UPDATE OF RECENT CASES AFFECTING CLINICAL NEGLIGENCE PRACTICE

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Capacity

Dunhill (by her Litigation Friend, Paul Tasker) v Burgin [2014] UKSC 18

Summary

Capacity must be judged by reference to the actual case which the claimant has, not by reference to the case which her legal representatives think is her case. Furthermore, the fact that it was unknown at the point of compromise that the claimant lacked compromise did not abrogate the effect of Part 21. As a matter of fact, approval had not been given and so the compromise was ineffective.

The claimant had suffered a head injury in a road traffic accident in 1999. By the time it came before the Supreme Court it was accepted by the defendant that the claim was worth £800,000 (the claimant said it was worth much more). The claim as actually pleaded was limited to £50,000 and at the first day of a liability and quantum trial in 2006 was compromised by the claimant and her counsel for £12,500. There was a consent order, but no one considered that the claimant lacked capacity. Subsequently, she took fresh advice and sought to set aside the Consent Order.

Given that capacity is "issue specific" an issue arose as to whether she did have capacity, when judged against the simple case originally pleaded, whereas she may not have had capacity in relation to the more complicated case she now presented. This case decides that capacity must refer to the actual decisions which a claimant (pre-proceedings, as well as after a claim is started) must be capable of making and the actual instructions she should be giving in relation to that claim. An underlying principle is the protection of the "protected party" not only from the other party, but from her own legal advisers.

Part 21.3(4) allows a court to "regularise" the position of an invalid step. In the circumstances of his case it would not be just to allow the compromise to stand.

The second issue raised by the Defendant was that the normal rule of the common law (*Imperial Loan Co v Stone*) was that a contract entered into by a person who lacked capacity or was a minor was not void, but was voidable. Following *Dietz v Lennig Chemicals Ltd* [1969] 1 AC 170, which the Supreme Court held they were bound by, the rule in Part 21 is sound and so a protected party who has a claim must have it approved in order for it to be enforceable. The position may be different in contract, per *Imperial Loan*.

There have been several important decisions relating to the issue of treatment for persons who lack capacity (per MCA 2005)

Aintree University Hospitals NHS Foundation Trust (Respondent) *v* James (Appellant) [2013] UKSC 67.

Summary

- The test, per S.1(4) of the Act is whether it is in the patient's "best interests" to provide the treatment, having regard to (a) the checklist set out at S4, and the 2007 Code of Practice.

- The "best interests" test is subjective: that is to say that when considering the wishes and feelings of the patient the court must consider that patient's wishes and feelings not what a reasonable patient would think. "The purpose of the best interests test is to consider matters from the patient's point of view".

- The fundamental question is "whether it is lawful to give the treatment, not whether it is lawful to withhold it". Remember that it is only lawful to provide invasive treatment with the patient's consent. It is not unlawful for a Doctor not to give treatment where the patient (of full capacity) refuses it. With an incapacitated patient (i.e. one who is not able to give consent) it is only lawful to give invasive treatment where "it is necessary in that patients best interests".

- Look at the welfare of the patient in the widest sense, not just medical, but social and psychological; consider the nature, invasiveness, degree of pain, and possible outcomes of the treatment. " … try and put themselves [the decision-makers] in the place of the individual patient and ask what his attitude to the treatment is or would be likely to be …."

- There is limited guidance as to what "futile" and "recovery" means in the Code of Practice: "futile" is when the treatment would not be effective or would be of no benefit to the patient; "recovery" does not mean a return to full health, but "a resumption of a quality of life which [that patient] would regard as worthwhile."

The SC, for the first time, considered that MCA 2005. In tragic but familiar circumstances: Mr James at the age of 67 was in critical care. He required mechanical ventilation, suffered from COPD; was provided with hydration and food through a naso-gastric tube. He had suffered a severe stroke leaving him with serious neurological deficits, including that he was "minimally aware" although sometimes responsive to his family and friends. His kidneys were damaged and operated at about 20% function. He suffered with chronic low blood pressure. He had suffered one cardiac arrest from which he had been resuscitated with prolonged CPR. He had suffered multiple infections with septic shock and organ failure. He had a "very low" chance of leaving critical care, let alone the Hospital.

