Ampersand Advocates

Summer Clinical Negligence Conference 2018

Case Summary

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SCOTLAND

D v Lanarkshire Acute Hospital NHS Trust [2017] CSIH 30

This was an appeal by the health board against a decision of the Lord Ordinary that a midwife was negligent during the birth of a baby such that he sustained a brachial plexus injury and would be permanently disabled as a result. The Lord Ordinary had accepted the evidence of the parents about the birth, that the labour had been delayed as a result of shoulder dystocia and then the midwife had used excessive force in delivering the baby.

The defenders appealed the decision arguing that the Lord Ordinary had got it plainly wrong and had misunderstood the evidence on material issues, reaching a conclusion for which there was no evidence.

The Inner House held that the judge had not reached an unreasonable conclusion or been plainly wrong. Effectively the judge had accepted the parent's evidence as credible and reliable which was very much a matter for the Lord Ordinary to assess. The judge had also rejected the midwife's evidence on key parts having had the benefit of hearing the witnesses.

Many of the submissions on appeal amounted to no more than an invitation to the appeal court to review the evidence again, which it was not prepared to do.

AW v Greater Glasgow Health Board [2017] CSIH 58

The mother of a child reclaimed against dismissal of her claim against the health board for injury to her child at birth which she alleged arose from failures of midwifery staff in the period before his birth. She alleged that at an ante natal appointment she had complained of symptoms which should have led to blood pressure and a urinary sample being taken, which had not been done. She was later referred for a scan at a subsequent ante natal appointment and it was identified that she had pre-eclampsia and required an emergency c-section. Her child was delivered eight weeks early and was found to suffer from cerebral palsy, which the mother argued arose from an acute hypoxic ischaemic insult occurring just prior to birth.

The Lord Ordinary decided that the case failed on causation – that an earlier c-section would not have been carried out, and that it was not clear that the cerebral palsy arose from the insult at birth.

The mother appealed on the basis that, *esto* the LO erred on causation, he had also previously erred in his assessment of the factual evidence.

The Inner House found that there was no basis to conclude that the LO had erred in his assessment of the evidence on credibility and reliability. There were clear primary findings in fact. On the evidence the mother would require to show that the delivery would have taken place earlier than it did, and she could not do so on balance of probability.

However, the Inner House found that the LO had failed to provide a judicial decision on causation and therefore the matter could be considered anew by the IH. On reconsideration the IH stated that there were still too many uncertainties and doubts raised by the evidence to find for the pursuer on causation. However, the decision contained some significant criticism of the Lord Ordinary's decision.

JD v Lothian Health Board [2017] CSIH 27

The pursuer reclaimed against the dismissal of his case for alleged negligence in misdiagnosis of his late onset hypeogonadtrophic hypogonadism. The pursuer was a party litigant and at debate his case was dismissed as there were no averments of clinical negligence on the Hunter v Hanley approach, and no proper actionable loss averred.

The reclaiming motion was refused, with Lord Glennie dissenting on one part relating to loss and damage.

The case contains some helpful guidance on the latitude that might be afforded to a party litigant in assessing what has been plead.

LT v Lothian NHS Health Board [2018] CSOH 29; GWD 12-170

This case involved an action for damages brought by a mother for injury alleged to have been sustained by her child at birth through the negligence of the registrar.

During birth the CTG had been variable. The pursuer maintained that the registrar had been negligent in (i) interpreting the CTG trace as normal, (ii) failing to expedite the birth, and (iii) failing to inform of the risk posed and get informed consent from the mother.

There was competing evidence regarding the interpretation of the CTG trace. The LO, on balance of probability, preferred the defender's expert CTG interpretation. On the issue of consent, she found that there was no evidence that a suspicious CT posed a relevant risk giving rise to a duty obliging the registrar to obtain further consent on how to proceed – effectively he was continuing on the basis of the initial consent to attempt vaginal birth.

ENGLAND

Liability and Breach of Duty

Lucy Diamond v Royal & Exeter NHS Foundation Trust [2017] EWHC 1495

A case where no-ne can resist using the claimant's full name in reports.

