# MEDICO LEGAL

MAGAZINE

ISSUE 18

Presented by:

specialist info

MEDICO LEGAL MAGAZINE

# Welcome to the Medico-Legal Magazine

Welcome to Issue 18 of the Medico-Legal Magazine, produced by SpecialistInfo and publishing partner Iconic Media Solutions Ltd.

This autumn issue of 2021 includes articles from three of the speakers at the Medico-Legal Conference held in the summer:

Lionel Stride, Barrister at Temple Garden Chambers, provides a brief overview of some material issues that may arise in clinical negligence terms in the time of coronavirus;

Julienne Vernon, Head of Dispute Resolution and Quality at NHS Resolution, shares the organisation's innovative approach to dispute resolution; and

Flora McCabe, Clinical Negligence and Medical Regulatory and Inquest Defence Lawyer, Lockton LLP, discusses what is expected of an expert witness.

Also in this issue, James Kinsey, Barrister at Exchange Chambers explains Civil Procedure Rules - Part 35 Questions for Expert Witnesses;

Amy Perry, Senior Associate, Clyde & Co LLP, discusses the recent indemnity insurance changes in GP and Primary Care claims; and

Shoshana Mitchell, Pupil Barrister, Normanton Chambers, summarises a recent landmark qualified one-way costs shifting ("QOCS") case.

Once again, the magazine will be circulated to up to 40,000 people in the industry, including doctors, insurance companies, law firms and medico-legal agencies. It now has a dedicated page on the Medico-Legal Section of the Specialistinfo.com website, where all the back issues can be viewed, and printed copies can be ordered from Iconic.

Specialistinfo maintains a database of contact details for up to 90,000 UK consultants and GPs, including approximately 11,000 consultants and GPs who undertake medico-legal work. We also provide Medico-Legal courses for expert witnesses and promote the members of the Faculty of Expert Witnesses (the FEW).

We welcome feedback from our readers, so please contact us with any suggestions for areas you would like to see covered in future issues or share your news and experiences with us.

Lisa Cheyne

Specialistinfo
Medico-Legal Magazine

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MEDICO LEGAL MAGAZINE

# MEDICO -LEGAL COURSES:

By Lisa Cheyne,
Medico-Legal Manager,
SpecialistInfo

## Training Courses for Expert Witnesses

The dates and locations for the confirmed ML courses that we are holding during 2021 and ealry 2022 are listed below with links to our booking page.

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- *13-17th December 2021* – London
- *10–14th January 2022* – London
- *24-28th January 2022* – Live Online
- *28th Feb-4th March 2022* – London
- *14-18th March 2022* – Manchester

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**SpecialistInfo** is committed to expanding our growing range of **Medico-Legal and Mediation Training Courses,** to keep expert witnesses compliant with CPR.

*Please be aware: Rules for expert evidence have changed since 2020 and it is recommended that all experts book an updating session to ensure they are compliant.*

Details of our upcoming Medico-Legal and Mediation courses are below and all confirmed dates are available on our course **website**.

To book your place(s) and for more information about all our 2022 courses, please click **here**, email **lisa@specialistinfo.com** or call me on **01423 787984**.

Kind regards

Lisa Cheyne
Medico-Legal Manager

specialist info

# CIVIL PROCEDURE RULES: PART 35 QUESTIONS FOR EXPERT WITNESSES

**by James Kinsey,** Exchange Chambers

James is a barrister at a leading set in the north of England, Exchange Chambers. He represents claimants and defendants in personal injury and employment matters. He is happy to receive correspondence at kinsey@exchangechambers.co.uk

Well-considered Civil Procedure Rule (CPR) Part 35 questions put to medico-legal experts can prove fatal to a claim. Recently, I was instructed late on in a case to advise a claimant who alleged he sustained soft tissues injuries arising from a road traffic accident involving a bus on which he was a passenger. The defendant's questions put to the claimant's GP expert led to the claimant's personal injury claim losing all prospects of success, an allegation that the case had been brought dishonestly, and ultimately the discontinuance of the claim.

At his medico-legal examination, the claimant stated that he was 'thrown forwards and backwards' on the bus causing him to suffer soft tissue injuries to his neck, left shoulder and right knee. Unbeknownst to the claimant, the bus contained a CCTV camera. The camera captured how the collision impacted upon the claimant's body, or as it transpired, not impacted upon the claimant's body. Contrary to the history provided to the expert, it was clear from the video that the claimant was not thrown forwards and backwards. Secondly, there was no visible sign of significant, if any, neck movement capable of causing a whiplash injury. Thirdly, there was no visual evidence to substantiate how the claimant injured his knee.

Naturally, the defendant asserted that the CCTV evidence demonstrated that the collision did not cause the claimant injury, and further that the video evidence showed the claimant had issued a claim dishonestly for the purpose of financial gain. The defendant then served the CCTV evidence with Part 35 questions to the claimant's expert. The expert opined that having viewed the video he doubted that the injuries alleged could have been caused by the collision.

After the expert's response, the claimant was in a perilous position. He no longer possessed medical evidence to establish, on the balance of probabilities, causation of injury. It was agreed that the claim was bound to fail. Worse, the dishonesty allegation was seriously emboldened.

As Part 35 questions can have a significant impact on litigation, it is important that experts have a clear understanding of the legal framework in which they sit. I recently conducted a seminar on behalf of SpecialistInfo on the essentials of medico-legal work for new and established medico-legal experts. Continuing in the same vein, this article considers why a party may ask Part 35 questions, the procedural rules, and what is expected of experts.

## Why ask Part 35 questions?

Why ask questions of an expert after a written report has been produced? It is a strategy not devoid of risk. Questions may reveal the questioning party's case strategy; highlight at a premature stage in the litigation matters which may later form part of cross-examination; and, if put in a perceived hectoring manner entrench the opposing expert's opinion. Perhaps they are an exercise in futility unless there's reason to believe putting questions will substantially improve the questioning party's case.

However, Part 35 questions are an important weapon in the litigation armoury. They can be used to clarify an opposing party's evidence in circumstances where the expert's opinion is unclear on key issues such as causation and prognosis. For example, in relation to causation of an orthopaedic injury, the expert may be asked to clarify the causal connection between an accident and ongoing pain in the context of pre-existing constitutional injuries. Secondly, the questions may be put to attempt to change an expert's opinion or to widen the expert's frame of reference so that they consider a range of different views. Thirdly, experts may face questions where they have not identified and addressed relevant entries in medical records and/or to fully assess the significance of relevant material within medical records which have been considered. Fourthly, experts may have to answer questions after a failure to comply with the provisions of CPR Practice Direction (PD) 35 para 3.2 concerning the formalities of reports. For example, where an expert has failed to give details of medical literature relied upon or in cases where there is a range of opinions on the matters dealt with and the expert had not summarised a range of opinions or given reasons for those opinions.

## The procedural rules[1]

What are the legal rules governing how questions are put to experts?

The procedural rules dictate the time when questions may be asked. Questions may be put once only and must be within 28 days of the service of the report (r.35.6(2)). However, the time frame may be longer or shorter depending on court directions.

Questions put within this timeframe must be *proportionate*. Unfortunately, the concept of proportionality is not defined. In assessing proportionality, it is useful to turn to the concept of proportionality found within the Overriding Objective of r.1.1. Reams of questions are more likely to be justified in more complex, important and valuable cases which in Personal Injury litigation usually means cases involving more significant life-changing injuries.

Even in cases involving complex brain injuries and multiple experts, the court may take a dim view of voluminous questions. In *Mustard v Flower* [2019] EWHC 2623 the defendant successfully applied to set aside questions put to the expert on an unprecedented scale. The questions were relevant and addressed acknowledged areas of omission in the defendant's experts' reports. However, the questions were found to be wholly disproportionate and unprecedented in length - in some cases the questions and exhibits ran to a whole file of material! Not unsurprisingly the defendant experts contacted the court to raise concerns about the proportionality of the questions. The court found that the omissions in the defendant's expert evidence could be better addressed by supplementary reports or by the process of joint meetings/statements.

