**AMPERSAND MEDICAL NEGLIGENCE CONFERENCE**

 **17 June 2019**

**“Procedural issues in clinical negligence litigation”, by Euan Mackenzie Q.C.**

**Introduction**

1. Introduction
* My talk is a high level overview that seeks to stimulate thought and discussion rather than setting out the procedure in detail and/or providing all of the answers!

**Structure**

1. Structure of talk
* Overview
* Look at three procedural issues in particular:
	+ witness statements
	+ expert witnesses, and
	+ a recent change in the rules requiring advance sanction for the instruction of experts and, in the Sheriff Court, for the instruction of Counsel
* (If time, will look at some other, miscellaneous, issues)
* Conclude by suggesting ways in which we can feed our experiences, and areas where we think there is room for improvement, back into the decision making process.

**Overview**

1. Overview
* Case management of more complex PI actions:
	+ RCS 42A & Practice Note No 6 of 2017
	+ Sheriff Court – chapter 36A of the Ordinary Cause Rules
	+ [NB Sheriffdom of Lothian and Borders, PN 3/2016, Personal Injury Actions – covers chapter 36 of OCR. Is there a comprehensive Practice Note for chapter 36A actions in ASPIC? If not, should there be?]
* **Aim** – to secure the efficient determination of the action (impliedly, in a way that does justice between the parties)
* For that aim to be achieved requires:
	+ Proactive preparation throughout (i.e. “frontloading” of actions)
	+ Early disclosure of evidence
	+ Most importantly, a focus at all stages on agreeing what can be agreed and narrowing the issues in dispute (i.e. the aim is to have short, focussed, proofs – in everyone’s interest)
	+ A measure of pragmatism, cooperation and goodwill on all sides (including the court)

**Witness statements**

1. Witness statements
* Treating clinicians
	+ Experts require an accurate and complete understanding of the facts on which to base their opinions
	+ The courts recognise that the entries in the medical records may not be a complete record of events (*McConnell v Ayrshire and Arran Health Board*, 2001 Rep LR 85; Lord Reed, paras [25] to [28])
	+ In clinical negligence actions, a factual statement is, therefore, desirable from the treating clinicians
* Form of statement?
	+ Factual report, statement, precognition or written Q&A?
	+ The practice has varied over the years; not sure if there is currently a settled or uniform practice
	+ If an inconsistency at proof, can put a prior report, statement (or written Q&A?) to a witness (but not a precognition)
* Where possible, statements should be exchanged before the By Order (Adjustment) Roll hearing (PN 6/2017, para 8)
* What if a treating clinician refuses?
	+ GMC guidance on Good Medical Practice (Para 55, must be open and honest with patients if things go wrong; if a patient under your care has suffered harm or distress, you should … explain fully and promptly what has happened. Para 61, you must respond promptly, fully and honestly to complaints. Para 72 (Openness and legal or disciplinary proceedings), you must be honest and trustworthy when giving evidence to courts or tribunals; you must make sure that any evidence you give or documents you sign are not false or misleading. Para 73, you must cooperate with formal inquiries and complaints procedures and must offer all relevant information)
	+ Expenses implications
* Does court have the power to compel a witness to provide a statement or precognition?
	+ *Henderson v Thomson*, 1911 SC 246 (cited in McPhail, Sheriff Court Practice, para 15.08, as authority for the proposition that: “The court will not order a witness to submit to a precognition”)
	+ In *Henderson*, the P sought an order for the D to disclose the names and addresses of witnesses and to allow her reasonable facilities to precognose them – the 1st Division refused, with the LP stating: “though for reasons of public policy the Courts can and will compel persons invitos to give testimony, they have never asserted, or tried to exercise, that power as regards giving precognitions. I have never heard of a compulsory order in a civil case to submit to precognition” (p249)
	+ Is this case still good law? If so, does it require to be reconsidered in light of modern case management practice?
* Can/should a commission be arranged to take the evidence of a treating clinician who refuses to provide a statement?
* Does the court have the power to compel a party to disclose a statement or precognition in its possession?
	+ *Post litem motam* privilege (i.e. documents prepared for or in anticipation of litigation)
	+ c.f. *Komori v Tayside Health Board*, 2010 SLT 387 – documents prepared in response to a complaint made to the Scottish Public Sector Ombudsman before proceedings were raised (and before the P had consulted a solicitor) were recoverable
* Commercial Court
	+ NB Guidance Note by the commercial judges on the use of signed witness statements or affidavits (Scotcourts website)
	+ Statements should not be “carefully edited” and “the court derives the most benefit from statements which carry the author’s authentic ‘voice’” (Lord Woolman, *SSE Generation Ltd v Hochtieff Solutions AG,* [2016] CSOH 177, para [256])
	+ NB in general, a greater use of signed witness statements or affidavits in commercial actions including, e.g. the court may direct that witness statements or affidavits shall stand as evidence in chief of the witness, subject to such further questioning in chief as the court may allow (RCS 47.12)
* **Conclusion/query**
	+ While the procedure (largely) works with the cooperation of parties and witnesses, that is not always the case
	+ Query whether this is an area that requires further consideration and guidance to achieve greater consistency?

