Neutral Citation Number: [2024] EWHC 1360 (KB)

Case No: QB-2020-002483

IN THE HIGH COURT OF JUSTICE
KING'S BENCH DIVISION

Royal Courts of Justice
Strand, London, WC2A 2LL

Date: 7 June 2024

Before:

DEXTER DIAS KC
(sitting as a Deputy High Court Judge)

- -

Between:

ALISON HEALEY
(Widow and Executrix of the Estate of Simon Andrew Healey, Deceased)

Claimant

-and-

MR DANIEL McGRATH

First Defendant/ Part 20 Defendant

-and-

RAMSAY HEALTH CARE UK OPERATIONS LIMITED

Second Defendant/ Part 20 Claimant

- -
- -

Adam Weitzman KC (instructed by **Kennedys**) for the **Part 20 Claimant**
Mr McGrath in person

Hearing dates: 17 April 2024

- -

Approved Judgment

This judgment was handed down remotely on 7 June 2024 by circulation to the parties or their representatives by e-mail and by release to the National Archives.

Dexter Dias KC:

(Sitting as a Deputy High Court Judge)

1. This is the judgment of the court.

2. To assist parties and the public follow the court's line of reasoning, the text is divided into 11 sections, as set out in the table below.

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B12: hearing bundle page number; S34: supplementary bundle

CS/DS §45 claimant/defendant skeleton paragraph number.

3. These are Part 20 contribution proceedings under the Civil Procedure Rules 1998 ("CPR"), following the compromise of a clinical negligence claim (the "main claim"). The Part 20 claimant and second defendant in the main claim is Ramsay Health Care UK Operations Limited ("Ramsay"). Ramsay is represented by Mr Weitzman KC. The Part 20 defendant and first defendant in the main claim is Mr Daniel McGrath. Mr McGrath has been appearing in person, but something more must be said about his participation in proceedings.

4. The claimant in the main claim was Mrs Alison Healey, the widow and executrix of the estate of Mr Simon Healey. Mr Healey died as a result of the negligence of both defendants following a right hemicolectomy (surgical) procedure at the Ramsay Berkshire Independent Hospital (the "Hospital") in August 2017. Mr McGrath is a Consultant General Surgeon, and performed the surgery on 1 August 2017. After what is called an anastomosis leak and resulting sepsis, tragically Mr Healey died on 10 August 2017.

5. Mr McGrath breached his duty of professional care towards Mr Healey and was thus negligent. Ramsay is liable for the admitted negligence of its employed nursing and auxiliary staff at the Hospital. In her report, which is not the subject of challenge, the

nursing expert Ms Botting identified "a failure by the nurses to (i) ask for more frequent reviews and (ii) to carry out more frequent observations, and, when the NEW [National Early Warning] score was 7, continuous observations".

6. Due to the failures in the care that her husband received, Mrs Healey brought a fatal claim on behalf of herself, the estate and Mr Healey's dependents. On 21 December 2022, captured in a Tomlin Order dated 6 February 2023, Ramsay settled the main claim with the main claimant on a unilateral basis for £1.2 million plus reasonable costs (subsequently agreed at £417,500), CRU (£nil) and NHS charges (£2,704). Ramsay reserved its position about a contribution claim. Previously, on 18 December 2020, Ramsay had served a contribution notice on Mr McGrath seeking indemnity or such contribution as is just and equitable.

7. Since 17 November 2022, when his former solicitors came off the record with the court's approval, Mr McGrath has appeared in person in the main claim and the Part 20 proceedings. However, he failed to attend the trial of the contribution proceedings before this court on 17 April 2024. That is the latest act in a course of non-engaging conduct by him. He also failed to file any lay or expert evidence in the Part 20 proceedings (although he did file a statement in main proceedings in May 2022); failed to file a skeleton argument; and failed to engage at all with the Ramsay's solicitors following a listing for summary judgment before HHJ Robinson on 29 January 2024. I find no possible basis not to proceed with the Part 20 trial and have received no submissions making such an application. Further, I have considered carefully such aspects of Mr McGrath's case as I could determine them, given his almost wholesale failure to participate. I sought submissions from Mr Weitzman in particular on issues of the causative contribution of nursing staff failures (and thus second defendant's contribution) to Mr Healey's death. I also pressed Mr Weitzman on aspects of his costs submissions. Given Mr McGrath's refusal to engage, the court faced a formidable obstacle to explore Mr McGrath's case beyond this.