Next, questions must only be put for the purpose of *clarification* unless the court gives permission, or the other party agrees (r.35.6(2)(c)). Again, and equally unhelpfully, 'clarification' is not defined in the rules. The commentary to the rules provides some elucidation: questions 'should not be used to require an expert to carry out new investigations or tests, to expand significantly on their report, or to conduct a form of cross-examination by post including on the expert's credibility unless the court gives permission.'

Courts have found that questions that ask an expert to proffer opinion outside the scope of their instructions are likely to go beyond clarification (e.g.: *Mutch v Allen* [2001] EWCA Civ 76 where an expert was asked if the claimant's injuries would have been less severe if a seatbelt was worn). Equally invitations to express an opinion conspicuously not previously expressed is also likely to go beyond clarification. For example, in *Wilson v Al-Khader* [2015] EWHC 4240, the claimant's expert opined that a claimant in a persistent vegetative state could survive for many years to come. As the expert had deliberately not provided an opinion on the life expectancy of the claimant, the defendant was not permitted to call for the expression of additional opinions

by questioning the anticipated life expectancy of a person in a persistent vegetative state, nor to inquire as to the specific anticipated life expectancy of the claimant.

Once questions have been put and answered they are treated as part of the expert's original report and therefore they have the same status as the main report (r.35.6(3)). This is important to remember as the expert's duties when drafting their main report apply equally to drafting answers to questions.

## What can be expected of experts?

A party may put, and an expert is expected to answer, questions whether they act as a single joint expert or an expert instructed by another party to proceedings. Should experts answer all questions asked?

An expert has a duty to respond to questions properly put. Good practice dictates communicating with an instructing party before answering questions so that the solicitor can assess if the questions are proportionate, put in time, and do no more than seek clarification. If an expert feels questions are improperly put or there is disagreement between the parties as to the propriety of questions, under CPR r.35.14 experts may file to court written requests for directions for the purpose of assisting them in answering questions.

If an expert does not answer questions properly put, the court may direct that the instructing party may not rely on their report or that an instructing party cannot recover the fees and expenses of instructing the expert. In these circumstances, it is likely that the non-instructing party would seek an order that the expert must answer questions on the condition the court considers that the questions were appropriately drafted.

Finally, the time for responding is not contained within the rules, but generally set by court directions and is usually in the region of 28 days. After this timeframe, when an expert's responds to questions by the other side, the expert should copy in both the instructing party and the questioner.

## Conclusion

The bus collision case I referred to at the start of the article is a salutary reminder to parties and experts alike of the potential power of Part 35 questions. Interestingly, in that case the defendant was given permission to put a second set of Part 35 questions to the claimant's expert. Not long after reviewing the CCTV and casting doubt on whether the claimant had sustained injuries, I was surprised to read that he had later produced an addendum report in which he volt-faced for a second time!

Despite his answers to the first set of questions, in the addendum report he opined that the claimant's medical records were in fact consistent with the treatment and history as provided to him and referred the court back to his opinion on causation within his original report. Due to the expert's inconsistent opinions, the defendant successfully sought permission to ask a second set of questions. In the second set of questions the defendant outlined entries in the claimant's medical records that were plainly inconsistent with the expert's opinion in his addendum report which he had either overlooked or poorly considered.

The second set of Part 35 answers concluded as did the first. The claimant's expert doubted that the claimant sustained injury in the road traffic accident. Unsurprisingly, the case was speedily discontinued!

References/links:

[1] https://www.justice.gov.uk/courts/procedure-rules/civil/rules/part35

# EXPECTATION OF AN EXPERT WITNESS

**by Flora McCabe,** Clinical Negligence and Medical Regulatory and Inquest Defence Lawyer, Lockton LLP Flora.McCabe@uk.lockton.com

Flora spoke at the Annual Medico-Legal Conference in June 2021, and she has written a summary of her presentation for Medico-Legal Magazine.

*"There is a worrying trend generally which seems to be developing in terms of failures by experts generally in litigation complying with their duties. Practice Direction 35 makes the position very clear."*

This was the damning analysis of the Honourable Mr Justice Fraser earlier this year, in *Beattie Passive Norse Ltd v Canham Consulting Ltd* (2021). Far from being an idiosyncratic viewpoint, Justice Fraser's stance is representative of some very real concerns about the quality of experts being appointed, their knowledge of their role, and the extent to which their instructing lawyers are educating them properly.

## Expert duties

It is all too easy to get swept up in the drama and pace of litigation, particularly where a defendant and/or their legal team are determined to win at any cost. A good expert must do all they can to resist what at best can be infectious over enthusiasm and at worse overt pressure to take a certain stance, and instead ensure that they are adhering to their duties, which are clearly stipulated in the Civil Procedure Rules ("CPR"). The Practice Direction which accompanies CPR 35 – the specific rules governing expert evidence and behaviour – makes it crystal clear that:

- Expert evidence should be the independent product of the expert uninfluenced by the pressures of litigation and that the expert's overriding duty is to the court and that this overrides any duty to his or her client.
- Experts should assist the court by providing objective, unbiased opinions on matters within their expertise, and should not assume the role of an advocate
- Experts must consider all material facts including those which might detract from their opinions
- Experts must make it clear when a matter falls outside their sphere of expertise and/or they are unable to reach a definitive opinion
- Experts must make it clear immediately to the Court if they change their opinion on any material matter
- Experts must make it clear which of the facts relied on in a report are within the expert's own knowledge

## Examples of failings

The tragic case of *Z* v *(1) University Hospitals Plymouth NHS Trust, (2) RS (& Others)* (December 2020) related to a Claimant who had severe and irreversible brain damage following cardiac arrest in November 2020. Here, the expert concerned was woefully underprepared, failed to interrogate his sources or indeed consider the salient documents, and was, unsurprisingly in light of all these deficiencies, unreliable and inconsistent when giving oral evidence. The Judge, as a result, concluded that he "*did not think [he could] place any weight on [the expert's] evidence*" for the family.

In a case from earlier this year, Dana UK Axle Ltd v Freudenberg FST Gmbh [2021] EWHC 1413 (TCC) Joanna Smith J excluded, during the trial itself, the entirety of the defendant's technical expert evidence due to "the full and startling extent of the Experts' breaches of CPR 35".

The Judge was not only damning of the experts but of their legal team:

*"The establishment of a level playing field in cases involving experts requires careful oversight and control on the part of the lawyers instructing those experts; all the more so in cases involving experts from other jurisdictions who may not be familiar with the rules that apply in this jurisdiction. For reasons which have not been explained, there has been no such oversight or control over the experts in this case."*

This is therefore a reminder to all experts that your lawyers should be giving you appropriate guidance on your duties to the Court; if they do not then you should speak up. They should also be instructing you in a timely fashion, making you aware of relevant deadlines, providing you with all documentation rather than cherry picking and remaining objective in their instructions to you. Please challenge them if not and make it very clear if you feel remotely uncomfortable with any task you are being asked to perform.

## The Consequences of failure to adhere to rules

Few cases illustrate more aptly the severe consequences of failing to adhere to an expert's duties than *Liverpool Victoria Insurance v Khan* [2019] EWCA Civ 392, [2019] 1 WLR 3833, on appeal from [2018] EWHC2581. The case relates to a personal injury matter where the Claimant was involved in a road traffic accident in December 2011. The GP expert had a thriving private practice in medico-legal work, conducted at various locations. This practice involved frequent examination of claimants in low-value personal injury claims. He produced around 5,000 reports a year. He assessed the Claimant for a medico-legal report about ten weeks after the accident.

The Claimant informed his solicitor that he was unhappy with the prognosis set out in the report. At the request of the solicitor, the GP produced an amended report without further examining the Claimant, and apparently relying on notes which had been incorporated in the original report. The revised report bore the same date as the original and gave no indication that there had been a previous report or any revisions made. However, it differed very significantly.

Particularly pertinent for the readership of this article is the gravity placed by the Court on the fact that the GP expert had signed a statement of truth on the new report – which all experts are required to do upon completion of an expert report – verifying what in fact was a report containing untruths. The Court reminded us that: '*contempt of court involving a false statement verified by a statement of truth ... is always serious, because it undermines the administration of justice*'.