The treating doctors and clinicians, and the family, disagreed as to what should be done in the event that he needed: invasive inotropic / vasopressor support in relation to his blood pressure; renal therapy which would include a central line to extricate his blood and clean it before re-introducing it; CPR in the event of another arrest. The latter was reported to be deeply invasive and indeed would likely produce pain and injury.

The Judge at first instance had refused the application saying that he was not persuaded that the three proposed treatments would necessarily be "futile" (two had been used successfully already); nor that they would fail to provide "recovery". He said, nevertheless, that it was in his view "unlikely" that further CPR would be in Mr James' best interests, in the event of another cardiac arrest.

By the time of the appeal (15 days later) new evidence was introduced because Mr James' condition had deteriorated significantly: he now required mechanical ventilation full time and even by that mechanism it was becoming difficult to maintain adequate oxygenation; his blood pressure had also deteriorated.

The Court of Appeal considered that the Judge had approached the question incorrectly and allowed the appeal. Sir Alan Ward suggested that "futility" of treatment should be considered in light of its true "goal" namely, "to secure therapeutic benefit for the patient, that is to say the treatment must, standing alone or with other medical care, have the real prospect of curing or at least palliating the life-threatening disease of illness from which the patient is suffering". He applied a test as regards "no prospect of recovery" which envisaged meaning "no prospect of recovering such a state of good health as will avert the looming prospect of death. Arden LJ started by considering Mr James wishes and suggested where that was in doubt then the test was "that the individual would act as a reasonable person would act".

10 days later (before the Court of Appeal had handed down their written reasons) Mr James suffered a cardiac arrest and died. The Supreme Court granted his Widow permission to appeal.

The Supreme Court agreed with the Court of Appeal's decision but differed with the Appeal Judges as to the proper route there. Lady Hale gave the approved Opinion of the Court.

A NHS Trust v DE (by his Litigation Friend, The OS) & Oths [2013] EWHC 2562 (Fam)

Summary

Despite recognising that the declarations sought would involve invasive treatment of a person who lacked the capacity to decide for himself where the invasive treatment (vasectomy) was not "necessary for his health", the Court granted the declaration.

This was a decision by Mrs Justice Eleanor King in the Court of Protection, which was reached before the decision in *James* above.
The case is notable since it is probably the first of its kind under the new Act (for history, see *F v West Berkshire HA* [1990] 2 AC 1) in that the application sought permission to provide a vasectomy for DE who was an adult male aged 36 who suffered with profound learning difficulties (he functioned at the age of a 6 – 9 year old), where the vasectomy was not required for any medical health reason (so-called "non-therapeutic treatment").
DE lived with his dedicated parents. He had a small amount of autonomy (catching a bus to an activity centre, but where he was put on the bus and met at the bus stop at the point of destination). He lacked litigation capacity and any capacity to decide whether to undergo a vasectomy.
He had begun a loving relationship with PQ a number of years earlier which had been modestly supervised, but PQ had become pregnant and gave birth to a child. Mother was unable to look after her baby and so a Special Guardianship Order was made in favour of her Grandmother. There was concern that DE was incapable of giving true consent to sexual intercourse with PQ so "protective measures" were put in place. DE was distressed by these events and was reported as saying he did not want more children. However, it was clear that he and PQ had a loving relationship and sexual intercourse was likely to re-occur in the future. Eventually it was concluded that DE did have the capacity to consent to sexual intercourse, but probably not to whether to employ contraception.
DE's parents had concluded that it was in DE's best interest to have a vasectomy. A Consultant Urologist had examined him and concluded that it was not in his best interest to undergo a vasectomy. The NHS sought a declaration that (a) DE did not have capacity to make a decision on whether to have a vasectomy, and (b) that it was "lawful and in his best interests" to undergo the procedure.
The Judge concluded that the use of ordinary contraceptive devices would leave a very significant risk of a further baby, where the evidence was quite clear that DE did not want this. It would also impact on his independence because of the natural reluctance to allow the opportunity of unprotected sexual intercourse. The Judge took into consideration that such a decision would render DE infertile for the rest of his life. She also thought that there was a positive benefit to DE of a vasectomy for the elimination of the stress that would be caused to his parents otherwise.
The Judge applied an objective test to the "best interests" test (wrongly – see *James* above).
What would (and almost did) make this case much more complicated was if DE was unable to give valid consent to sexual intercourse – that would have given rise to potential criminal offences by PQ, and possibly his carers if they could have been shown to have "incited" or perhaps even been "accessories".

