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CLINICAL NEGLIGENCE CLAIMS – in the context of Covid 19

Webinar note – 09 June 2020

Heather Beckett of Goldsmith Chambers has drafted this note intended to assist solicitors with considerations in respect of potential clinical negligence claims which have arisen during the period whilst provision of medical services has been impacted by the Covid 19 pandemic and also some effects of the pandemic on cases already "in the system".

INDEMNITY VS IMMUNITY FROM SUIT

1. In respect of liability in tort, consequent on death, personal injury or loss, arising out of or in connection with a breach of a duty of care owed, the Coronavirus Act 2020 Section 11 provides for indemnity for persons providing health service activity diagnosing, caring for or treating individuals with or suspected of having coronavirus disease whether or not the care or treatment is in respect of coronavirus. This also includes caring for or treating individuals infected or contaminated or suspected or having been infected or contaminated and diagnosing or determining whether a person has been infected or contaminated.

   Presumably this latter would include advice given to callers to NHS 111 and most recently in respect of the contract tracers that have been recruited.

2. The Act also provides for indemnity for persons providing health service activity diagnosing, caring for or treating, when the usual persons providing those services are unable to do so either as a consequence of providing services to those with or suspected of having coronavirus or because of "a reason related to coronavirus".

   This presumably covers health service providers who have been redeployed to areas where they do not usually work, and also those retired nurses and doctors who have returned to the front-line during the pandemic to increase the available workforce overall and also because some health service providers themselves will inevitably become infected.

3. The legislation therefore appears to accept that there is a need for indemnity,- provision and that is likely to be mostly under the existing NHS arrangements – eg via the Clinical Negligence Scheme for Trusts and the Clinical Negligence Scheme for GPs.

4. This is not, therefore "Immunity from suit" and is not a "licence to act negligently". It does not change the "basic" position in relation to clinical negligence claims, nor the requirements to establish an appropriate claim for damages. If a duty of care is owed, and that duty is breached, and as a result a patient suffers harm (which is reasonably foreseeable), then there is a moral and legal right to bring a claim. The Covid 19 pandemic and the Coronavirus Act 2020 have not changed that.

DUTY OF CARE

5. *FB v Princess Alexandra Hospital* [2017] EWCA Civ 334:

   affirmed the principle that the standard of care of a hospital doctor should be judged by the standard of skill and care appropriate to the post which he or she is fulfilling. The health authority or health trust is liable if the doctor whom it puts into a particular position does not possess (and therefore does not exercise) the requisite degree of skill for the task in hand.

   This has potential relevance in situations where individuals have been re-deployed to unfamiliar clinical areas/tasks and also in respect of inexperienced staff (eg final year medical students "acting up") or clinicians whose knowledge/experience may not be recent (eg returning retired staff).

CONTEXT

6. Context is always important and this will also be relevant to clinical negligence claims arising during the Covid 19 pandemic.

   In *Mulholland v Medway NHS Foundation Trust* [2015] EWHC 268 (QB), Mr Justice Green at paragraph 90 specifically addressed the significant of context:

   "In forming a conclusion about the conduct of a practitioner working within triage within an A & E Department context cannot be ignored. The assessment of breach of duty is not an abstract exercise but one formed within a context…the A & E department was busy seeing up to 200 patients per day…The reasonable nurse is one who operates in a busy A & E which has a procedure which the nurse will follow for streaming and which does not contemplate an exhaustive diagnosis being formed".

   In *Morrison v Liverpool Women's NHS Foundation Trust* [2020] EWHC 91 (QB), Mr Justice Turner at paragraph 24 said:

   "*A balance has to be struck between the needs of any given patient and any other competing professional demands placed upon the clinicians involved. Sometimes, the seriousness and urgency of a patient's presentation and the absence of any conflicting factors will mandate a swift and decisive response. On other occasions, it is equally obvious that the needs of the patient must be deprioritised to allow the clinicians to attend other demands on their time as a matter of priority".*

   And at paragraph 25:

   "There may be cases in which the risk to the patient is sufficiently low as to justify a postponement of treatment… However, where the risk is significant and

increasing a closer consideration of the competing considerations will be called for".

7. "Covid 19" will not, alone, be sufficient reason for failure to meet an appropriate standard of care. An illustration can be drawn from the case of *Pope v NHS Commissioning Board* [2015] 9 WLUK 380 (unreported). A patient with flu-like illness attended a walk-in centre during the swine flu pandemic of 2009. National guidance was to manage such presentations as swine flu. An experienced nurse failed to measure the blood oxygen saturation levels, the requisite machine to do so not being available. That was not a reasonable basis for not following the guidance, there was failure to refer accordingly and avoidable harm resulted.

