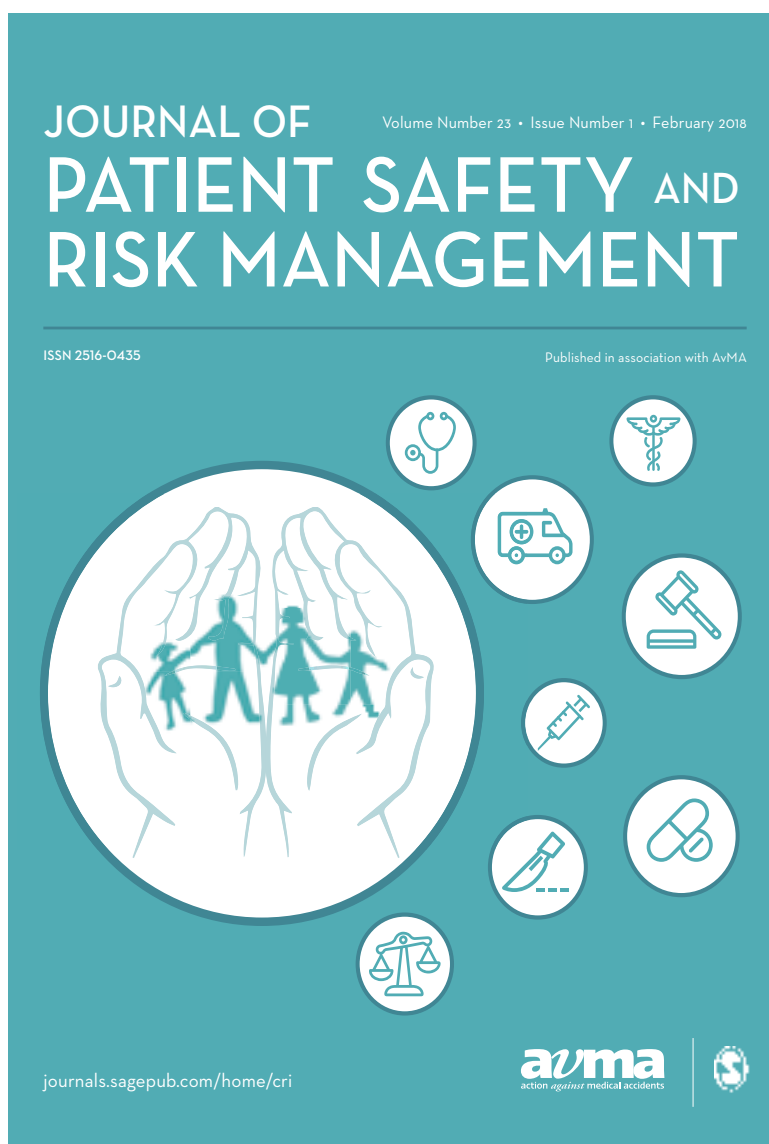
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Representing Families at Inquests: A Practical Guide

15 May 2018, Hardwicke Chambers, London

The important work conducted by AvMA's inquest service is the basis for this conference, which is designed to be a comprehensive guide to the practice and procedures when representing a family at an inquest.

Leading legal experts will take you through the preparation process, helping you to understand the complex issue of disclosure, management of expert evidence and Article 2. An update on case law, funding issues and post-inquest remedies will also be discussed. The event is aimed at intermediate to advanced level solicitors, junior barristers and healthcare professionals. The conference will be immediately followed by a networking drinks reception, kindly hosted by Hardwicke Chambers.

AvMA Annual Golf Day

28 June 2018, Singing Hills Golf Course, West Sussex

The fourteenth AvMA Golf Day will take place on Thursday 28 June 2018 at a new course – the beautiful Singing Hills Golf Course in Albourne, West Sussex

(www.singinghillsgolfcourse.co.uk), set in an area of outstanding natural beauty with the South Downs as the backdrop. The Welcome Event for the Annual Clinical Negligence Conference will take place later that evening at the Hilton Brighton Metropole (25 minutes' drive away), so the Golf Day offers the perfect start to the essential event for clinical negligence specialists.

We will be playing Stableford Rules in teams of four and you are invited to either enter your own team or we will be happy to form a team for you with other individuals. The cost is only £98 + VAT per golfer, which includes breakfast rolls on arrival, 18 holes of golf and a buffet and prize-giving at the end of the day.

30th Annual Clinical Negligence Conference

29-30 June 2018, Hilton Brighton Metropole

Join us in Brighton for the 30th ACNC! This is the annual event that brings the clinical negligence community together to learn and discuss the latest developments, policies and strategies in clinical negligence and medical law. Early bird booking is now open, with the full conference programme available in late March. The programme this year will explore the perils and pitfalls of diagnosis in a clinical negligence context with a focus on surgery, as well as covering many other key medico-legal topics at such an important time for clinical negligence practitioners. Sponsorship and exhibition packages are also available.

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