Deprivation of Liberty

Cheshire West and Chester Council v P (by his Litigation Friend, the OS)

Summary

This case is important if you are advising on whether actions can be taken in respect of a person in a Hospital or a Care home which would have the effect, ostensibly, of depriving him of his liberty – which offends against Article 5 of his Fundamental rights.
It is a long Judgment of the Court of Appeal (Munby LJ) but essentially decides that in deciding whether the restraints being put on an individual constitute a deprivation of liberty that is to be judged against a comparator of like characteristics, i.e. comparing the relative normality of that person's life with their

relevant condition as against someone with similar characteristics. Here, the patient exhibited extreme and bizarre behaviour which required restraint at times. One had to look at all the circumstances as a whole. The type of restraint, its duration, the effects of it. Distinguish between imposing "restrictions" which can be acceptable, and removing "liberty".

GPs and the Ambulance Service

Beech (by his Litigation Friend, Joanne Mounsey) v (1) A P Timney, (2) A W Paterson [2013] EWHC 2345

Summary

From March 2003 the Claimant suffered with early morning headaches; in November 2003 he suffered a stroke. He had attended D1 (his GP) who had recorded his blood pressure as 110/80 (the norm or ideal would be about 120/80). Later D2 an Oral/Maxillary Consultant Surgeon removed some wisdom teeth without taking his blood pressure. He also saw an Urologist who did not take his BP. When he suffered his stroke tests revealed an abnormally high BP. The trial was on preliminary issues as to (a) whether the GP had incorrectly recorded the BP when it was probably 180/100 or higher; and (b) whether if taken and recorded properly treatment would have been instituted which would have prevented the stroke.

The GPs records were poor; his witness statement exhibited confusion about the appropriate prescription for high BP; nonetheless Turner J accepted his evidence on the basis that it was unlikely an experienced GP would have made such an error. C's case essentially depended on showing that C must have had high blood pressure at the time of the examination. D's expert evidence which showed that the stroke was caused against a backdrop of elevated (but not extraordinarily so) BP. Furthermore, causation was not established since treatment for high blood pressure would not have obviated the stroke.

Appleton v Medway NHS Foundation Trust [07/11/2013]

C suffered from diabetes and sought Hospital treatment when his foot became infected. Initial treatment was the provision of anti-biotics. When he re-attended, still infected, he was not provided with a broad-spectrum antibiotic, nor seen by a vascular surgeon, and was discharged. The next day he was admitted, but seen only by junior doctors. It was not until 3 days after admission that he was seen by a vascular surgeon. A succession of toe amputations followed, and then amputation of his lower leg.

It was accepted that the failure to admit him and treat him via a vascular surgeon when he attended on the second occasion was negligent. However, it was contended, rightly, that the cause of the amputations was not the infection (which could have been treated better) but the underlying diabetes.

The Judge concluded that there was insufficient evidence for C to establish that the infection (which he found not to be a deep infection) caused (in the "material contribution" sense) the amputation.

Orwell (Executrix of the estate of DAVID ORWELL, Decd) v Salford Royal NHS Trust Foundation [2013] EWHC 3245 (QB)

In the course of a rectal operation C sustained compartment syndrome to his left leg. The evidence was that after 8 untreated hours muscle death would be occasioned, and would be complete after 24 hours. Negligently, when C complained of symptoms in his leg, a Doctor did not attend within the hour. When he was attended, negligently, Compartment Syndrome was not considered as a possible cause. Consequently, it was not until 17 hours later that a fasciotomy was performed, by which time almost all the muscle was dead. In fact C died from unrelated causes sometime later.

Loretta Oliver v Gary Williams [2013] EWHC 600 (QB)

Summary

The Claimant's bowel symptoms provoked the GP into referring her for investigation at the Hospital. Either it was not received by the Hospital or not acted upon because they did not notify her of an appointment. She did not attend her GP until 6 months later. She was then urgently referred. Cancer of

the Ovary was detected. She then underwent surgery to remove all malignant tissue. The delay meant that her surgery was 5.5 months late, but it had not affected the staging or treatment given. Apart from the relatively minor consequence of being troubled with her symptoms for 5.5 months longer than she should have, the primary issue was whether her life expectancy had been impaired by the delay. That involved consideration of what volume of cancerous tissue would have been left had the operation been conducted sooner, and whether that evidence established the impairment.
C could not establish what difference in volume of cancerous material there would have been if the operation had been conducted 5+ months sooner than it was, compared with what was actually left in the later operation. This lead to the conclusion that although one could say that her chances of 10-year survival may have diminished, it could not be said that her delay had made a material contribution to her loss of life expectancy. *Gregg v Scott* prevented an award being made for the loss of chance that her life expectancy had been diminished by the delay.

