BRIEFING
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END OF TERM CASELAW UPDATE

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This article considers the important clinical negligence decisions over the first half of 2021.

In summary:

i. There have been three important reported cases involving fundamental dishonesty pleadings by NHS trusts. This is rapidly becoming a defining area of medical negligence law and all practitioners should be aware of it.

ii. The Supreme Court has delivered an extremely important judgment defining the limits of claims for pure economic loss arising from medical negligence in *Khan v Meadows*.

iii. There has been substantial consideration of the test for negligence and the standard of care. The test in *Bolam* and *Bolitho* remains undisturbed.

iv. Clarification on the test for causation in medical negligence cases has been provided in *Davies v Frimley NHS Trust*, an important point perhaps surprisingly not appealed from the High Court.

v. Vicarious liability is becoming an increasingly complex topic, and this has recently been extended to vicarious liability for self-employed dental surgeons in *Hughes v Rattan*. This is a developing area and requires close attention.

vi. There have been two more cases in the long line of authorities on secondary psychiatric injuries arising from the death or serious injury of a loved one. Essentially, the position remains unchanged from *Paul v Wolverhampton NHS Trust* and ultimately *Alcock*, but we have two newer examples.

vii. There have been timely reminders on points related to expert evidence, success fees, and rights of action against insurers.

Updated Cases

i. *Brint v Barking, Havering and Redbridge University Hospitals NHS Trust* [2021] EWHC 290 (QB)
ii. *Calderdale & Huddersfield NHS Foundation Trust v Metcalf* [2021] EWHC 611 (QB)
iii. *Davies v Frimley Health NHS Foundation Trust* [2021] EWHC 169 (QB)

iv. *Doyle v Habib* [2021] EWHC 1733 (QB)
v. *Dunn v Greater Glasgow Health Board* [2021] CSOH 68
vi. *Hughes v Rattan* [2021] EWHC 2032 (QB)
vii. *Iddon v Warner* [2021] 3 WLUK 432
viii. *Ismail v Joyce* [2020] EWHC 3453 (QB)
ix. *Khan v Meadows (Rev1)* [2021] UKSC 21
x. *Toombes v Mitchell* [2020] EWHC 3506 (QB)

Earlier Cases

i. *Alcock v Chief Constable of South Yorkshire Police* [1992] 1 AC 310
ii. *Barclays Bank plc v Various Claimants* [2020] UKSC 13
iii. *Bolitho v City and Hackney Health Authority* [1998] AC 232
iv. *Calderdale and Huddersfield NHS Foundation Trust v Sandip Singh Atwal* [2018] EWCH 961 (QB)
v. *Paul v The Royal Wolverhampton NHS Trust* [2020] EWHC 1415 (QB)
vi. *Razumas v Ministry of Justice* [2018] EWHC 215 (QB)
vii. *South Australia Asset Management Corp v York Montague Ltd* [1996] UKHL 10
viii. *Woodland v Swimming Teachers Association* [2013] UKSC 66

Fundamental Dishonesty

There is clearly an increasing tendency for NHS trusts or GPs to plead fundamental dishonesty; and then to seek committal, in respect of exaggerated but otherwise genuine claims brought against them. Cases on this subject have defined this area of law in 2021 so far.

In almost every case, this arises when the Claimant has suffered genuine injury from medical negligence, but goes on to claim devastating symptoms which are simply untrue; and the defendant discovers this following covert surveillance of the Claimant.

A finding of fundamental dishonesty in such circumstances will a) lead to the dismissal of the underlying claim except as a set-off against the Defendant's costs under s.57 CJCA 2015; b) lead to QOCS being disapplied under CPR 44.16, and no doubt a ruinous costs order; and c) if proven to the criminal standard, can lead to an order for committal under CPR 81.3.

All of these applied in *Calderdale & Huddersfield NHS Foundation Trust v Metcalf* [2021] EWHC 611 (QB), where a claimant was sentenced to 6 months imprisonment following the dismissal of her claim on grounds of fundamental dishonesty as a result of exaggeration of symptoms.