The claimant underwent spinal fusion, but post operatively developed an abdominal hernia. She attended the general surgeon who decided to repair the hernia with open mesh repair and abdominal wall reconstruction. Following surgery the claimant continued to complain of abdominal swelling and pain. It wasn't until almost 3 years later, after being assessed by another surgeon, that she underwent a hernia repair with a single stitch and full abdominoplasty.

The claimant alleged that the spinal surgeon failed to examine her abdomen at his post operative review where she complained of abdominal distension. Secondly she alleged that the general surgeon did not get her informed consent before proceeding to the hernia repair with mesh. She was successful in the first part of her case against the spinal surgeon, and that matter did not go to appeal.

In relation to the issue of consent the judge preferred the evidence of the claimant and her mother. The general thrust related to the issue of warning about the implication of mesh repair for any subsequent pregnancy, and the surgeon had failed to ask about her intentions in relation to getting pregnant. The surgeon was under a duty to mention the alternative treatment of repair with a single suture.

In relation to causation, however, the judge found that the alternative of suture repair had a high, if not inevitable, failure rate, and potential recurrence of a hernia. The crucial question was what the claimant would have decided to do if properly advised of the alternative treatment. The judge found that although the claimant was reliable, her view was clouded by the knowledge that she acquired on speaking to the second surgeon who carried out the stitch repair. Although the claimant was giving her evidence honestly, it di not automatically follow that what she now believed to be the case would in fact have been her position at the material time.

The judge held that even had she been in a position to give proper informed consent, her decision would not have altered, and the mesh repair would have been undertaken.

Meadows v Dr Khan [2017] EWHC 2990; [2018] 4 WLR 8

This is a claim for wrongful birth. Mrs Meadows claimed for the additional cost of raising her son who suffered from both Haemophilia and autism.

The claimant had sought advice from the defender to enquire whether she was a carried for the haemophilia gene. She underwent a standard blood test, which was clear, however in order to make the relevant diagnosis she needed to be referred to a haematologist to undergo specific gene testing. She subsequently became pregnant and gave birth to her son.

The legal question is whether a mother who consults a doctor with a view to avoiding the birth of a child with a particular disability recover damages for the additional costs associated with an unrelated disability?

The judge found that the autism arose out of a pregnancy that would have been terminated but for the defender's negligence. The scope of the duty in the case extended to preventing birth of the claimant's son, and all of the consequences that brought with it.

TW v Royal Bolton Hospital NHS Foundation Trust [2017] EWHC 3139

The claimant was injured by a period of near total hypoxic ischaemia following collapse of his circulation shortly before his birth. Had the child been born seven minutes earlier he would have been spared brain injury.

Before arrival at the delivery unit on the morning of the birth the mother had telephoned twice seeking advice after her waters broke. The issue of breach of duty focussed on whether the defender was in breach for failing to invite the claimant's mother to come to hospital when she first telephoned and it was clear that her waters had broken. The judge found that she should have been invited to attend the unit when she first called and that it was a breach of duty to have failed to do so.

The issue of causation depended upon a reconstruction of what would have happened, in exact timings, had the claimant's mother been invited to attend when she called. On such detailed reconstruction, taken from evidence of timings from the various medical staff involved, he held that delivery would have been achieved no less than 7 minutes earlier, and the claimant therefor succeeded.

The case is interesting, now only because it underlines the precise factual reconstruction that may be required to pinpoint issues of causation, but also for the fact that it was the telephone records in this case, obtained late in the day, that proved critical in identifying the correct timeline – documentation which is not ordinarily recovered in the course of a medical negligence case.

Sullivan v Guy's and St Thomas' NHS Foundation Trust [2017] EWHC 602; [2017] Med L R 260

The claimant was born with congenital heart disease and in 1998 underwent surgery as an infant to correct the disorder. Whilst the surgery itself was successful the claimant suffered serious brain damage following the surgery. The surgery involved inducing a period of circulatory arrest for around 30 minutes, usually ensuring that the patient's temperature was reduced to 18c- to ensure that brain damage did not occur. The treating surgeon, in accordance with is usual practice, only reduced the temperature to 24c- and it was argued that this created an unacceptable risk of brain damage.

