Claims for clinical negligence

Patients who have been harmed as a result of negligent care can claim financial compensation. Such civil claims for negligence follow set legal rules which vary across the UK jurisdictions.

This guidance is general and applies to all areas of the UK. Where there are jurisdictional differences these are pointed out.

Basic considerations

There are strict time limits within which a patient must raise a claim for negligence; if these are not met, the right to bring a claim will be lost. For a mentally competent adult patient, the time limit is three years from the date of the alleged negligence, or from the date on which the patient became aware (or ought reasonably to have been aware) that they have suffered a loss, which may have been connected to the care provided. Where a case is brought by relatives in relation to the death of a patient, the three year period will run from the date of death.

In the case of children, the relevant date is extended until three years after their 18th birthday, regardless of when the treatment took place. In a case involving treatment of a six year old child, for example, another 15 years will pass before the claim 'timebars'.

Where an adult patient lacks mental capacity, there is no time limitation on when a clinical negligence claim may be raised on their behalf. If the patient re-gains capacity, then the three year clock will start to run from that point.

In certain circumstances, the court may allow a claim to proceed despite the fact that it has time-barred, if it is considered equitable to do so. This is, however, rare and the court would take account of any prejudice to the defending clinician in allowing a late claim to proceed (for example, if witnesses are no longer available or relevant records may have been destroyed).

For a negligence claim to succeed, the claimant must prove the following three elements:

1. There is a duty of care owed by the clinician to the patient;
2. The duty has been breached (in terms of the test outlined below). ; and
3. The breach in the duty has caused harm to the patient (and the harm was reasonably foreseeable). This is referred to as 'causation'.

In most cases of clinical negligence, the first requirement is easily met; the second and third are those which usually require detailed investigation and analysis.

Breach of Duty

It is well-established law in England that a clinician is not negligent if they have acted in accordance with a responsible body of opinion; to be negligent the doctor must have acted in a way in which no reasonable doctor acting in the same circumstances would have acted (the '*Bolam standard'*). The case of *Bolitho* qualified this, narrowing the scope of the test to reflect that the court must be satisfied that the body of opinion relied upon has a logical basis: the ultimate decision therefore rests with the judge, who is not bound to follow the medical experts.

In Scotland the leading authority is the case of *Hunter v Hanley*. This provides that a claimant must be able to prove that there was an established practice, that the clinician has not adopted that practice and that the course adopted was one which no other clinician (of the same discipline) of ordinary skill would have taken, had they been acting with ordinary care.

"In the realm of diagnosis and treatment there is ample scope for a genuine difference of opinion and one man clearly is not negligent merely because his conclusion differs from that of other professional men"

In order to succeed with an action for clinical negligence, a claimant therefore requires to obtain expert evidence from a clinician of the same specialism, commenting on the standard of care provided against the appropriate legal test, as set out above.

On receipt of a claim for negligence against an MDDUS member, we will obtain our own expert evidence on breach of duty, to establish whether a defence to the claim is available. This is often the most anxious part of a claim for our members, who are concerned to have an independent overview of the standard of care that they provided.

Often the clinician involved will have no knowledge of the fact that a claim is to be made until some years after the event. In this situation, it can be difficult to remember the precise detail of the relevant consultations. A clinician subject to a claim may therefore have to rely on the clinical records made at the relevant time and on their usual practice in such circumstances. This underlines the importance of accurate, contemporaneous record-keeping.

Causation

After considering breach of duty, attention turns to the concept of causation, i.e. did the breach of duty cause (or materially contribute to) the loss complained of? This involves consideration of the 'but for' test, i.e. but for the alleged negligence, what is likely to have happened?

The standard of proof in these claims is "on the balance of probability" i.e. the chance that something happened is more than 50 per cent.

It is often the case, even where breach of duty can be established, that the claimant has either not suffered any loss, or would have suffered the same losses, in any event, even if there had been no negligence. In this situation a claimant cannot succeed with their claim; compensation is not available simply in recognition of the fact that there has been a breach of duty and causation is a key aspect of these cases.

Again, this often involves the instruction of further expert evidence to determine what caused the loss complained of by the claimant, on the balance of probabilities, and what would have happened in the absence of any negligence.

Procedure

Claims are usually intimated well in advance of court proceedings to allow adequate investigation and the possibility of an agreed outcome, without recourse to court. If a claim gets to court this can be very expensive because of the legal costs involved.

A claim may be intimated in a number of ways:

England – in England there is a statutory pre-action protocol for medical negligence cases, which aims to resolve these cases without the need for court proceedings. The protocol sets out a clear process for recovery of healthcare records and notification of a claim. The claimant requires to send a letter of claim, which includes a summary of the facts, allegations of negligence, any expert evidence available, injuries suffered and any other financial losses incurred. A formal response must then be sent within four months. If this process does not result in settlement of the claim, court proceedings can be raised, but there are penalties in costs for a claimant who raises proceedings without first following the protocol steps.

Scotland – In Scotland there is currently no compulsory pre-action protocol for clinical negligence cases and claimants can therefore choose to raise proceedings when they wish (although it is generally in the interests of both parties to explore and discuss the claim pre-litigation, with a view to minimising expenses on both sides, if settlement can be reached). A pre-action protocol for clinical negligence cases was previously piloted in Scotland and, at the time of writing, it is anticipated that a compulsory pre-action protocol may be brought into force later in 2021.

Wales –The system mirrors that in England.

Northern Ireland – The system mirrors that in England, but courts are reluctant to impose penalties for non-compliance with the pre-action protocols.

Jersey/Guernsey/Isle of Man – there are no formal pre-action protocols, however, the overriding objective is for all parties to deal with matters expeditiously and proportionately to save expenses.

Hearings

Ultimately, even if court proceedings require to be raised, the vast majority of claims will still be abandoned or settled long before a hearing of evidence is required. If such a resolution is not achievable, a formal hearing known as a Trial (England, Wales and Northern Ireland) or Proof (Scotland) will be held. Factual and expert evidence will be led by both parties, following which a judge (or, in some limited circumstances, a civil jury) will reach a decision on the case.

In the event that such a hearing is required, MDDUS will work closely with our members to ensure that they are prepared to give evidence and have a clear understanding of the process involved.

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Compensation in a clinical negligence case is intended to return the claimant, as far as possible, to the position they would have been in, but for the negligence. The amount agreed by the parties or fixed by the court will reflect the level of pain and suffering, the type of injury (more serious injuries attract greater awards) and financial losses which include loss of potential earnings / pension, disadvantage on the labour market, the cost of any necessary remedial treatment and payments needed for extra care and assistance.

Once we have obtained the necessary expert evidence on breach of duty and causation and any further evidence necessary to quantify the claim, we will be in a position to assess the merits of the case and to advise members further in relation to the prospects of a successful defence or, where appropriate, offering an out of court settlement.

Key points

- Claims can arise many years after an event.
- Medical records are essential evidence in any claim.
- **There are strict timetables when dealing with claims and it is important to avoid delays in responding to correspondence.**
- Alert MDDUS to correspondence intimating a claim as soon as you receive it.
- Cooperate in a timely manner when involved in any claim investigation.
- The investigation of a claim for negligence can take several years. There are undoubtedly stresses associated with being subject to a claim and it is important to seek support from the MDDUS team as and when needed.