Crucially for this readership, the Court does not distinguish between intentional and reckless statements: experts will '*usually*' be 'almost as culpable' for making false statements '*recklessly*' as they would be for making statements '*intentionally*'.

## How to avoid making errors

Get the basics right

- A CV that accurately reflects experience and is neither over long nor out of date
- Prove your independence and that you have no theories or practices you are especially wedded to
- Ensure when you accept an instruction that you were in practice at the time in question
- Confirm that you have expertise/experience/qualifications in the relevant field; simply do not accept instructions which put you in difficulty because you are not well qualified or knowledgeable enough to deal with them. *Arksey v Cambridge University Hospitals NHS Foundation Trust* [2019] Is an excellent example of where an expert was caught out in this manner at the Oral evidence stage, which was found "unimpressive". The Judge opined that: "there was a failure on his part to address the questions that he was being asked: I had no doubt, that this was a deliberate ploy on his part to avoid answering the questions, rather than any kind of misunderstanding on his part as to what he was being asked, and the technique was adopted by him because of the difficulty he found himself in, in addressing the questions".

## Know the legal test

*Thimmaya v Lancashire NHSFT + Jamil (30 January 2020)*, illustrates the consequences where an expert is cross-examined and cannot explain the legal test in question – the Bolam test in this instance, in the

course of a clinical negligence matter. Very sadly, the expert in question's understanding was impaired by mental health issues that he was struggling with. As such, he should have ceased acceptance of medicolegal work, and it was ruled improper, unreasonable, negligent to have persisted. A third-party costs order was made for £88,000 in the Defendant's favour against the Claimant's expert.

## Ensure your report is top quality!

- Get dates/quotations right
- Be up-to-date
- Aim for balance in approach
- Defer to those in other fields where appropriate
- Sensible citation of literature
- Don't go overboard in volume of literature
- Be relevant
- Ask yourself "what are the key issues for the judge to decide in this case at trial?"

## Do not ignore key facts or issues

This entails:

- Taking a realistic approach to the facts of the claim
- Dealing with both/all versions of the facts;
- Not ignoring difficulties (e.g. in the medical records);
- Being very aware that the judge is the arbiter of fact;
- Not being railroaded by your opposite number;
- Having concrete examples/literature to back up viewpoint;
- Returning for further discussion another day if need be;
- Not being over the top or overly passionate or spirited in your arguments.

## Proper Joint Statement

- Consider taking the initiative in recording the discussions;
- Give detailed reasons for opinions expressed;
- Make concessions if appropriate (but explain your reasoning)

Finally, should you be one of the few to be privileged enough to attend a Trial then please ensure that you:

- Are a team player;
- Know the papers/issues/medical records;
- Know the literature;
- Listen properly to questions;
- Maintain equilibrium (especially with the judge);
- Work out what the judge wants/likes;
- Don't attempt to be an advocate.

## Expert Indemnity

It is crucial that you hold appropriate insurance in the event that you are brought into a complaint or claim.

Lockton offer comprehensive cover for those who do expert witness work. Lockton is one of the leading advisors on professional indemnity insurance. We have unparalleled knowledge of the coverage available under professional indemnity insurance policies, and strong relationships with a wide array of top professional indemnity providers. But our expertise does not stop with insurance. We make it our business to understand the specific risks and challenges inherent in your specific area of expert witness practice.

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Hopefully, from both your perspective and that of your clients, you will never face a claim, but if you do, it will give you significant peace of mind to know that you hold adequate indemnity.

**About the author:** Flora McCabe is Head of Advocacy and Risk Management in Lockton LLP's Healthcare Practice, in addition to expert witness cover, her team offer specialist indemnity cover for doctors, dentists and healthcare corporates including:

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Lockton LLP more widely offer indemnity across all sectors and practices.

# IT'S ALL GUNG-HO FROM HERE: QOCS IN LIGHT OF HO V ADELEKUN [2021] UKSC 43

**by Shoshana Mitchell,** Pupil Barrister, Normanton Chambers

There is little doubt that if you are a personal injury practitioner then you will have heard of the ground-breaking decision of *Ho v Adelekun* [2021] UKSC 43. This decision will have ramifications across the personal injury landscape. The Supreme Court held that the Court has no discretion to order costs set-off in qualified one-way costs shifting ("QOCS") cases.

This article goes back to the basics to address four key questions:

1. What is QOCS?
2. What is set-off?
3. What is this case about? and
4. What are the implications of this decision?

## What is QOCS?

Since April 2013, QOCS was introduced in Civil Procedure Rules (CPR) 44.13 to 44.17. Its implementation was to provide claimants with protection from defendants' costs in personal injury claims, claims under the Fatal Accidents Act 1976 and claims under s1(1) of the Law Reform (Miscellaneous Provisions) Act 1934 (Civil Procedure Rule 44.13).

QOCS ensures that any costs order made against a claimant is enforceable only up to the amount of any damages and interest recovered by the claimant. Therefore, an order for costs, such as an interim application or the failure to beat a Part 36 offer made by the defendant, can only be enforced up to the level of damages and interest awarded to the claimant. If the claimant is unsuccessful, then the defendant cannot enforce payment for their costs without permission from the court (CPR 44.14(1)).

There are a number of exceptions to the general rule:

1. The claimant discloses no reasonable grounds for bringing a claim (CPR 44.15(a));
2. The proceedings are an abuse of process (CPR 44.15(b));
3. The conduct of the claimant or someone acting on the claimant's behalf with the claimant's knowledge of such conduct is likely to obstruct the just disposal of proceedings (CPR 44.15(c)); and
4. A claim is found to be fundamentally dishonest (CPR 44.15(d)).

## What is set-off?

QOCS is distinct from set-off. CPR 44.12 provides that the Court may "set off the amount assessed against the amount the party is entitled to be paid and direct that party to pay any balance" where a party entitled to costs is also liable to pay costs. If a claimant owes the defendant £50,000 and the defendant owes the claimant £100,000, then the defendant can set-off the £50,000 against £100,000. This would result in the defendant paying £50,000 to the claimant.

Set-off and QOCS are important issues, particularly to defendants. If set-off is allowed, then defendants are able to enforce its costs order against the claimant's costs. Consider an example where QOCS is in operation; the defendant's costs order is £3,000 and a claimant's costs order is £6,000. The judgment sum is £2,000. Defendants can enforce the costs order in its favour against the claimant's damages and interest, without the need for permission. The defendant would be able to enforce £2,000 of its costs order against the claimant's damages. If set-off against the claimant's costs was allowed, then the defendant would only have to pay the claimant costs of £5,000. If set-off was not allowed, then the defendant would have to pay £6,000 to the claimant. Therefore, the defendant is better off in the sum of £1,000 if the court allowed set-off against the claimant's costs.

Can set-off be used in QOCS cases? The Court of Appeal in *Howe v Motor Insurance Bureau* (No 2) [2017] EWCA Civ 2523 (Howe) considered this question. It was necessary to interpret CPR 44.14(1), which states that:

*"Subject to rules 44.15 and 44.16 orders for costs made against a claimant may be enforced without the permission of the court, but only to the extent that the aggregate amount in money terms of such orders does not exceed the aggregate amount in money terms of any orders for damages and interest made in favour of the claimant".*

The Claimant contended that this rule precludes set-off of costs. However, the court disagreed. The Court decided it had jurisdiction in QOCS cases to order the set-off of the parties' respective costs entitlement. In this case, the Court exercised its discretion in favour of the Defendant by setting off the costs order in favour of the Defendant against the Claimant's costs order.

## The Facts of *Ho v Adelekun* [2021] UKSC 43

The Claimant, Ms Adelekun, issued proceedings relating to the injuries she sustained in a road traffic accident (RTA). The claim left the RTA Protocol as liability was not admitted. Ordinally, fixed costs would apply to claims that leave the RTA Protocol. The Claimant accepted a Part 36 offer, and the terms of settlement were set out in a Consent Order. One of the terms of the offer stated "costs to be subject to detailed assessment if not agreed". According to the Defendant, Ms Ho, the Claimant was entitled to no more than fixed costs which were estimated at about £14,500 to £16,000. The Claimant, in contrast, argued that she was not limited to fixed costs and claimed some £42,000 in costs. The Court of Appeal held that the Claimant was only entitled to fixed costs.