**Expert witnesses**

1. Expert Witnesses
* Aim - to make sure that one’s expert is as prepared as possible in order that their opinion will stand up to scrutiny at the proof (and/or at the joint meeting between the experts)
* Open Record consultation
	+ Check expertise (get full CV)
	+ Check expert understands duties of expert witness (*Kennedy v Cordia (Services) LLP*, [2016] UKSC 6, per Lords Reed and Hodge, para [52], quoting with approval the summary by Cresswell J in The Ikarian Reefer)
	+ Check expert has taken into account all relevant (and up to date) information and medical records (including imaging)
	+ Check that you understand the expert’s opinion and, importantly, the reasons for their opinion
	+ Check expert’s response to other side’s position (on Record, if reports not yet exchanged)
	+ Supporting literature?
	+ May require to ask expert to consider revising their report before report is intimated (e.g. if did not have a complete and accurate understanding of the facts, if applied the wrong legal test etc), but wording of report/opinion is, of course, entirely a matter for the expert (as they will have to defend their opinion at the proof)
* Closed Record consultation
	+ May require to consult with expert again when the other side’s expert reports are available, after closure of the Record. What points do they agree with, what points do they disagree with and what are their reasons for any areas of disagreement? Why should your expert be preferred? Literature that helps resolve any dispute?
	+ May wish a supplementary report or letter commenting on the other side’s expert report(s)
* If it has been a long time since last consulted with expert may wish to consult with expert again before any joint meeting of experts
	+ To consider any developments/additional information since you last consulted and to refresh consideration of their opinion, the reasons for the opinion, any supporting literature and, importantly, the other side’s expert report(s)
	+ Consider (a) sending note of consultation to expert (to remind them of the views they expressed at consultation) and (b) asking for a short letter summarising their views on the key points in the case (may reflect the items in the agenda)
* Joint meeting of experts
	+ Aim – to agree and narrow the issues
	+ Pros and cons (lawyers lose control but (1) can try and ensure expert is as prepared for the meeting as possible (see above), (2) if a concession is going to be made, better to know in advance of proof and (3) should help in narrowing the issues in dispute/shortening the proof)
	+ Agenda (suggest short; not overly prescriptive; open rather than closed questions; give experts room to have a genuine discussion about the case) [possible style attached – no one style fits all, at least where the specific questions are concerned]
	+ Should also seek to agree relevant literature (suggest that consideration also be given to seeking to agree literature/diagrams etc that provide the decision maker with an introductory “mini-tutorial” on the relevant anatomy, condition/disease, treatment, main medical terms etc)
	+ Agree discussion between experts to be in confidence and not to be referred to at the proof, but that experts will produce a joint note, statement or report setting out the matters on which they agree and the matters on which they disagree (including their reasons for disagreement)
	+ Agenda prepared by which party? A draft prepared by pursuer and then subject to adjustment and agreement with the defender? What if parties can’t agree? Require two sets of questions for experts?
* English guidance on agendas for joint meetings of experts[[1]](#footnote-1)
	+ Civil Procedure Rules, Part 35 (Experts and Assessors): joint meeting of experts not mandatory, is at the discretion of the court; the court may direct that, following their discussion, the experts prepare a statement setting out those issues on which “they agree, and they disagree, with a summary of their reasons for disagreeing”; the content of the discussion cannot be referred to at the trial unless parties agree; the parties are not bound by any agreement that parties reach (unless parties agree to be so bound)
	+ Practice Direction 35 and Guidance for the Instruction of Experts in Civil Claims (Aug 2014): Part 35 is intended to limit the use of oral expert evidence to that which is reasonably required; the purpose of joint meetings is not for experts to settle cases “but to agree and narrow issues”; an agenda is not mandatory but, where one is necessary, parties should attempt to agree one that helps the experts focus on the issues that need to be discussed; the agenda must not be in the form of leading questions
	+ *Saunders v Manchester University Hospitals NHS Foundation Trust* [2018] EWHC 343 (QB), Mrs Justice Yip, paras 34 and 35: both parties’ expert reports were clear and easy to read; however, their (60 page) joint statement was disappointing and did not fulfil the purpose of the meeting identified in the rules “to agree and narrow issues”; the problem appears to have arisen from parties being unable to agree a single agenda and two separate agendas being put to the experts; *“Sometimes less is more as far as the agenda is concerned. Parties should adopt a common sense and collaborative approach rather than allowing this stage of the litigation to become a battleground. Frankly, the approach to the joint statement in this case achieved nothing of value”*
* Commercial court
	+ At the Procedural Hearing the court may: “direct that skilled witnesses should meet with a view to reaching agreement and identifying areas of disagreement, and may order them thereafter to produce a joint note, to be lodged in process … identifying areas of agreement and disagreement, and the basis of any disagreement” (RCS 47.12(2)(h))
* At proof
	+ Reports of experts treated as evidence in chief?
	+ “Hot tubbing”? (Lord Woolman, *SSE Generation Ltd, supra,* [2016] CSOH 177, para [258] – most useful where there is a narrow technical dispute and less so where there is little common ground between the parties or the level of detail is too great)
* **Conclusion/query**
	+ Is there a need for greater guidance on joint meeting of experts (including, perhaps, example/style agendas) to achieve a greater shared understanding and consistency of practice?
	+ Is there a need for guidance on the best means of taking the evidence of experts at proof (e.g. reports treated as evidence in chief)? Should the issue, at least, be considered at the Procedural Hearings?