A fundamentally dishonest Claimant has a potential way out of trouble under s.57(2) CJCA 2015 by showing that they would suffer "substantial injustice" if their claim was dismissed as a result. But this is something of a mirage, and a further recent case - *Iddon v Warner* [2021] 3 WLUK 432 - illustrates this. There was no finding of substantial injustice notwithstanding the fact that the Claimant would lose a home purchased through interim payments, or would lose out on compensation against a genuine tortfeasor, or had shown remorse, or could no longer obtain treatment she genuinely required. Essentially, personal mitigation or severe personal consequences will almost certainly not be sufficient. As in *Razumas v Ministry of Justice* [2018] EWHC 215 (QB), something more than all of these was required. In fact, as at July 2021, the writer is unfamiliar with any reported decision where a finding of substantial injustice has so far followed a finding of fundamental dishonesty. It seems probable that it could only potentially arise where the dishonesty has been on the part of a non-Claimant where the Claimant is innocent of participation, such as, for example, on the part of a litigation friend or possibly a witness or expert.

This is a very recent development in the law, and it is still only 3 years since judgment in the first such application of this kind by an NHS trust - *Calderdale and Huddersfield NHS Foundation Trust v Sandip Singh Atwal* [2018] EWCH 961 (QB). It may well be no co-incidence that the same NHS trust was involved in both this case and in *Metcalf*, presumably different trusts will have different levels of capacity and willingness to investigate and prosecute cases of this kind.

However, *Brint v Barking, Havering and Redbridge University Hospitals NHS Trust* [2021] EWHC 290 (QB) provides a timely reminder that fundamental dishonesty is not always easy to prove. In this case, HHJ Platt found of the Claimant's evidence at [102]

that: *"I am satisfied that the claimant genuinely believed in the truth of the evidence that she gave and that, applying the standards of ordinary decent people I find as a fact that although her evidence was wholly unreliable in the sense that I do not accept it, she has not been dishonest. I therefore reject the allegation of fundamental dishonesty."* It is, therefore, the subjective belief in the truth or falsity of the evidence, however unreasonable that belief is, which matters.

Pure Economic Loss

The Supreme Court has given judgment in *Khan v Meadows (Rev1)* [2021] UKSC 21, a very important authority on causation, remoteness, and damages in respect of pure economic loss arising from medical negligence. In short, *South Australia Asset Management Corp v York Montague Ltd* [1996] UKHL 10 principles in respect of pure economic loss apply to medical negligence.

The Claimant had sought advice from the Defendant as to whether she carried the haemophilia gene. She did, but was negligently advised that she did not. Had she been correctly advised, she would have sought prenatal haemophilia testing; and would as a result have discovered that her son would be born with haemophilia. Had she made this discovery, she would have sought termination of the pregnancy. In the event, the Claimant's son was born and suffered from haemophilia. She claimed the costs of treatment of that haemophilia, and liability for these costs was admitted by the Defendant.

So far so simple, but here lies the complication - the Claimant's son *also* developed autism, and the Claimant claimed further costs in respect of the treatment required as a result of this condition. That autism was not caused by the haemophilia or directly attributable to the Defendant's negligence, save, of course, that the Claimant's son would not have been born but for the negligence.

Ought the Claimant be able to recover such financial loss? Or ought commercial pure economic loss principles apply to a claim arising from medical negligence of this kind?

Held - claim dismissed on appeal. A court faced with such a claim must ask itself six questions:

i. Was the harm actionable in principle?

ii. Did the risks of that harm fall within the duty to the Claimant?

iii. Did the Defendant breach that duty?

iv. Was the loss actually caused by that breach of duty?

v. Was there a sufficient factual nexus between the harm for which damages were sought and the duty of care?

vi. Was the loss irrecoverable for any other reason (Remoteness? An intervening new case? The duty to mitigate?)?

In this case:

i. The costs of caring for the child's autism were clearly actionable.

ii. The scope of the duty, however, was only in respect of the haemophilia. The Defendant had not been approached for any other reason.

iii. Breach was admitted.

iv. The breach had caused the Claimant not to seek a termination and so, factually, there was causation from the original negligence.

v. However, there was no sufficient factual nexus. The Defendant was not under a duty to advise on unrelated risks associated with; that was not the advice which had been sought.

vi. No other matter was raised including remoteness. The writer questions the latter - it is difficult to see how a birth with autism can be reasonably foreseen as a result of a negligent false negative in a haemophilia screening test - and the court's reasoning on this point is not clearly set out. It seems the point was never pleaded.