The case subsequently returned to the Court of Appeal to deal with the issue of QOCS. The Claimant contended that despite being ordered to pay the Defendant's costs, the order could not be enforced against her. As such, the Claimant submitted that the Defendant must pay her fixed costs of £16,700 and this should not be absorbed by the costs order of £48,600 she owes the Defendant. The Defendant contended that she should not pay the fixed recoverable costs of £16,700 to the Claimant as they should be set-off against the £48,600 costs that the Claimant owes her.

The Claimant sought to argue that the Court did not have the jurisdiction to award the set-off as QOCS is a self-contained provision. QOCS gives claimants protection from having to bear the defendant's costs, except in particular circumstances as under CPR 44.14. Whilst this submission was contrary to the Court of Appeal's decision in *Howe*, the Claimant contended that the decision was *per incurium* as the Court had overlooked an applicable principle. The Court of Appeal disagreed with the Claimant stating that "there is no reason to suppose that the Court decided *Howe* in ignorance of any relevant statute, CPR provision or previous decision of its own". On this basis, the Court of Appeal felt bound to follow *Howe*, which ultimately meant that the Court had the jurisdiction to direct costs set-off.

Permission to appeal was granted. On 6 October 2021, the Supreme Court handed down its unanimous decision which found in favour of the Claimant. The Supreme Court held that CPR 44.14 was ambiguous. However, the Supreme Court held that there was no jurisdiction to order set-off against costs. In reaching their decision, the Supreme Court considered the fact that:

1. Set-off of costs against damages required less assistance from the court than set-off against costs. The latter requires the court's discretion under CPR 44.12.
2. Cost orders are not mentioned at all in CPR 44.14.

Consequently, the Defendant must pay the Claimant's full pre-settlement costs of £16,700 and cannot enforce the Court of Appeal costs order against the Claimant.

## Implications of the Decision

The decision in *Ho* has caused a stir amongst practitioners. For claimant firms, this is no doubt a welcomed decision. It provides reassurance for claimant firms as claimant costs are now protected from any costs order in favour of the defendant. In particular, this clarification is helpful to claimant practitioners when considering whether to accept a defendant's Part 36 offer or not. In the words of Bolt Burdon Kemp, Adelekun's representatives, the decision protects claimant firms in the same position from "potential financial ruin".

Defendant firms are now in a more precarious position. Critics of the decision have suggested that claimant firms have been given the green light to make inflated costs claims, safe in the knowledge that even if defendant firm successfully resist them, then victory will be won at too great a cost to have been commercially successful. However, it is important to remember that this is a case where there was no court determination that the original claim was anything but honest. There will be instances where claimants seeking to inflate costs claims will not be protected as there are still safeguards, such as where the claimant's conduct obstruct the just disposal of proceedings and/or where the claim is an abuse of process.

For now, this decision sets a clear precedent for future cases. In this sense, it brings certainty to a previously murky area. However, this is not the end for QOCS and set-off. The Supreme Court made it clear that there is an ambiguity within the CPR and the judiciary are not in the best position to decide questions of construction. The Supreme Court highlighted that the Civil Procedure Rule Committee (CPRC) are better equipped to put right any ambiguities in the CPR. Therefore, the CPRC should amend the relevant rule if, in their view, the purpose of QOCS and the overriding objective is not upheld by the Supreme Court's decision.

If you would like to discuss any matters raised in this article, please contact me on shoshana.mitchell@normantonchambers.com



# CLINICAL NEGLIGENCE IN THE TIME OF CORONAVIRUS

**by Lionel Stride,** Barrister at Temple Garden Chambers, London
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Lionel has a High Court and multi-track practice specialising in personal injury, clinical negligence and health & safety with complementary expertise in aviation and product liability (particularly in the context of prosthetic and medical/surgical equipment failures, as well as aviation and light aircraft accidents), inquests, costs, insurance contracts and civil fraud.

With hindsight, one could argue that the Coronavirus Act 2020 s. 11 grimly foreshadowed the unique challenge that the Covid-19 pandemic would present to medical practitioners. In essence, this section grants the Secretary of State the power to provide indemnity coverage for the clinical negligence of health care workers and others carrying out NHS activities connected to the covid-19 pandemic; this is intended as a safety net for services that fall outside pre-existing indemnity arrangements. It seems to me that the draftsmen/women of the Act foresaw that a deluge of clinical negligence claims might arise from the pandemic and therefore made specific provision to protect medical practitioners; a point reinforced by s. 30, which removes the requirement that inquests be held into coronavirus deaths, as is mandated for other notifiable diseases.

Why is the Covid-19 context situation so susceptible to legal action for clinical negligence? Partly, because Covid-19 is a novel virus, and one which is highly infectious; but, perhaps more importantly, because the pandemic forces clinicians to make decisions under pressure and in conditions of scarcity. All things which make errors leading to litigation more likely. This article provides a brief overview of some material issues that may arise.

## Standard of Care

One of the most striking features of the health care system's response to the pandemic has been the drafting-in of final year medical/nursing students, as well as retired medical professionals, to bolster the ranks of front-line clinicians.

The most pressing question, from a legal perspective, is then what *standard of care* will be applicable to these recruits, whose training has either not been entirely completed or is potentially out-of-date. Will the Courts apply a lower standard of care to reflect the nature of the medical emergency and the inexperience (or lack of recent clinical experience) of some of these recruits?

The case of *FB v Princess Alexandra Hospital NHS Trust* (2017), which concerned the negligence of a junior doctor, suggests that the answer will be 'no': the fact that the clinician was inexperienced did not diminish the required standard of skill and care. The relevant standard is that of a reasonably competent practitioner working in the specific role in which the defendant is working at the material time – the experience or length of service of the doctor is not relevant to considering whether there has been a breach of duty.

What is less clear is how this principle will apply to the army of NHS volunteers called for by the Health Secretary. However, they are generally not holding themselves out as having specific medical experience (nor are they performing medical tasks). This issue is therefore likely to be of less pressing concern.

## Clinical Decision Making

Another key issue – from which negligence claims are bound to arise – is the consequence of the


pandemic on broader clinical decision making (its impact on non-virus infected patients). Put at its highest, the issue is this: by what metric should medical professionals prioritise one patient over another in circumstances where resources are stretched?

The National Institute for Health and Care Excellence ('NICE') produced guidelines – relating to patients requiring critical care, kidney dialysis and cancer treatment – which proposed that all patients admitted to hospital should be assessed as usual for frailty "*irrespective of Covid-19 status*". Therefore, a patient may bring a clinical negligence action on the basis that the treatment of their serious non-virus condition was unreasonably delayed on account of the pandemic.

Moreover (and this is perhaps a more likely scenario), even if an at-risk non-virus individual, such as a cancer patient, is treated, the responsible clinician will also need to consider the increased risk of their condition deteriorating through exposure to the virus due to a weakened immune system.

Consequently, the decision to treat a vulnerable patient who has later died from Coronavirus that is contracted during the period of his/her hospitalisation may also be criticised.

## Pope v NHS Commissioning Board (2015)

At this point, it may be helpful to work through a broadly comparable case law example: ***Pope v NHS Commissioning Board* (2015),** which considered clinical negligence in the context of swine-flu.

The facts of this case are as follows. The claimant felt unwell and believed that she had contracted swine-flu. She attended a health centre where she was seen by an experienced nurse who examined her and advised her to return home and rest. Two days later the claimant was admitted to A&E, where she suffered a cardiac arrest. She was resuscitated but had sustained brain damage which left her profoundly disabled. Investigations revealed that she had swine-flu complicated by pneumonia. The patient subsequently brought an action against the NHS for clinical negligence.

The Court ruled that there had been a breach of duty and that this was causative of the claimant's brain damage: under national guidance, any flu-like illness was to be managed as swine flu; had the treating nurse done so, she would have measured the patient's blood saturation levels, found these to be low and referred and admitted her to hospital; had the patient been admitted, she would have been treated appropriately for swine flu and would have avoided the cardiac arrest.