**New rules for advance sanction of experts (and Counsel)**

1. Expenses
* New rules re allowable outlays at taxation (including skilled witnesses and, in the Sheriff Court, the instruction of Counsel)
* Act of Sederunt (Taxation of Judicial Expenses Rules) 2019 (SSI 75/2019) (applies to actions raised on or after 29 April 2019) (see, in particular, rules 4.5, 5.1, 5.3 and 5.4)
* For chapter 42A Court of Session actions (but not chapter 43 actions) there is a requirement to obtain sanction for experts in advance of the work being carried out (the court may allow retrospective sanction on cause shown)
* The same requirement for advance sanction applies to the instruction of experts in chapter 36A OCR Sheriff Court actions (but not in chapter 36 OCR actions)
* For chapter 36A OCR Sheriff Court actions (but not chapter 36 OCR actions) there is a need to obtain sanction for the instruction of Counsel in advance of the work being carried out (again, with the possibility of retrospective sanction on cause shown)
* What is the rationale for these changes to the rules? (possibly, related to the Taylor reforms and the Civil Litigation (Expenses and Group Proceedings) (S) Act 2018?)
* See Note by Lady Carmichael in *Davidson v Grampian Health Board*, 24 May 2019 (a motion before calling seeking authority per RCS 43.1A to raise as an ordinary action and, under the new Act of Sederunt, for retrospective and prospective certification of skilled witnesses)
* **Conclusion/query**
	+ The rules appear to introduce unnecessary and unhelpful additional complexity
	+ Was there adequate consultation with PI practitioners before these rules were introduced?
	+ Query whether the previous position should be re-instated (i.e. sanction sought at end of cases, once the work has been done and a more informed view can be taken on whether it was reasonable to instruct the experts and/or Counsel)

**Miscellaneous Procedural Issues**

1. Hearings
* By Order (Adjustment) Roll (no later than 7 days after Record has closed)
	+ Written Statement of Proposals for Further Procedure
	+ Lord Ord to hear from parties with a view to ascertaining (a) the matters in dispute and (b) readiness to proceed to proof, including on matters (1) to (22) [checklist]
	+ An opportunity for parties to seek further information/notice, make calls etc
* (may seek a further hearing on the By Order (Adjustment) Roll)
	+ worth considering if there are o/s matters and if there is likely to be a significant delay before the next calling of the case (i.e. the procedural hearing circa 6 months before the proof)
* Procedural hearing (no later than 6 months before the proof)
* Further procedural hearing (no later than 2 months before the proof)
1. Notices to Admit
* Once Record closes – check if there are averments that ought to be admitted (part of Note on Line)
* Possible to agree that a statement from a witness is equivalent to their oral evidence?
* Earnings information (and other components of heads of claim)
* Productions
* Can be converted to a Joint Minute of Admissions if not happy with particular wording in NOA
1. Productions
* Paginated
* Electronic format (c.f. in Commercial actions, productions need only be lodged in electronic format – PN 1/2017, para 25)
* A joint bundle of productions (for second or more hearings on the By Order (A) Roll hearing – PN 6/2017, para 14)
* Where productions are over 500 pages, a core bundle (as above and paras 28-30)
* A paginated joint bundle of medical records (no later than 4 months before the proof – RCS 42A-5(1)(c))
* **Conclusion/query**
	+ Should there simply be a requirement to consider whether a core bundle would be helpful c.f. a requirement for a core bundle in every case?
	+ Should there be a requirement for parties to consider lodging an agreed chronology? (i.e. setting out what medical treatment was received and when, with references to the page and production numbers) (NB observation of Lord Woolman in *SSE Generation Ltd*, para [255], “It is unfortunate that parties were unable to narrow the scope of the proof by entering into a joint minute of agreement. An agreed chronology and an agreed list of issues would also have been helpful”.)