The question in the case was whether there was an accepted standard in 1998 regarding the temp to which an infant should be reduced for such an operation. The judge found that this was an area where views varied, quite reasonably, about what technique worked better. It was difficult for the court to resolve difference of competing views within medical practice. The treating surgeon's views had to be accorded respect. The fact that other colleagues might have disagreed with his approach did not, of itself, make his approach negligent.

It was held that there was no established consensus concerning safe practice in 1998.

FB v Rana [2017] EWCA Civ 334; [2017] Med L R 279

When she was 1 year and 1 month the claimant's parents brought her to A & E where it was alleged there was a failure to diagnose pneumococcal meningitis which caused multiple brain infarcts. The claimant suffered permanent brain damage.

The examination had been carried out in the early hours of the morning by a Senior House Officer. It was alleged that she (i) failed to take a relevant history, and (ii) failed to conduct an adequate examination. The claimant argued that if properly done she would have been referred to the paediatric team, but instead she was simply discharged. At first instance the judge found that there was no breach by the SHO.

On appeal the issue became the standard to be expected from an inexperienced SHO. The court concluded that the doctor had failed to elicit why the parents had brought the claimant to hospital in the early hours of the morning, probably through a flawed approach to taking the history. The SHO wrongly assumed that parents witnessing something frightening (eg eye rolling in this case) would volunteer such information to the doctor. Secondly, having reached the view that the claimant was well, she failed to establish why the parents had brought the child into hospital in the early hours of the morning. As a result, she failed to ask the crucial question about what precipitated the attendance. Following that approach the court concluded that she had not concluded the history taking to the standard to be expected of a competent SHO.

The judgement of Lord Justice Jackson is helpful because it considers in some detail the relevant standard of skill and care to be expected, and in particular the effect of inexperience when considering the competency of a doctor.

ABC v St George's Healthcare NHS Trust [2017] EWCA Cov 336; [2017] Med L R 368

This is an interesting case, and quite novel. It concerns whether there is any duty on clinicians to disclose details relating to genetic and hereditary conditions. The claimant's father had been diagnosed with Huntington's disease, which posed a 50% chance of a child developing the same disease. The claimant became pregnant and her father specifically asked that his condition be kept confidential from his daughter so as not to distress her. Later the diagnosis was accidentally revealed to the daughter, she underwent testing herself and discovered that she too was a carrier of the disease and could pass it on to her child.

The claimant sued on the basis that, had she been aware of her father's diagnosis she would have undergone the testing sooner and would, upon discovering that she had the gene, have terminated

her pregnancy as she did not want her child growing up with the possibility of having the burden of an extremely unwell and dependent mother, or to be an orphan.

The case is a potentially interesting development of the common law. The courts have incrementally been upholding patient autonomy more and more. This case takes that a step further by considering whether third parties need to be informed about confidential information that might impact upon their health.

Procedurally the case was rejected at first instance. On appeal the appeal court had to determine whether there was a potentially justiciable case, and it decided that there was, with the case being remitted for trial. Watch this space…

Darnley v Croydon Health Services NHS Trust [2017] EWCA Civ 151; [2018] 2 WLR 54

In this case an A & E receptionist gave incorrect information to a patient about waiting times. At first instance the judge held that a duty should not be imposed in the circumstances and this is the appeal hearing following on from that decision.

The claimant sustained a head injury and attended at A & E. He was informed by one fo the receptionists that it would be 4 – 5 hours before he was seen. After 19 minutes he left with his friend without notifying reception staff that he was leaving. Later his condition deteriorated, he was taken back to the same hospital by ambulance, and a Ct scan revealed an extradural haematoma. It was too late to prevent permanent injury and he was left with left hemiplegia and long-term disabilities.