What can we learn from this judgment? Whilst every case turns on its own facts, the essential principle in *Pope* is that even in times of unprecedented health crises the Courts approach the issue of alleged clinical negligence as they always do; by examining the state of knowledge of the medical profession at the material times and asking whether a reasonable body of professionals would have acted in the same way. That said, the extent of any strain on resources and potentially more limited ability to perform some types of emergency care will undoubtedly impact on this analysis. I would therefore expect 'pandemic's strain on resources' to be a defence that is commonly deployed. To be successful, however, cogent evidence of the particular impact on a given hospital department will be needed. It is unlikely that a general complaint about lack of resources will suffice.

Reference:

[1] https://www.legislation.gov.uk/ukpga/2020/7/section/11/2020-04-02



# RESOLVING NHS CLAIMS THROUGH DISPUTE RESOLUTION

**By Julienne Vernon, Head of Dispute Resolution and Quality at NHS Resolution**

In this article Julienne Vernon, Head of Dispute Resolution and Quality at NHS Resolution, shares the organisation's innovative approach to dispute resolution.

NHS Resolution[1] (formally known as the NHS Litigation Authority) is an arm's length body of the Department of Health and Social Care. Our primary function is to administer indemnity schemes for clinical negligence and other liabilities for the NHS in England and to manage the associated compensation claims, share learning and improvement, and preserve financial resources for patient care.

In 2020/21, NHS Resolution paid £2.7163 billion in compensation and associated legal costs. £464.4 million of that figure accounted for claimant legal costs and £157.3 million for NHS legal costs. The vast majority of claims are resolved without the commencement of formal court proceedings and less than 1% of claims are taken to trial. In 2020/21 we settled 15,674 clinical and non-clinical claims of which 74.7% were settled without the need for formal court proceedings.

By the publication of successive business plans, NHS Resolution, has openly communicated and reaffirmed its philosophy and approach to claims management to patients, claimants and their lawyers, healthcare providers and other stakeholder groups. ***"We believe that resolution of disputes in healthcare can be achieved in a way that facilitates a relationship of trust between the parties, is aligned to the principles of a just and learning culture and preserves vital resources for patient care."***[2]

We are committed to the delivery of fair, efficient and costs effective resolution by exploring all forms of dispute resolution in order to reduce the number of claims falling into formal court proceedings, thereby keeping patients, claimants and NHS staff out of court.

We are therefore actively testing a wide range of creative dispute resolution techniques and working in collaboration with claimant lawyers with the aim *"... to ensure that we systematically deploy the right intervention on the right case at the right time to avoid unnecessary cost."*[3] The interventions deployed include, formal written offers, early exchange of expert evidence, telephone discussions, lawyers' meetings, mediation, global resolution meetings, and alternative dispute resolution project initiatives.

Our experience of mediation, global resolution meetings and stock-take meetings are explored in this article.

## Mediation

NHS Resolution appreciates that going to court is financially and emotionally costly and can be very daunting for claimants their families and for NHS staff.

In December 2016 NHS Resolution took the ground-breaking step of launching a bespoke claims mediation service which is designed to support patients, families and NHS staff in working together towards the resolution of incidents, legal claims and costs disputes, and to avoid the need, expense, and potential emotional stress of going to court.

Following the re-procurement of the service in May 2020 the mediation service providers are the Centre for Effective Dispute Resolution (CEDR)[4] and Trust Mediation Limited[5] appointed

to mediate disputes arising from personal injury and clinical negligence incidents and claims; and St. John's Buildings Limited[6] and Costs-ADR[7] to mediate disputes arising from the recoverability of legal costs.

NHS Resolution will fund the cost of the mediator's fee and expenses in all cases where the claimant is unrepresented and where liability is admitted in whole or in part. In all other cases and in all costs mediations the mediator's fees are shared equally by the parties.

Since the inception of the service over 1,400 claims have been mediated. Year-on-year the volume of the claims mediated increased until the pandemic year of 2020/21. In 2019/20 427 cases proceeded to mediation and 81% of the mediated cases settled on the mediation day or within 28 days of the mediation (up 7% on 2018/19). In 2020/21, understandably as a consequence of the pandemic there was a reduction in the volume of claims mediated and 299 cases proceeded to mediation. However, the settlement rate remained high with 77% of the cases settling on the mediation day or within 28 days of the mediation.

We have carried out an evaluation of the mediation service in order to understand the efficacy of mediation as a resolution tool and its benefits, and the findings were published in a report in February 2020, "**Mediation in healthcare claims – an evaluation**"[8], which demonstrated:

- Mediation is proven to be an effective forum for claims resolution by providing injured patients and their families with the opportunity to receive face-to-face explanations and apologies.
- Time can be spent listening and responding to the particular concerns of a patient and their family.
- The process provides a platform to claimants, patients and their families to articulate concerns that would not ordinarily be addressed in other forms of dispute resolution.
- The forum also provides benefits to clinicians, allowing them to bring closure to historical concerns. The evaluation also demonstrated that claims are more likely to settle if a clinician is present.

Despite the challenges of the pandemic, the continuity of the service has been maintained by online platforms such as MS Teams and Zoom. This has not diminished the opportunities for engagement with claimants and the delivery of direct apologies. Online mediation has proven to be very successful and it is likely this format will remain popular. The feedback received from mediators and claimant lawyers is that online mediations are less daunting for claimants who are more comfortable in their home environment. NHS healthcare providers find that the online model provides flexibility for clinicians with limited time for attending such meetings.

## Resolution Meetings (Global Settlement Meetings)

Greater collaboration with claimant law firms during the pandemic has provided us with an opportunity to increase the volume of our resolution meetings with claimant law firms. These meetings were introduced with the intention of bringing about swift settlements by direct face-to-face negotiations.

The process involves NHS Resolution and/or a nominated legal panel lawyer agreeing a list of claims for discussion with a particular claimant law firm and scheduling the 'resolution' meeting to discuss each claim. The meetings allow the parties to discuss claims that have either stalled or are about to enter proceedings. There is also the opportunity to settle multiple claims in one event in the absence of which the parties may have been required to arrange individual joint settlement meetings.

The meetings have facilitated the building of strong working relationships and we have received positive feedback from the claimant law firms involved, in addition the life cycle for settled claims are significantly reduced, thereby curtailing the escalation of legal costs. Following the pandemic these meetings are also successfully conducted online.

## Stock-take meetings

This is another creative approach we have adopted to promote claims resolution. The stock-take process involves scheduling formal meetings with claimant lawyers at fixed stages during a claim, such as following service of the Letter of Response and prior to the service of formal court proceedings. At these fixed stages, the parties can identify the risks with their respective claims and avoid the issue of court proceedings if possible.

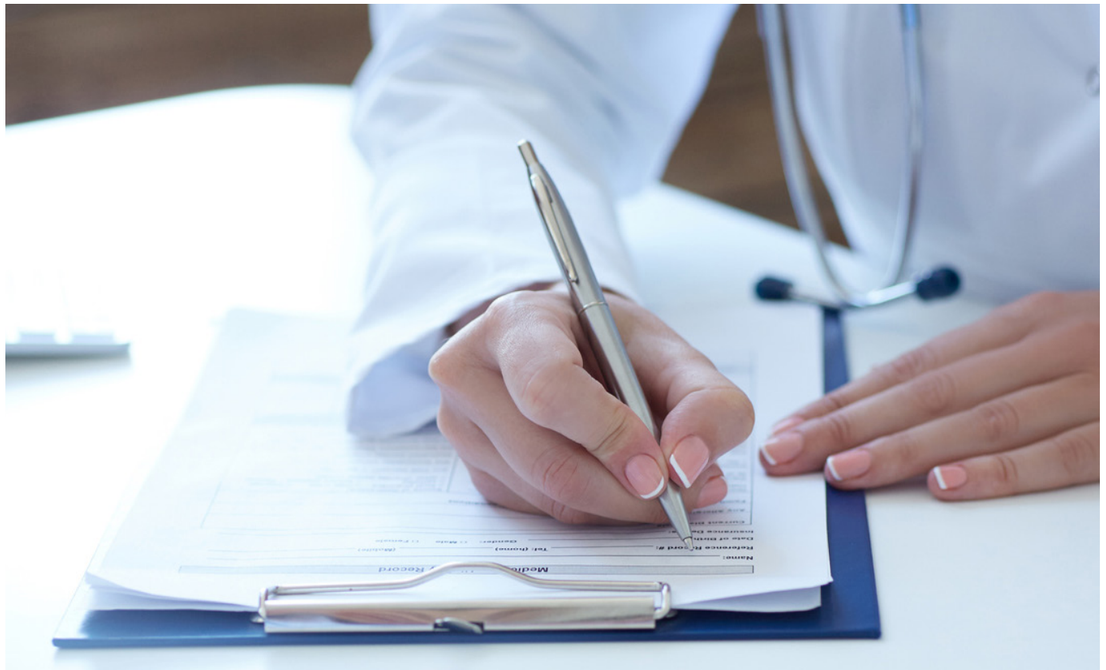
This is a relatively new process and we have been encouraged by the active engagement from the claimant law firms involved and their feedback that this process can be expanded further.