On the subject of claims arising from children born with disabilities as a result of medical negligence, recall that while claims for damages resulting from the very fact of a child's existence (for example, negligent contraceptive advice) are excluded under the Congenital Disabilities (Civil Liability) Act 1976, that does not apply to matters arising before the child's birth giving rise to a disability. This was explored in *Toombes v Mitchell* [2020] EWHC 3506 (QB).

Proving Negligence / Standard of Care:

There have been two recent reminders that a finding of negligence will not be made out where the form of treatment was a reasonable exercise of expert judgment taking into account both risks and benefits, and where a responsible body of expert medical practitioners faced with those circumstances would genuinely have taken the same view (not merely, for example that the doctor in question believed that this was so).

Two examples of claims dismissed on this basis were in *Negus & Anor v Guy's and St Thomas' NHS Foundation Trust* [2021] EWHC 643 (QB) in respect of the implant of an allegedly undersized heart valve; and in *Doyle v Habib* [2021] EWHC 1733 (QB), an allegedly unnecessary operation.

The underlying test is very helpfully explained by Eady J in *Negus* at [48] and [49] and reading of these paragraphs is recommended if faced with arguments of this kind. Essentially, the position remains as described in *Bolitho v City and Hackney Health Authority* [1998] AC 232.

However, what is negligent is also to be considered in context, as described in *Ismail v Joyce* [2020] EWHC 3453 (QB). The Claimant presented with night sweats and a three-week-old persistent cough, which the GP diagnosed as a simple upper respiratory tract infection and treated with antibiotics. In fact, the Claimant suffered from tuberculosis, and required a chest x-ray to check for this condition. The resulting delay in diagnosis meant that the Claimant suffered life changing neurological injuries and was confined to a wheelchair. The original diagnosis, while wrong, would have been reasonable in most circumstances as tuberculosis is generally uncommon in the UK, but the Claimant lived in Newham, an area with perhaps the highest level of tuberculosis prevalence in the UK, and rates approximately ten times higher than the national average. In such circumstances, failure to consider the possibility of tuberculosis was negligent.

Causation

There has been important clarification on the test for causation in *Davies v Frimley Health NHS Foundation Trust* [2021] EWHC 169 (QB). The Claimant argued that a distinct doctrine of material contribution could apply to cases involving a disease process which caused an indivisible injury (death), and where it was not possible to medically determine whether, at the moment the negligence occurred, the disease process had passed a critical phase so as to establish 'but for' causation. The Claimant failed on the material contribution legal argument, but succeeded on the facts by meeting the conventional "but for" test; with HHJ Auerbach holding at [200] that: "*I start with what is, I believe, clear. First, where the harm is divisible, a party will be liable if their culpable conduct made a contribution to the harm, to the extent of that contribution. Secondly, where the harm is indivisible, a party will be liable for the whole of it, if they caused it, applying "but for" principles.*" An interesting point, and the writer is not convinced that it has been wholly settled. Watch this space.

There has also been a potentially helpful reminder from the Scottish Court of Session in *Dunn v Greater Glasgow Health Board* [2021] CSOH 68 that post hoc ergo propter hoc is a logical fallacy and that the mere emergence or worsening of symptoms after an operation does not necessarily mean that this was caused by the operation being conducted in a negligent manner. It would be wise for parties and solicitors to remind themselves that both causation and negligence must be proven, neither necessarily speaks for themselves simply on grounds of chronology.

Vicarious Liability

In *Hughes v Rattan* [2021] EWHC 2032 (QB), the owner of a dental practice was found, as a preliminary issue, to

be potentially vicariously liable for the actions of self-employed dentists working from that practice on the basis that the relationship between them was sufficiently akin to employment. This is an area of the law in motion and could have enormous implications for the insurance industry and medical negligence generally. Practitioners would be well advised to be familiar with *Woodland v Swimming Teachers Association* [2013] UKSC 66 (non delegable duties) and *Barclays Bank plc v Various Claimants* [2020] UKSC 13 (vicarious liability), as it is plain that this will have a significant impact on this kind of claim going forward.