In fact, the hospital triage system meant that a triage nurse would have examined the claimant within 30 minutes of arrival.

By majority the court of appeal held that a receptionist's duties are clerical. It is not their function or duty to give any wider advice to patients. When the receptionist told the claimant the likely waiting time, albeit wrong, she did not assume responsibility to the claimant for catastrophic consequences he might suffer if he walked out of the hospital. It would not be fair, just and reasonable to impose upon the receptionist a duty not to provide inaccurate information about waiting times. Lord Justice Jackson stated "…there comes a point when people must accept responsibility for their own actions. The claimant was told to wait. He chose not to. Without informing anyone of his decision, he simply walked out of the hospital".

Consent

Duce v Worcestershire Acute Hospitals NHS Trust [2018] EWCA Civ 1307

The claimant's PI claim was dismissed and this judgement is the outcome of her appeal against the health board.

In 2008 the appellant underwent a total hysterectomy and bilateral salpingo-ophrectomy after suffering from heavy and painful periods. Post surgery she suffered from neuropathic pain. She

claimed that the Trust had negligently failed to warn her of the risk of developing chronic post-surgical pain. The judge at first instance found against her on liability and causation.

On appeal the appellant argued that the judge had (i) failed to consider whether the risk of CPSP was 'material as per Montgomery, (ii) failed to apply the proper test of causation and (iii) erred in finding that if she had been properly consented then she would still have had the operation.

Her appeal was dismissed. The court held that Montgomery had been properly applied by the trial judge. Materiality of risk did not arise in this case because gynaecologists in 2008 would have regarded the risk of CPSP as insufficient to justify warning of such a risk. A clinician is not required to warn of a risk that he cold not reasonably be taken to be aware of.

There case includes an interesting discussion about Chester v Afshar causation.

Webster v Burton Hospitals NHS Foundation Trust [2017] EWCA Civ 62; [2017] Med L R 113

The case concerned a hypoxic ischemic insult to the claimant's brain caused by a relatively short period of cord compression at the time of birth. Breach of duty was admitted. The mother had previously undergone a scan at 32 weeks which had a combination of abnormalities that should have prompted further ultrasound scanning. The claimant argued that such scanning would have indicated that induced labour should have been offered at term, rather than as happened, the pregnancy was allowed to continue to 42 weeks. The defender argued that the further scans would most likely have provided reassurance and no induced labour would have been offered.

The judge found that even if the additional scans had been undertaken it was unlikely that anything would have arisen which required to be discussed with the claimant's mother that would have led to a different decision on labour. There was discussion about Montgomery and the fact that the case reinforced the doctor's obligation to present material risks and uncertainties of different treatments, the possibility of alternative treatment being sensitive to the characteristics of the patient.

The question became - what should the obstetrician have told the claimant's mother had further scans been undertaken? The trial judge had found there was "an emerging but recent and incomplete material showing increased risks of delay in labour in cases with this combination of features". On that basis the judge found that following Montgomery the obstetrician would have been required to discuss this information with the claimant's mother and set out the arguments in favour on non-intervention.

Thefaut v Johnston [2017] EWHC 497; [2017] Med L R 319

This case related to informed consent in respect of elective spinal surgery to deal with the claimant's leg and back pain. During the operation the claimant sustained non-negligent nerve injury which resulted in permanent pain and sensory loss. The focus of the case was whether the claimant gave informed consent to the procedure.

The surgeon had discussed the operation with the patient and had followed that up with a letter. The judge found that the process of obtaining consent was inadequate. He found that the surgeon

had materially overstated the chances of eradicating the claimant's back pain and the potential outcome following surgery; had formulated his advice in a manner which suggested cure was a 'racing certainty', and was far too optimistic in his assessment; failed to advise of the inherent risk that any surgery even if non-negligent could affect detrimentally his condition; and failed to advise of the inherent risks associated with anaesthesia. The claimant should have been informed that there was a 50:50 chance of success of eradicating his back pain, and a 5% risk of making things worse. Compared with that the claimant would have had a recovery trajectory of 12 months with gradually receding pain if he had not had the operation.

