Consent, causation, and competence

Dr Jock Mackenzie provides a round-up of recent clinical negligence case law

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In *Sandra Maria Correia v University Hospital of North Staffordshire NHS Trust* [2017] EWCA Civ 356, the Court of Appeal considered the claimant's (C) appeal against a lower court finding that, while an operation had been performed negligently, it had not caused chronic regional pain syndrome (CRPS).

C suffered with a painful foot neuroma and a surgeon proposed to perform a rare three-stage procedure. It was common ground that all three stages needed to be performed for the operation to be carried out competently, but neither the consent form nor the operation note mentioned stage three (nerve relocation). The recorder found the procedure was performed negligently and there was no appeal against that finding. However, two issues arose on appeal: consent and causation.

Regarding consent, C asserted that, in omitting stage three, the surgeon had not performed the operation to which C had consented and had failed to warn of the material risks of the surgery, namely the neuroma was likely to reform if the nerve was not relocated. C argued that, following *Chester v Afshar* [2005] 1 AC 134, the injury was within the scope of the duty to warn and, had she been so warned, she would not have proceeded with the surgery and did not need to show the negligence caused the damage.

The Court of Appeal dismissed C's argument: the consent process had been acceptable and the negligent omission of the third stage did not negate valid consent; as such, the injury was not 'intimately linked' to the duty to warn and *Chester* was of 'scant support'. Further, C had made no contention that she would not have proceeded with, or would have deferred, surgery had she been warned and no such point had been pleaded, therefore there was no evidence to support the point on appeal.

On the issue of causation, the recorder had determined that, although the neuroma had probably reformed post-operatively because the nerve had not been relocated, that was not the cause of C's ongoing pain. The court did acknowledge some valid criticism of the recorder with respect to a failure to consider a possible material contribution argument following *Bailey v Ministry of Defence* [2008] EWCA Civ 883, but on all the evidence considered the recorder was entitled to reject C's expert's evidence, although it was noted in passing that not every judge would have concluded that C failed on causation.

Standard of competence

In another appeal case, *FB (suing by her mother and litigation friend, WAC) v Princess Alexandra Hospital NHS Trust* [2017] EWCA Civ 334, the Court of Appeal considered the claimant's (F) appeal against Mr Justice Jay's decision that an A&E senior house officer (SHO) had not been in breach in failing to take an adequate history, conduct an adequate examination, and refer F to the paediatric team.. When F arrived at hospital, the A&E SHO considered that she had an upper respiratory tract infection (URTI) and discharged her. However, she returned to A&E later that day with pneumococcal meningitis and suffered multiple brain infarcts.

Regarding the examination, the judge found that the experts concluded that F would likely have shown 'abnormal state variation' when the SHO examined her and have appeared more unwell than if she had just a URTI. However, the judge also found that the signs were subtle and would need an expert eye to identify them, concluding that it would not be unacceptable for an SHO to fail to do so.

Regarding the history, the SHO had failed to record that one of F's symptoms was eye rolling, which is what had precipitated the A&E attendance. F's parents would have provided this information if asked. The judge found that an A&E consultant or a paediatrician would have embarked upon a line of enquiry that would likely have elicited this history, but again concluded the SHO was not negligent for failing to do so.

The appeal concerned the standard of competence of a district general hospital A&E

SHO taking a history and performing an examination. As to the latter, the expert evidence was that the ability to pick up subtle signs came with experience; however, as to the history, the expert evidence supported that an A&E SHO should have asked F's parents what had prompted attendance and the court considered that this failure was a breach of duty.

Lord Justice Jackson noted that a hospital doctor was to be judged by the standard of skill appropriate to the post they were fulfilling and their particular experience or length of service were to be left out of account (*Wilsher v Essex Area Health Authority* [1987] 1 QB 730 considered). Further, a health authority was liable if the doctor it put in a particular position did not possess the requisite skills. In this case, the A&E SHO was to be judged against the standard of a reasonably competent A&E SHO: that they were 'relatively inexperienced' did not diminish, and that they had some paediatric experience did not elevate, the required standard.

Causation issues

In *Velarde v Guy's & St Thomas NHS Foundation Trust* [2017] EWHC 1250 (QB), Mr Justice Langstaff considered whether post-operative management following a pulmonary arterial banding procedure was acceptable, after the claimant (V) suffered a significant brain injury from cerebral venous sinus thrombosis. V's case was that this 'clot' was due to unacceptable care in two respects: too little fluid administered, and too much captopril given too quickly.

The judge concluded that, although captopril was increased at a rate faster than in many units, some units would have adopted such a rate; in any event, the approach required tailoring to the individual patient. With respect to the fluid restriction, there was good reason in V's case to restrict fluid, the restriction was only moderate and was closely monitored, and, while the regime was strict, it was not below an acceptable standard. If it had been necessary to decide causation, the judge would have concluded the mechanism was essentially as asserted by V, but, nevertheless, the injury would not have been reasonably foreseeable. V's claim failed.

In a case concerning abdominal hernia mesh repair surgery, *Diamond v Royal Devon & Exeter NHS Foundation Trust* [2017] EWHC 1495 (QB), His Honour Judge Freedman concluded there was a breach of duty on two issues: first, the failure by a surgeon to conduct an abdominal examination at a review appointment, resulting in a two-month delay to surgery for which he awarded £7,500, and second, a failure to obtain proper informed consent regarding the potential adverse effects on any future pregnancy of a mesh rather than a primary suture repair. However, as the surgeon would still reasonably have recommended mesh repair and the claimant would have followed that advice, causation was not established. Further, assertions that a mere failure to warn of risks, without more, gives rise to a free-standing claim in damages failed (*Montgomery v Lanarkshire Health Board* [2015] 2 WLR 768 and *Chester* considered; *Correia* followed).

No loss

In *Smith v Barking Havering & Redbridge NHS Trust* [2017] EWHC 943 (QB), His Honour Judge Reddihough considered that a surgeon had not failed properly to identify the claimant's (S) sigmoid colon polyp, resulting in ongoing bowel symptoms and an eventual sigmoid colectomy. He had not negligently failed to carry out appropriate investigations; but, even if he had, the polyp would not have been located; even if it had been, the same surgery would have been performed; and, in any event, S's ongoing symptoms were due to diverticulitis rather than the polyp, so there was no loss.

Psychiatric injury claims

Mr Justice Goss had to determine breach of duty and 'nervous shock', causation having been conceded, in *RE and others v Calderdale & Huddersfield NHS Foundation Trust* [2017] EWHC 824 (QB), in which the claimant (RE) suffered a serious brain injury in the moments around her birth. The judge concluded that there was a breach of duty and appropriate earlier delivery would have avoided all damage. He also went on to find in favour of psychiatric injury claims for PTSD by the claimant's mother, who was a primary victim – although it would have been found even if she was a secondary victim – and the grandmother, who was a secondary victim.

Alternative treatments

Finally, in *Hegarty v University Hospitals Birmingham NHS Foundation Trust* (LTL,26 June 2017, extempore), Judge Platts considered that a claim based on the requirement to offer alternative treatments to surgery, namely doing nothing, using medication, or having injections, failed on the basis that the claimant (H) would have proceeded with surgery in any event. However, H succeeded regarding negligent nursing treatment and was awarded damages of £8,000. SJ

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