**Feedback**

1. Working Groups
* The Scottish Civil Justice Council (SCJC)
	+ Personal Injury Committee (minutes on SCJC website)
	+ A sub-group of the Personal Injury Committee (led by Maria Maguire Q.C. and including Amber Galbraith, Advocate) is currently considering amendment to chapter 42A of the RCS and an amended Practice Note (and whether it would also be appropriate for the equivalent Sheriff Court Rules to be amended)
	+ Consideration currently being given to: a clinical negligence pre-action protocol; a proposed Act of Sederunt re Qualified One Way Costs Shifting
	+ Feedback is welcome - scjc@scotcourts.gov.uk
* Court of Session Personal Injury User Group
* All Scotland Personal Injury Court User Group – NationalPICourt@scotcourts.gov.uk
1. Conclusion
* The rules work reasonably well but there is always room for improvement and, I suggest, a greater consistency of practice
* There is a need for “open loop” decision making i.e. with practitioners’ experience of what works and what doesn’t work being fed back into the various working groups and rule making bodies and I would encourage everyone to do so!

**A v B**

**[possible] AGENDA FOR JOINT MEETING OF EXPERTS**

1. Parties are agreed that their respective medical experts should meet to discuss the issues in the case with a view to identifying the matters on which they agree and do not agree, including their reasons for any such disagreement.
2. For the assistance of the experts parties have agreed a list of the main questions that they consider should be addressed at the meeting (appendix 1).
3. [Parties have also agreed a chronology of the deceased’s treatment with reference to the medical records (appendix 2).]
4. For the assistance of the Court, the experts should seek to agree the main medical and scientific literature in this case (including any medical and scientific literature that may assist the Court in understanding the relevant anatomy, condition/disease, treatment and medical terminology etc). The experts should also indicate any particular literature, including particular passages, that they consider it would be helpful for the presiding judge to read in advance of the proof.
5. For the assistance of the Court, the experts should produce a joint report within fourteen days of their meetingsetting out the matters on which they are agreed and the matters on which they are not agreed. The experts should state reasons for the views they express.
6. While the joint report will be admissible in evidence, all discussions between the experts are confidential and what is said or represented during the meeting will not be admissible in evidence.
7. The expert witnesses are to consider only the cases and answers averred on Record and matters relevant to those.

**Appendix 1**

**[NB: more specific questions (i.e. relating to the particular facts and circumstances of the case) are likely to be appropriate but the general questions suggested below may assist in providing a framework for drafting more focussed questions]**

**Negligence**

1. Whether, during the periods referred to on Record, there was a usual and normal practice among Consultant [] Surgeons, in relation to any of the alleged acts and omissions averred in Article [] of Condescendence (at pages [] to [] of the Closed Record).
2. Whether any of these alleged acts and omissions, if established in fact, constituted a departure from any such usual and normal practice.
3. Whether any of these alleged acts and omissions, if established in fact, constituted a course of action that no Consultant [] Surgeon of ordinary skill would have taken if acting with ordinary care.

**Causation**

1. What loss, injury and damage, if any, was caused by the acts and omissions averred in Article [] of Condescendence (at pages [] to [] of the Closed Record)?

**Causation (fatal case/delay in diagnosing cancer)**

1. What investigations, if any, are likely to have been undertaken if the deceased had been referred to an oncologist following the attendance with his GP on []?
2. Whether, if the deceased had been referred to an oncologist following the attendance with his GP on [], cancer is likely to have been (a) present and (b) detected?
3. If cancer is likely to have been present, what stage and grade is it likely to have been?
4. On the hypothesis that cancer is likely to have been detected if the deceased had been referred to an oncologist following the attendance with his GP on [], (a) what is the deceased’s treatment, if any, likely to have been and (b) what would have been his life expectancy following any such treatment?
5. Whether any of the acts and omissions in Article [] of Condescendence, if established in fact, caused or materially contributed to the deceased’s death?
6. Whether, on the hypothesis that these acts and omissions had not occurred, the deceased is likely to have survived beyond [date of death] and, if so, for how much longer would he have lived?
1. I am grateful to Jamie Dawson, Advocate, for drawing my attention to the relevant procedure and authorities in England [↑](#footnote-ref-1)