Properly advised the judge concluded that the claimant would not have had the surgery, or would have had it on a different day. If that had happened then the injury would not have been sustained.

The case provides a practical gloss on Montgomery to the extent that doctors need to explain the risks and benefits of various treatment options that are material to each patient. In practice when assessing these risks and benefits this is likely to involve various face to face meetings and discussions to ensure that the patient gives informed consent. In reality this means altering the way in which pre-operative appointments are managed to ensure that parties get the opportunity to discuss these risks and options.

Correia v University Hospital of North Staffordshire NHS Trust [2017] EWCA Civ 356; [2017] Med L R 292

The claimant underwent surgery for a painful neuroma in her foot. Following surgery, she developed a neuropathic pain which was diagnosed as Chronic Regional Pain Syndrome. Interestingly, although the judge found that the operation had been carried out negligently, he did not find that the injury and pain suffered post operatively could necessarily be related to the negligence.

The main issue which arose on appeal was that of consent. The claimant had agreed to a three-stage operation assuming that a neuroma was found when she was operated upon. It was the third part of the operation, reattaching the nerve ending properly, that had been negligently performed. The judge found, however, that this did not make the operation a different operation for the purposes of consent. Effectively she couldn't say that, having been properly informed about the operation, she would not have consented to it, because she was properly informed about the operations and she did consent. There is no duty to advise of the possibility of negligence – negligence causing injury would be compensated under breach of duty, it did not impinge on the issue of consent.

Hassell v Hillingdon Hospitals NHS Foundation Trust [2018] EWHC 164

The claimant underwent spinal surgery which left her with tetraparesis and permanently disabled. One of the issues raised in the case was that of consent. The court found that the claimant had not been made aware of the material risks of the operation and the alternative treatment options. She was only told about the risk of cord damage on the day of the surgery, and both parties accepted that was not sufficient to give informed consent.

On the issue of causation the court had to determine whether the claimant would have undergone the surgery had she been aware of the risks and alternatives. In this case the judge found that the claimant was very concerned about the risk of paralysis and would have wanted to explore

conservative options such a physio to safeguard against that risk. Had she been able to give informed consent she would not have undergone the operation at that time.

Interestingly the court found it more difficult to determine what had actually caused the injury during the surgery, and whether the cause was negligent. The judge found that he could not find for one potential cause over another on the basis of the expert evidence, and the claimant accordingly failed on that aspect of her case.

Quantum

JR v Sheffield Teaching Hospitals NHS Foundation Trust [2017] EWCA Civ 2077

An interesting decision on quantification looking at the vexed issue of accommodation and how the change in the discount rate impacted upon the usual applied formulas of calculation. The judge applied the Roberts v Johnstone approach as he was bound to do, but emphasised the need to find a solution to the 'accommodation conundrum'. It is clear from this decision that there will be no 'quick fix' to the uncertainty over how to calculate accommodation costs.

The case was appealed and the appeal hearing was keenly awaited by practitioners hoping for some clarity on the issue. In the event prior to the appeal hearing the defender made an offer "which the claimant could not refuse" in respect of accommodation. So, the issue has not required to be canvassed this time around.

Shaw v Dr Kovac and or [2017] EWCA Civ 1028; [2018] 2 All ER 71

An 86 year old man died following an operation for aortic valve implant. It was claimed by his daughter that neither the deceased nor his family were given proper information as to the true nature of and risks inherent in the actual surgical procedure deployed. The defender admitted liability and £5500 was awarded for pain, suffering and loss of amenity.

On appeal it was argued that the judge should, in addition, have awarded a sum representing a further and distinct head of loss – compensation for what was escribed as the unlawful invasion of the personal rights of the deceased and his loss of personal autonomy (with an award of £50k sought).

The court held that this was not a distinct cause of action. A failure to give proper advice so as to obtain consent is properly formulated as an action in negligence/breach of duty.