Expert Evidence

Scott Hoyle v (1) Julia Rogers (2) Jade Rogers (3) Secretary of State for Transport (3) IATA [2014] EWCA Civ 257.

Summary

An air crash accident investigation was carried out by the Air Accident Investigation branch of the Transport Department. It was carried out by several experts who contributed and who had varying degrees of expertise. The report contained opinion some of which might be considered expert, some of which might be considered conclusions or opinions as to what had happened. Its admissibility was objected to including by the Secretary of State.

The Court of Appeal allowed it to be admitted in full. It commented that in relation to "expertise" the hurdle was not particularly high, and the various contributors could be ascertained. The fact that it contained some inadmissible material mattered not because the trial judge could excise that from his thinking. He could also attach such weight as he saw fit, taking into account the level of expertise. It was admissible under the Civil Evidence Act 1968 not under Part 35.

Post *Andrew Mitchell MP v News Group Newspapers Ltd* [2013] EWCA Civ 1537

It is not intended to rehearse all of the Case Management decisions which have followed on from the Court of Appeal's upholding of a Master's decision to impose a sanction where the Form H had not been filed and served in time and there had been no attempt to discuss the budget in advance. The result being a loss of several thousand pounds of claimant's costs.

The Court of Appeal in *Mitchell* make a shift away from focusing exclusively on doing justice in the individual case. They said that doing justice was not something distinct from the overriding objective; justice in an individual case was only achievable through the proper application of the CPR consistently with the overriding objective. The case decided that court orders, the rules and practice directions were to be regarded as of paramount importance and given great weight. If a sanction was imposed then relief from it should only be granted if the breach was "trivial" and was made promptly, or the defaulting party persuaded the court that there was a "good reason" for the default. The starting point was that the sanction had been properly imposed.

Durrant v Chief Constable of Avon & Somerset [2013] EWCA Civ 1624 followed, the Respondent had missed the first deadline for service of witness statements and then missed the extended time which had been coupled with a sanction that the Respondent could not rely on evidence not served by that date. At trial the Judge granted relief. He had not had the benefit of the decision in *Mitchell*. The Court of Appeal

overturned his discretionary case management decision saying that he had erred in principle. The Judgment makes quite clear that a harsh degree of intolerance to non-compliance with court ordered deadlines must follow.

In *M A Lloyd & Sons Ltd (T/A KPM Marine) v PPC International Ltd (T/A Professional Powercraft* [2014] EWHC 41 (QB) Turner J followed the *Mitchell* lead. The Claimant's difficulties were brushed aside as incompetencies. It was pointed out, in particular, that the Claimant should have made applications for extended time prospectively, and had not (despite the fact that the general practice was not consistent with such an approach where, as here, the Defendant had been compliant to adjusting the time deadlines).

In *Associated Electrical Industries Ltd v Alstom UK* Andrew Smith J refused to grant relief from sanction despite saying expressly that as between the parties justice would dictate that result. It was clear that he felt wounded by adverse criticism in the Court of Appeal of a decision of his granting relief in the case of *Rayaan al Iraq Co Ltd v Trans Victory Marine Inc* [2013] EWHC 2969. The case bears reading for the thinly veiled criticisms of *Mitchell.*

The influence of *Mitchell* has spread: in *Steven Clarke v Barclays Bank & Lamberts Surveyors* [2014] EWHC (Ch D) 505 a Deputy Judge refused permission for the use of a second expert where the first expert had retired and indicated that he no longer wanted to give evidence, but where that party had then failed to inform the other party for 6 months, and had not made an expeditious application for a new expert. This was said to be a serious abuse of the court's process.

The Senior Master has now said that standard directions for Case Management in the Queen's Bench Division should include permission to the parties to extend time for service of witness statements by up to 28 days without a further court order where that did not affect the timetable for Trial.

Clearly, the ramifications of *Mitchell* will ripple out for some time to come

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