## Summary

NHS Resolution has demonstrated by promotion of a variety of dispute resolution techniques, the establishment of a bespoke claims mediation service and collaborative working with claimant lawyers in a number of projects, that it is driving change and innovation in the deployment of dispute resolution. We will continue to seek out, test and evaluate, new and exciting interventions which will deliver fair, efficient and costs effective resolution and also achieve learning from the incident.

If you are interested in becoming a Civil Mediation Council Accredited Mediator, then have a look at the Mediation courses available on the SpecialistInfo training page: **www.specialistinfo.com/a_ml_mediation.php**

References:
[1] https://resolution.nhs.uk/
[2] NHS Resolution Business Plan 2021/22
[3] NHS Resolution Business Plan 2021/22
[4] www.cedr.com/solve/services/?p=33
[5] https://www.trustmediation.org.uk/nhs-resolution/
[6] https://stjohnsbuildings.com/nhs-resolution-mediation-service
[7] http://www.costs-adr.com/nhs-resolution-mediation-service
[8] https://resolution.nhs.uk/2020/02/12/mediation-in-healthcare-claims-an-evaluation



# AN INTRODUCTION TO GP AND OTHER PRIMARY CARE CLAIMS

**by Amy Perry,** Senior Associate, Clyde & Co LLP Email: Amy.Perry@clydeco.com

## What are GP and Primary Care claims?

The predominant focus of these types of claim tends to involve care provided by General Practitioners. However, they can also involve nursing staff, health care assistants, admin staff and receptionists.

## What legal principles apply?

The same legal principles apply to GP and Primary Care claims as any other clinical negligence claim; namely, breach of a duty of care and causation. A Claimant will need to establish both, as well as their entitlement to damages, to succeed with a claim. By way of brief reminder;

Breach of duty – when a duty of care is owed and the care provided would be considered reasonable by a responsible body of other individuals of comparable experience (the *Bolam* test), and

Causation – whether, if there was a breach of duty, this caused or materially contributed to the individual suffering an injury (the "but for" test).

## How are individuals involved in these types of claims?

As to the capacity that a GP, or indeed, any other individual working in Primary Care can be involved in a claim is either in respect of their individual care, or, as a Partner of the Practice.



When an individual is involved in respect of their own action or inaction, this is fairly straightforward. However, the role of the Partnership can be more complex.

The Partnership (by its Partners) is responsible for the systems and polices in place. The Partnership is also responsible (vicariously liable) for the actions of their employees that did not, or were not required to, have their own separate indemnity, or in situations where the individual involved could not be traced/would not engage.

There are also situations where someone can be involved in both capacities; for example, a GP, who was also a Partner, may have made the decision to commence a Claimant on a particular inappropriate medication. However, due to failures with the systems in place at the time, that medication is repeatedly prescribed over months or years without proper review. The GP would be responsible for their own individual care in respect of the decision to prescribe but would also be partly responsible, along with any other Partners, for the failures that allowed it to be repeatedly prescribed unchecked.

## How does GP and Primary Care indemnity work?

Prior to 2019, these types of cases have predominantly been the responsibility of the Medical Defence Organisations (namely, the MDDUS, MPS and MDU). GPs and other clinical staff in a Primary Care setting required their own indemnity in respect of the care they provided, and the care provided by others, if they are a Partner. This is something they would need to arrange themselves and would renew every year, with an associated premium.

However, following the introduction of the State Backed Indemnity Scheme, in cases which relate to care provided after April 2019, the responsibility for these cases is increasingly shifting to NHS Resolution and NHS Wales who have historically been responsible for the care provided in Secondary Care services (namely, NHS Trusts).

We also have, for the time being, the Existing Liabilities Scheme. As a result of agreements with the MDDUS and MPS, NHS Resolution and NHS Wales have assumed the responsibility of GP and Primary care cases relating to care provided prior to 2019.

## Nuances of GP and Primary Care claims

Although the same legal principles apply to GPs, there are some particular nuances to this type of work:

1. The role of the Defendant; the individual who provided the care being criticised will most likely be named in the proceedings, often resulting in the Defendant understandably taking a more active interest in the claim. From a Claimant's perspective, they will often still be receiving treatment at the Practice and may have an established relationship with the staff or the Defendant they are suing, which it is important to be mindful of and manage appropriately;
2. The types of care provided; GPs and other Primary Care clinicians often act as gatekeepers for Secondary Care, and it is common for at least one allegation, if not the entire case, to relate to a failure to refer. This is less common as an allegation in cases involving Secondary Care;
3. Types of medical conditions involved; the most common types of injury are delay in diagnosis of cancer and failure to diagnose other acute conditions such as heart attacks.. However, there are some conditions which are incredibly rare in practice; we see a disproportionate number of claims relating to these injuries because they are potentially life altering and, hence, more expensive and more likely to result in a claim being brought. An example of this would be Cauda Equina Syndrome;
4. Co-Defendants; it very common for cases involving GPs and Primary Care to involve co-Defendants, and sometimes, this can be a very lengthy list including other GPs, nurses, and potentially, Trusts. Whilst the issues

relating to management of cases involving co-Defendants will begin to ease as the State Backed Indemnity Scheme progresses, for now, parties try to work together in a constructive manner;

5. The appropriate experts instructed; whilst this might seem straightforward, it is increasingly common for GPs to have a specialist interest in a particular area of medicine, such as dermatology or diabetes. These clinicians will have, as the name suggests, a more specialist knowledge in that particular area and will be held to a higher standard than GPs without a specialist interest. This can present challenges in respect of the types of experts instructed on breach of duty. It would always be preferable to instruct a GP expert with the same specialist interest, but if this is not possible, a general GP and a specialist (such as those often instructed in respect of causation), may be required;
6. Importance of factual evidence; Clinicians in Primary Care will often only have a very limited timeframe in which to consult with the patient, examine if necessary, decide on a treatment plan and make a note. As can be expected, it is difficult to include significant detail in the notes so, often, these are fairly brief with the use of shorthand. If the notes cannot be relied on as a complete picture of what occurred, the factual evidence of the parties will be paramount to supplement this. Often with Primary Care Defendants, who may see many patients in one day, they cannot specifically recall the Claimant (particularly if significant time has passed). It is, therefore, important to establish standard practices early on.

