CLINICAL LAW INSIGHT: September 2018

Liability

Consent: Court of Appeal confirmed relevant risks are a matter for experts and the Claimant must show 'but for' causation.
In *Duce v Worcestershire Hospitals NHS Trust (2018)*, the Claimant had undergone a total abdominal hysterectomy and bilateral salpingo-oopherectomy. She suffered from chronic post-surgical neuropathic pain. She alleged that she should have been warned of this risk. Both parties' experts agreed that neuropathic pain was not commonplace and not well understood by gynaecologists. The Defendant argued that doctors could not be under a duty to warn of a risk they were not aware of. On causation, the Claimant argued that as this was an undisclosed risk, it was irrelevant whether she would have gone ahead with surgery or not. At trial the claim was dismissed and the Claimant appealed.

Appeal dismissed. The relevant risks were a matter for expert evidence. The Claimant needed to demonstrate a 'but for' causative effect of the alleged breach of duty and that the operation would not have taken place when it did.

Read our in-depth Insight and NHS Resolution's analysis of the case.

No compensation for loss arising from Claimant's criminal conduct.
The Claimant killed her mother during a psychotic episode due to the Defendant's negligence. She sought to recover damages. In the Crown Court she had been convicted of manslaughter by diminished responsibility, psychiatry experts having agreed that she had some responsibility. In *Henderson v Dorset Healthcare University NHS Foundation Trust (2018)* the Court of Appeal decided that she could not recover damages against the Trust as this was barred by the doctrine of illegality.

Comment: the psychiatric evidence from the criminal trial was central to the Defendant being able to rely on the doctrine that a Claimant cannot benefit from an illegal act. The case was not dissimilar on the facts from the leading case of *Clunis v Camden and Islington Health Authority (1998)*

Sudden Neonatal Collapse not caused by breastfeeding advice
In the case of *Clements v Imperial College Healthcare NHS Trust (2018)*, it was alleged that a midwife had given incorrect advice on breastfeeding and this had led to the baby being asphyxiated by her mother's breast tissue, causing brain damage. The High Court determined that the advice given that babies would move to breathe during breastfeeding was not negligent and that the cause of Cerys' collapse remained unexplained.

Read our press release on the case.

Dishonest Claimant found to be in contempt of court and imprisoned

Mr Atwal had claimed in excess of £800,000 following negligent treatment of two fractured fingers and a cut lower lip. This included substantial sums for loss of earnings and future care on the basis that he could not work and was significantly incapacitated. He sought to accept the Trust's £30,000 Part 36 offer 5 years late and only 2 months before trial. It applied for his committal for contempt of court. Fourteen allegations of contempt were proven including false statements which related to his ability to work and his general level of disability and associated needs. Subsequently he was sentenced to 3 months in prison.

Comment: Calderdale & Huddersfield NHS Foundation Trust v Atwal (2018) was a landmark decision. The judge felt that an immediate custodial sentence was necessary to mark the seriousness of the contempt and as a deterrent.

An exaggerated claim was found not to be dishonest

In the case of *Wright v Satellite Information Services (2018*), the Defendant appealed judgment in Claimant's favour following an accident at work. The trial judge had reduced his future care claim from £73,000 to £2,100. The High Court determined that the exaggerated claim for care costs did not fatally flaw the entire claim, which was not fundamentally dishonest. The Claimant's own evidence did not support the assessment of the care expert whose report was the basis for the claim for future care costs.

Comment: Wright can be contrasted with the leading case on dishonesty of *Sinfield (2018)*, where the Claimant produced fake invoices to support a claim for gardening services. As a result his entire claim was struck out. What constitutes 'dishonesty' will be fact sensitive in every case.

Defendant's post incident investigation and lack of apology criticised, despite claim being dismissed.

In *NAX v Kings College Hospital NHS Foundation Trust (2018),* the child Claimant had moderate learning difficulties and autistic traits. She underwent brain surgery for removal of a benign tumour but suffered prolonged post-operative seizures. As a result further brain damage occurred. At trial her claim failed on causation, although breach of duty was proven. Despite this, Mrs Justice Yip felt the Defendant owed the Claimant's mother an apology. The mother had concerns at the time that her daughter's care was not adequately managed and this was compounded by what the judge considered an inadequate investigation. There was no Serious Incident Investigation Report save in respect of a discrete aspect of care which was never thought to have caused harm. The judge accepted that she could not order an apology, but thought the Defendant should at least consider the possibility of giving one.

Comment: This case illustrates the importance of saying sorry even in circumstances where liability can be defended. NHS Resolution have produced guidance on saying sorry and how it fits with the duty of candour.

Quantum

Civil Liability Bill latest

The Bill had its first reading in the House of Commons before the summer recess. The Ministry of Justice has announced that the whiplash reforms will be postponed. It is understood that this will not affect the part of the Bill which deals with review of the process for setting the discount rate. It seems unlikely that a new discount rate will apply before Spring 2019 at the earliest.