Secondary Psychiatric Harm

There have been two recent secondary victim decisions following the decision in *Paul & Anor v The Royal Wolverhampton NHS Trust* [2020] EWHC 1415 (QB) last year. In *Paul*, Chamberlain J at [73] said "*In my judgment, the ratio of Taylor v A. Novo is that, in a case where the defendant's negligence results in an "event" giving rise to injury in a primary victim, a secondary victim can claim for psychiatric injury only where it is caused by witnessing that event rather than any subsequent, discrete event which is the consequence of it, however sudden or shocking that subsequent event may be. It is true that, at [30] of his judgment (see [29] above), Lord Dyson reasons that it would be undesirable to allow recovery in a case where "death had occurred months, and possibly years, after the accident". But this is a concern about delay between "the accident" (i.e. the event) and its later consequence. As I noted at [63] above, there is nothing to suggest that there would be any reason to deny recovery simply because the accident or event occurred months or years after the negligence which caused it.*"

The recent cases are:

i. *King v Royal United Hospitals Bath NHS Foundation Trust* [2021] EWHC 1576 (QB) an unsuccessful claim for damages for PSTD by a father who was told that his newborn son might potentially die. Sad though this was, it was not a “sudden or unexpected shock” within the meaning of *Alcock*.

ii. *Polmear & Anor v Royal Cornwall Hospitals NHS Trust* [2021] EWHC 196 (QB), a successful claim for damages by parents of a child who suffered a sudden and unexpected collapse as a result of the underlying negligence. It was held that this did meet the requirements in *Alcock*.

Expert Evidence

Two short points on expert evidence arise from recent caselaw:

i. It can plausibly be said that some clinical negligence claims may be wholly/largely dependent on expert evidence. As a result, it followed in *Baidoo v Barking, Havering, and Redbridge University Hospitals NHS Trust* [2021] 6 WLUK 227 that where a Claimant either fails to instruct an expert, or that expert can no longer assist (e.g. by attending trial or participating in a CPR PD35 para.9 meeting), and there is no real prospect of the Claimant engaging replacement experts, then the claim has no real prospect of success, and the claim is liable to summary judgment.

ii. In *Weller v Royal Cornwall Hospitals NHS Trust* [2021] 7 WLUK 308, a neuropsychologist recommended referral to a neurologist. The Defendant sought to rely on both reports, which the court at first instance refused on costs management grounds. The Defendant’s appeal was allowed; held that where an expert recommends referral to a second expert in a different field, a court should be very reluctant to reject that advice, and, it follows, that the parties should generally follow it.

Rights of Action Against Insurers

Another interesting Scottish authority in *Gemmell v KSL Hair Ltd*[2021] SAC (Civ) 6 relevant to the Third Parties (Rights against Insurers) Act 2010. An insurer can, in principle, defend such a claim on the basis of a clause excluding liability for negligently caused personal injury, in this particular case. The Claimant’s argument - that negligently performed cosmetic surgery was not personal injury but something else - was regarded as producing an absurd result which could not be read into the insurance clause. Both arguments are well worth being familiar with.

Success Fees

Lastly, *Chocken v Oxford University Hospitals NHS Foundation Trust* [2020] EWHC 3269 (QB) provides important guidance on the principles to be considered when assessing the permitted rate of a pre-LASPO 2012 success fee:

i. The reasonableness of the success fee is assessed by the facts and circumstances as they reasonably appeared at the time of the CFA and not in hindsight;

ii. The benchmark is the level of risk from the perspective of a reasonably careful solicitor.

iii. A two-stage success fee dependant on whether or not settlement was potentially achievable could be reasonable in some circumstances. However, this did not always justify a higher fee closer to trial. The stages had to be justified.

iv. While the mere fact that a claim was high value or complex did not necessarily increase the risk of losing, but did still justify a higher fee as there were more pitfalls and assessing a Part 36 offer was harder.

All change under LASPO, of course, but the same considerations are likely to be relevant in the more recent context.

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