8. In response to the disruption to medical services posed by Covid 19, NICE has produced several "Rapid Guidelines"[1] in relation to, for example (this is not an exhaustive list):

   - Delivery of radiotherapy
   - Dialysis service delivery
   - Acute myocardial injury.

9. Although the recent case of *Price v Cwm Taf University Health Board* [2019] EWHC 938 (QB) established that departure from NICE guidelines is not necessarily *prima facie* evidence of negligence it also established that a clinical decision which departs from NICE Guidelines is likely to call for an explanation which adequately explains and justifies the decision. The nature and degree of detail required in relation to the explanation will depend on all the circumstances. In light of this and *Pope v NHS Commissioning Board,* it would seem that whereas some delays in assessment and/or treatment may be properly justifiable in the context of Covid 19, whereas in non-Covid times they would not have been. Others however will continue to represent a breach of duty of care in all the circumstances.

CASES ALREADY "IN THE SYSTEM"

10. Limitation issues:

    These have been addressed in Goldsmith Chambers' Practice Note on "Time limits in the age of Covid-19". However, in general terms, it must be remembered that neither the Coronavirus Act 2020 nor the "emergency" Civil Procedure Rules amendments in Practice Directions 51Y, 51Z and 51ZA change the position on limitation periods. It is always the wisest course to avoid leaving things to the last minute. If necessary, practitioners should seek to work with opponents to agree

[1] https;//www.nice.org.uk/covid-19 – downloaded on 08 June 2020

extensions on limitation and/or agreement of extension on time for service of a claim form/particulars of claim where appropriate.

11. Medical evidence:

Whilst PD 16.4.3 sets out in "mandatory" terms:

"*where the claimant is relying on the evidence of a medical practitioner the claimant must attach to or serve with his particulars of claim a report from a medical practitioner about the personal injuries which he alleges in his claim"* (emphasis added);

medical experts whose supportive screening or outline opinion has already been obtained may not currently be in a position to "finalise" the necessary medical report in a format to accompany the Particulars of Claim.

Here, *Mark v Universal Coatings and Services Limited* [2018] EWHC 3206 (QB) may be of assistance. Mr Justice Martin Spencer held that there is no implied sanction for failing to serve a medical report, commenting that there is a "*wide range of personal injury litigation",* with a "*significant difference between at one end of the scale, a simple running-down action and, at the other end…a complicated clinical negligence action…".* Failure to serve a medical report with the Particulars of Claim can (in the appropriate circumstances) be addressed by stating in the covering letter when the Particulars of Claim are served that this this will follow. The court can then case manage the claim accordingly. A further approach would be to seek agreement that service of the medical report (and hence also the Defence) may be delayed.

12. Quantum issues:

There may well be impact on the value of claims for future loss of earnings in existing claims, as the effects of job losses which are likely to continue given the economic effects of the pandemic become even more apparent. This will need to be factored in when negotiating and considering offers to settle and clients' expectations need to be managed accordingly.

13. ADR:

Clinical negligence claims can be protracted at the best of times. The delay now added to the process because of court closures, adjourned hearings and remote working of legal representatives together with the economic issues referred to, may mean that defendants will make and claimants will wish to consider accepting offers to settle for damages somewhat lower than they would otherwise have considered. It is always important that in such situations clients are appropriately advised regarding quantum and adequate records of the reasoned advice given made.

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EXPERT EVIDENCE IN NEW CLAIMS ARISING DURING PANDEMIC

14. The relevant expertise of an expert in relation to the claim in hand always needs to be considered. When a case is heavily "context-specific", it will be important to ensure that any expert is able to assist the court in relation to the context of working under "Covid-19 modified conditions".

    It will therefore be necessary to consider this when instructing an expert. This could preclude some experts who have retired from practice and not returned during the pandemic from being considered ideal to assist the court in the just disposal of the case. It will be sensible to include within instructions to experts considering issues of breach of duty and causation a specific request to consider the contextual effects of the conditions prevailing at the relevant time.

INCREASE OR DECREASE IN CLINICAL NEGLIGENCE CLAIM ENQUIRIES IN THE FUTURE?

15. It is obviously too early to know for sure. Varying thoughts are:

    - There will be fewer claims because people are extremely grateful for the efforts of NHS workers.
    - There will be fewer successful claims because of the effects of context on breach of duty in all the circumstances.
    - People will be encouraged to bring claims because they are suffering financially.

16. As always with clinical negligence claims, sensible investigation/advice early on is recommended, bearing in mind that establishing breach of duty may be more difficult than usual, depending on context but also firmly remembering that establishing causation of loss is just as important.

This note is for general information only and is not intended to constitute legal advice on any general or specific legal matter. For legal advice on particular cases please contact Ben Cressey, Senior Civil Team Clerk, on 0207 427 6810 to discuss instructing Counsel.

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