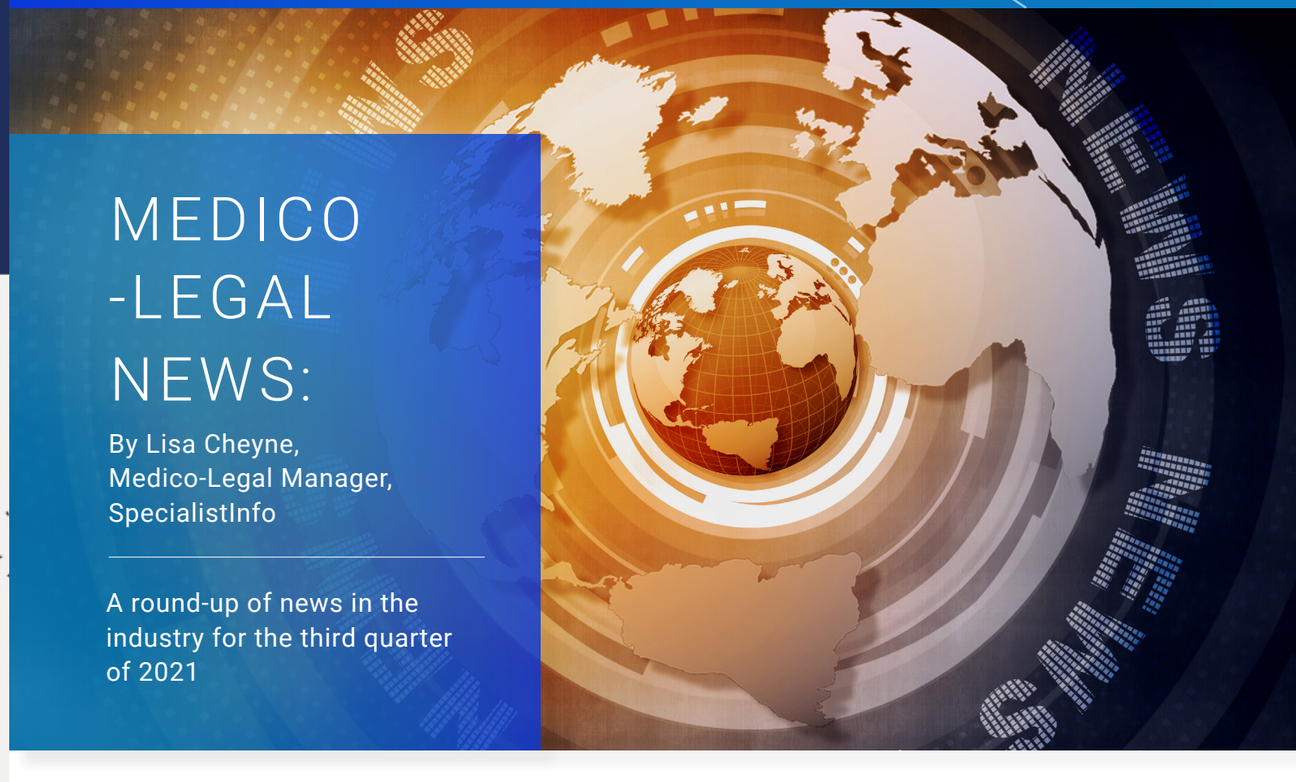
## Emerging trends in Primary Care claims

Traditionally, claims relating to Primary Care would involve GPs or nursing staff. However, as Practices expand to accommodate a growing number of patients, and adapt to the requirement to streamline services, delegation of certain responsibilities to non-clinically trained members of staff has increased. This presents new challenges and raises questions as to the expectations placed on, for example, receptionists and admin staff.

Furthermore, with the increased rollout of telephone or video triage to ensure that patients are seen by the appropriate care provider, there has been a steady increase in claims relating to incorrect streaming and/or failure to identify concerning symptoms which would have been elicited with a face to face consultation first. Linked with this is the increased use of video consultations; previously favoured for convenience and more recently, a necessity during the covid 19 pandemic.

Additionally, as the general public become better informed and more aware of the rights and responsibilities they are owed by Primary Care providers, claims relating to other issues outside of the conventional clinical negligence claims are becoming more frequent, such as claims under the Data Protection Act 2018 and GDPR, and the Equality Act 2010. These claims highlight the importance of not only providing appropriate clinical care, but also ensuring that patients' sensitive data is stored and processed appropriately, and that reasonable provision is made for all, irrespective of any disability or personal characteristic (as defined by statute), or additional needs they may have.

Finally, as with all sectors, the recent covid 19 pandemic has had a significant impact across the NHS as a whole. Not only is it likely that we will see an increase in claims relating to delays arising from restricted access to routine Secondary Care services following the need to strictly prioritise, streamline and redeploy, we anticipate and are starting to see claims relating to failure to diagnose covid 19 and/or symptoms associated with long covid and other residual injuries associated with the virus including mental health. As a result of the pandemic, we expect to see an increase of delay in diagnosis claims, in particular, delay in diagnosis of cancer.



# MEDICO -LEGAL NEWS:

By Lisa Cheyne,
Medico-Legal Manager,
SpecialistInfo

A round-up of news in the industry for the third quarter of 2021

NEWS

## Government Consults on the Next Steps to Address the Costs of Clinical Negligence

MPs have urged the government to end any adversarial element of the clinical negligence system, by awarding compensation for maternity cases based on whether an incident was avoidable rather than a requirement to prove negligence.

Parliamentary Health and Social Care Committee chair and former health secretary, Jeremy Hunt, recalled how he would regularly sign off a multi-million pound payment to a family whose child was disabled for life through a medical error. This has reached the 'obscene situation' where the £2.4bn cost of negligence is now higher than the cost of every doctor and nurse working in maternity units in England.

According to Hunt, "We need a system where people are entitled to compensation as soon as it is accepted that a mistake was made"

"Under the law, the only way to get that compensation is if a court agrees that there was clinical negligence."

"Quite understandably, parents will fight to get that compensation and, also understandably, the doctors, nurses and midwives become defensive if they are accused of clinical negligence. It does not have to be that way. We need a system where people are entitled to compensation as soon as it is accepted that a mistake was made without the necessity to prove clinical negligence."

The government will also consult on an element of fixed recoverable costs for lower-value claims.

Read more: https://committees.parliament.uk/work/1518/nhs-litigation-reform/

## Tavistock Clinic Ruling on Consent in Children Seeking Puberty Blockers for Gender Dysphoria

The Court of Appeal has now heard and handed down judgment in Bell v Tavistock [2021] EWCA Civ 1363, overturning the legality of the findings of the High Court in 2020.

In the original case, two individuals brought judicial review proceedings against the NHS Trust responsible for GIDS, England's Gender Identity Development Service. The claimants challenged Tavistock's practice of prescribing puberty blockers to under-18s with gender dysphoria, and sought a declaration that Tavistock's practice was unlawful in the absence of an order from the Court determining that the treatment was in the child's best interest.

The High Court approached the judicial review by asking two questions:

1. Are children and young people capable of giving informed consent to the puberty blocking treatment as a matter of law? The law on informed consent was not disputed: that for children (under 16) the test of Gillick competence applied, and that for young people (16 to 17) there was a statutory presumption of capacity (s8 FLRA 1969).
2. If so, does the Defendant's service provide them with sufficient information about the treatment and its consequences, such that they are able to give informed consent in practice?

The court made a declaration that, in order to have Gillick competence, a child had to understand, weigh and retain eight specific pieces of information, which it set out, and that a child under 16 was very unlikely to be able to do this. That was the full extent of the declaration that was made; the remainder of the High Court's findings stood as guidance only.

The Court of Appeal recognised the difficulties and complexities associated with the question of whether under 18s were competent to consent to the prescription of puberty blockers, but it was for clinicians to exercise their judgment knowing how important it was for the patient's consent to be properly obtained according to the particular individual circumstances. Clinicians would be alive to the possibility of regulatory or civil action which allows the issue of whether consent has been properly obtained to be tested in individual cases.

Read more: https://www.judiciary.uk/wp-content/uploads/2021/09/Bell-v-Tavistock-summary-170921.pdf

## UK Health Security Agency Launches

The UK Health Security Agency (UKHSA) became operational on 1 October, taking over both the health protection functions of Public Health England and all activities of NHS Test and Trace.

Chief Executive, Dr Jenny Harries, said, "The creation of UKHSA has meant reimagining the country's health security defences and how we can keep people safe and save lives.

"Transforming the public health system is about ensuring we meet current health protection challenges, but it is also about protecting us from those yet to come".

She concluded, "The UKHSA will work to do just that. We will build a standing capacity to prepare for, prevent and respond to all threats to health, including future pandemics and infectious diseases, as well as chemical, biological, radiological, nuclear and environmental hazards".