Inquests

Senior Coroner's 'cab rank' policy for handling burials unlawful
The Coroner had adopted a 'cab rank' policy for burials. This was challenged in the High Court by a Jewish burial society in the case of *R v Senior Coroner for Inner North London (2018)*. The Coroner's refusal to prioritise burials on the basis of the religion of the deceased/ families was found to be unlawful. The policy was irrational, discriminated against those with certain religious beliefs and unlawfully fettered the coroner's discretion when decision-making. Following this decision the Chief Coroner has issued a guidance note

Read our in-depth Insight on the case

New guidance on public funding for family representation at article 2 inquests
The government has issued guidance about how the exceptional case funding scheme should operate in future. It is intended to ease the burden of the application process. The changes are the first step in a wide-ranging review of public funding for inquests. Public funding is now likely to be awarded for representation of the bereaved at article 2 inquests. In wider public interest cases the interest must be 'significant' (e.g. identifying large scale systemic failings) and the benefits to be derived from the applicant being represented must be tangible and accrue to a large number of people. In making decisions, particular attention should be paid to all the facts including family circumstances (including distress) and only the applicant's means will be tested.

Read our in-depth Insight on the guidance

Article 2 inquest not required where 'mere error' or 'ordinary negligence'
Mr Parkinson was unhappy that the coroner had not carried out an article 2 investigation into his mother's death in hospital from natural causes (pneumonia). On arrival in A&E the junior doctor who assessed her considered that she was already dying. He treated her, but not to the extent the family wanted and she died shortly afterwards. Mr Parkinson applied for a judicial review of the coroner's decision. In *R (Parkinson) v Senior Coroner for Kent (2018)* it was decided that 'mere error' or 'ordinary negligence' did not engage article 2 of the European Convention on Human Rights. There was no systems error. The Court acknowledged that there may be exceptional cases, where a failure to provide emergency medical treatment despite being aware that a person's life would be put at risk, arises due to a systems error.

Comment: The crucial distinction in determining whether article 2 is engaged is between a breach of duty which is a systemic error and one which is due to 'ordinary' clinical negligence. In some cases there will be an element of both and the risk of an article 2 inquiry remains.

Criminal standard of proof no longer required in suicide inquests
The Coroner considered that a short form conclusion of suicide was not open to jury at an inquest into the death of a prisoner found hanging in his cell. He invited them to return a narrative conclusion on the basis of whether it was more likely than not that he intended to kill himself and whether the prison authorities had contributed to the outcome. The jury concluded that '*on the balance of probabilities it is more likely than not that the deceased intended to fatally hang himself.'* The Claimant appealed arguing that the criminal standard of proof (beyond reasonable doubt) was required. *In R (on the application of Thomas Maughan) v HM Coroner for Oxfordshire (2018)* the Divisional Court decided that when a suicide conclusion was a consideration, it was the civil rather than the criminal standard of proof that was required.

Read our in-depth Insight on the case

Reforms to death certification: introduction of Medical Examiners

The government has published its response to the consultation on changes to the system for death certification in England & Wales. A non-statutory local ME system will be introduced in April 2019 and a National Medical Examiner will be appointed. MEs will independently review and confirm the cause of all deaths not referred to a coroner. When the opportunity arises post April 2019, the government intends to put the ME system on a statutory footing.

Comment: The results from ME pilot schemes showed an overall increase in healthcare related death referrals to Coroners. The introduction of MEs nationally may mean more inquests and healthcare organisations should plan accordingly.

Advisory

CQC and NHSI review of Serious Incident Framework

A review of the SIF is taking place following reports highlighting NHS organisations' struggles to underpin their SIIs with the 7 principles of patient safety. A number of key factors contributing to poor investigations are identified: defensive culture /lack of trust; inappropriate use of SI process; misalignment of oversight and assurance; lack of time and expertise and; inconsistent use of evidence-based methodology. It is anticipated that the new framework will be published by the end of 2018.

Comment: This review coupled with the establishment of the Health Service Investigations Branch last year, provides a unique opportunity to enhance the effectiveness of patient safety investigations and to learn lessons to prevent future harm.

Gross negligence manslaughter in healthcare

The Williams rapid review report has been published and recommends changes in the way that GNM cases are investigated and dealt with. The aim is to support a 'just and learning culture', which will lead to improved patient safety. The recommendations include publication of revised guidance; consideration of systemic and human factors as well as individual actions; greater involvement of bereaved families in the process; removal of the GMC's right to appeal Fitness to Practice decisions by its Medical Practitioners Tribunal Service and removal of its ability to request reflective material when investigating FTP cases.

Dr Hadiza Bawa-Garba was convicted of GNM following the death of Jack Adcock. Following a FTP hearing the MPTS imposed a period of suspension, but the GMC appealed and the Divisional Court erased her from the Medical Register. Dr Bawa-Garba appealed and in August the Court of Appeal overturned the decision. Read our in-depth Insight on the case.

New safeguarding children guidance

The guidance replaces 'Working Together to Safeguard Children' (2015). It applies to all organisations and agencies with functions relating to children and to all children up to age 18, whether living with families, in state care or independently. It focuses on core legal requirements - what must be done to keep children safe. A child centred approach to safeguarding is 'fundamental' and to be effective it needs a co-ordinated multi-agency approach. The guidance should be complied with unless exceptional circumstances arise.

Comment: Healthcare providers should review their child safeguarding policies and protocols to ensure that they comply with the new guidance.

Court approval not required to withdraw clinically assisted nutrition and hydration in agreed prolonged disorder of consciousness cases

In *An NHS Trust v Y (2018)* the Supreme Court has confirmed that where family and clinicians are agreed that it is in the best interests of a PDOC patient, for CANH to be withdrawn, there is no requirement to seek approval of the court. Clinicians must follow the Mental Capacity Act and relevant guidance when making a decision. If the decision is 'finely balanced' or there is a difference of medical opinion or a lack of agreement on a proposed course of action, an application to court should still be made.

Read our in-depth Insight on the case.

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