Read more: https://www.gov.uk/government/news/uk-health-security-agency-launches-with-a-relentless-focus-on-keeping-the-nation-safe




## The Medico-Legal Conference is going ahead in London next year on 28th June 2022.

After being highly rated by delegate feedback at the 2021 conference, Alexander Hutton QC, Hailsham Chambers, has agreed to be Keynote Speaker for the 2022 conference.

Several other speakers have now been confirmed – please visit the conference website below for more details and to secure an early-bird ticket for 2022: http://www.medicolegalconference.com/

Please contact craig.kelly@iconicmediasolutions.co.uk for further information if you are interested in sponsoring the programme or hosting a stand at the event next year in London on 28th June 2022.

NEWS
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## Holiday Sickness Claimant loses in Court of Appeal despite defendant offering no evidence

The court heard that claimant Peter Griffiths brought a claim worth £29,000 after suffering gastric illness resulting in hospitalisation, while on an all-inclusive holiday in Turkey. *Griffiths v Tui* was lost in the county court, but Griffiths' appeal was upheld by Mr Justice Martin Spencer in the High Court.

The Court of Appeal found in favour of the defendant, Tui, by a 2 to 1 majority. Tui offered no evidence to support their case and did not cross-examine the claimant's instructed expert. The ruling on uncontroverted evidence (i.e. not disputed at the time) in Griffiths v Tui will be worrying for personal injury firms with hundreds of holiday sickness claims waiting on this result.

The trial judge, Her Honour Judge Truman, said the expert's report was 'minimalist' and it did not satisfy the requirements set out in Wood v TUI, ruling that the fact Griffiths had been ill was not by itself sufficient for his claim to succeed.

In her judgment, Asplin LJ said 'the report was insufficient to satisfy the burden of proof in relation to causation which fell upon Mr Griffiths because of its deficiencies.'

In his dissenting judgment, Bean LJ said Griffiths did not have a fair trial of his claim and he would have dismissed TUI's appeal.

He added: 'Mr Griffiths must be wondering what he did wrong. He instructed a leading firm of personal injury solicitors, who in turn instructed an eminent microbiologist whose integrity has not been questioned.

'Mr Griffiths and his wife gave evidence at the trial, were cross-examined, and were found by the judge to be entirely honest witnesses. The eminent expert gave his opinion that on the balance of probabilities Mr Griffiths' illness was caused by the consumption of contaminated food or fluid supplied by the hotel. No contrary evidence was disclosed or called, and the expert was not cross-examined. Yet the claimant lost his case.'

Irwin Mitchell, representing the claimant are seeking permission to appeal to the Supreme Court.

Read more: https://www.lawgazette.co.uk/news/claimant-loses-in-court-of-appeal-despite-defendant-offering-no-evidence/5110096.article

## The BMA has Moved to A Neutral Position on Assisted Dying

The BMA adopted a neutral position on PAD (physician-assisted dying) at the annual meeting in September 2021, ending 15 years of opposition to proposed legislation. The following statement was released by the BMA:

"We represent doctors and medical students who, like the wider public, hold a wide range of views on physician-assisted dying.

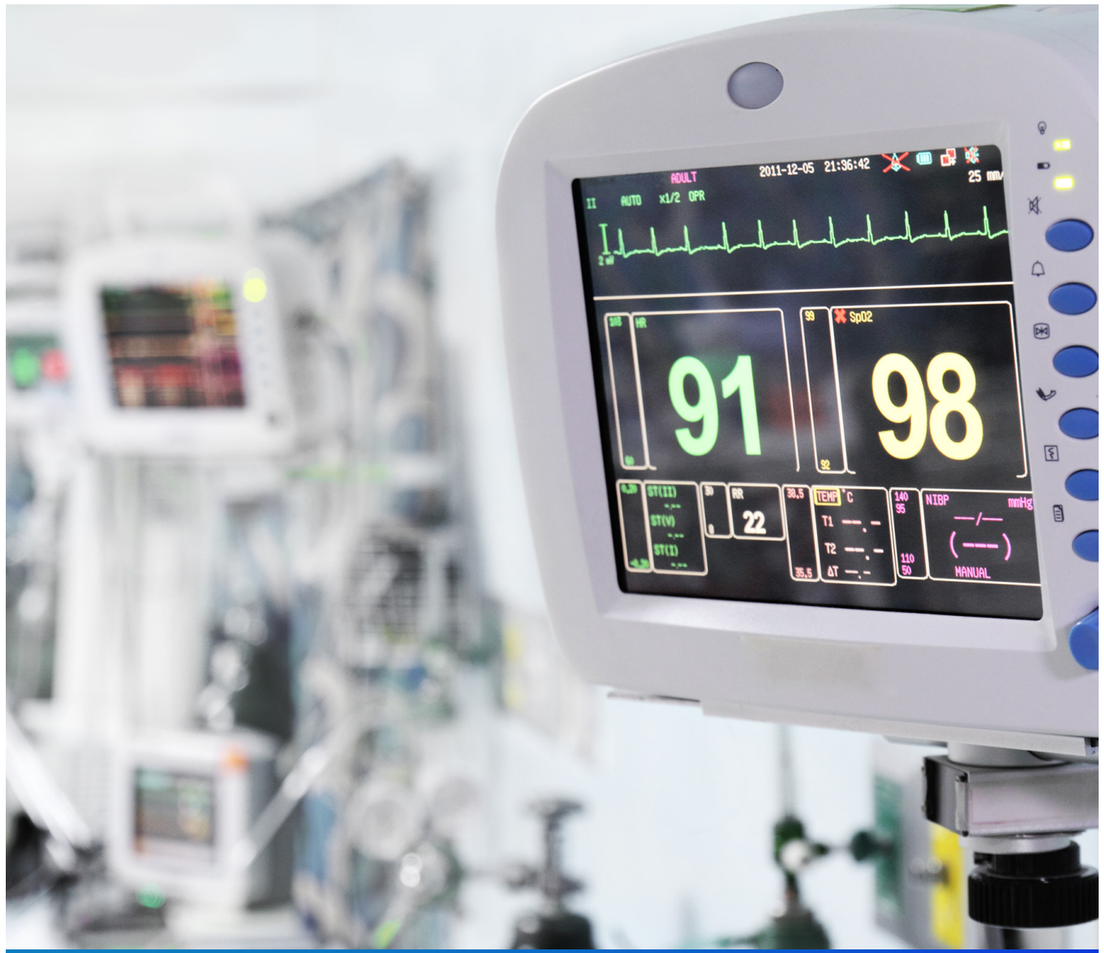
On 14 September 2021 our policy-making body (the representative body) voted in favour of a motion changing the BMA's policy from opposition to a change in the law on assisted dying, to a position of neutrality.

This means we will neither support nor oppose attempts to change the law. We will not be silent on this issue, however. We have a responsibility to represent our members' interests and concerns in any future legislative proposals and will continue to engage with our members to determine their views.

The debate at our annual meeting was informed by the results of a survey of our members in 2020. This survey was not a policy-making exercise but was one of a number of factors that representatives took into account when making their decision.

Representatives also reiterated their call for robust protection for conscientious objection should the law change in the future".

Read more: https://www.bma.org.uk/advice-and-support/ethics/end-of-life/physician-assisted-dying




## MHRA launches public consultation on future of medical device regulation

The Medicines and Healthcare products Regulatory Agency (MHRA), launched a 10-week public consultation on 16th September on changes to how medical devices will be regulated across the UK.

Medical devices in the UK are currently regulated under the Medical Devices Regulations 2002. Following the UK's departure from the European Union, the MHRA now has the opportunity to create a world-leading regime that prioritises patient safety while fostering innovation, including streamlining the approval of medical devices.

The MHRA is the regulator for medical devices used in the UK. We are seeking views from across the medical devices and healthcare sectors, medical practitioners, patients and the wider public, to inform our future approach. We would like to hear from those who research, manufacture, supply and use medical devices.

The consultation will close at 11.45pm on 25 November 2021.

Read more: https://www.surveys.mhra.gov.uk/613cff3142a2b02700706bad

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