8. Despite his absence and non-engagement, I judge it important in the public interest, and especially as a courtesy to Mrs Healey and her children, who may wish to know what has happened in further proceedings resulting from Mr Healey's death, to provide a judgment for the record setting out the court's thinking in reaching the conclusions it has.

§II. LAW

9. The legal principles on the question of apportionment are settled and clear. Section 51 of the Senior Courts Act 1981 ("SCA") provides, insofar as it is material:

> "**51 Costs in civil division of Court of Appeal, High Court and county courts.**
>
> (1) Subject to the provisions of this or any other enactment and to rules of court, the costs of and incidental to all proceedings in—
>
> …
>
> (b) the High Court;

…

shall be in the discretion of the court.

(2) Without prejudice to any general power to make rules of court, such rules may make provision for regulating matters relating to the costs of those proceedings including, in particular, prescribing scales of costs to be paid to legal or other representatives

(3) The court shall have full power to determine by whom and to what extent the costs are to be paid."

10. Part 44 of the CPR provides insofar as it is material:

"Discretion as to costs

44.2

(1) The court has discretion as to –

(a) whether costs are payable by one party to another;

(b) the amount of those costs; and

(c) when they are to be paid.

(2) If the court decides to make an order about costs –

(a) the general rule is that the unsuccessful party will be ordered to pay the costs of the successful party; but

(b) the court may make a different order.

(3) The general rule does not apply to the following proceedings –

(a) proceedings in the Court of Appeal on an application or appeal made in connection with proceedings in the Family Division; or

(b) proceedings in the Court of Appeal from a judgment, direction, decision or order given or made in probate proceedings or family proceedings.

(4) In deciding what order (if any) to make about costs, the court will have regard to all the circumstances, including –

(a) the conduct of all the parties;

(b) whether a party has succeeded on part of its case, even if that party has not been wholly successful; and

(c) any admissible offer to settle made by a party which is drawn to the court's attention, and which is not an offer to which costs consequences under Part 36 apply.

(5) The conduct of the parties includes –

(a) conduct before, as well as during, the proceedings and in particular the extent to which the parties followed the Practice Direction – Pre-Action Conduct or any relevant pre-action protocol;

(b) whether it was reasonable for a party to raise, pursue or contest a particular allegation or issue;

(c) the manner in which a party has pursued or defended its case or a particular allegation or issue"

11. The Civil Liability (Contribution) Act 1978 ("CLCA") provides at Section 2(1):

> "(1) Subject to subsection (3) below, in any proceedings for contribution under section 1 above the amount of the contribution recoverable from any person shall be such as may be found by the court to be just and equitable having regard to the extent of that person's responsibility for the damage in question."

12. The Court of Appeal gave further guidance in *Downs v Chappell* [1997] 1 WLR 426 ("*Downs v Chappell*"), where Hobhouse LJ said at 445H:

> "The extent of a person's responsibility involves both the degree of his fault and the degree to which it contributed to the damage in question. It is just and equitable to take into account both the seriousness of the respective parties' faults and their causative relevance. A more serious fault having less causative impact on the plaintiff's damage may represent an equivalent responsibility to a less serious fault which had a greater causative impact. The present case is such a case. The judge was entitled to decline to distinguish between the responsibility of the two defendants for the damage to the plaintiffs."

§III. ISSUES

13. The court was invited to rule upon two broad matters (1) apportionment (divided in fault and causative contribution as per *Downs v Chappell*) and (2) costs (three distinct issues). Therefore, the prime issues can be further subdivided into narrower questions, resulting in five issues:

    (1) Fault

    (2) Causative contribution

    (3) Costs: Claimant's costs

    (4) Costs: Ramsay's main claim costs

    (5) Costs: Ramsay's Part 20 costs

§IV. EVIDENCE

14. The court has carefully considered the pertinent evidence in the filed bundles, and reserved judgment to review the material again following the trial to reflect on the evidence in light of the submissions made. In this section, I do not set down all the relevant evidence as that would unnecessarily and unhelpfully extend the length of the judgment. Here the most relevant evidence that influenced the court's decision is noted. That said, I am reminded of the words of the Court of Appeal in *Re B (A Child) (Adequacy of Reasons)* [2022] EWCA Civ 407. McFarlane P stated at [58] that a judgment is "not a summing-up in which every possibly relevant piece of evidence must be mentioned" (Proposition (4)). Thus, I focus on what is important.

Mr McGrath

15. Mr McGrath's statement is dated 9 May 2022 and extends to 43 paragraphs. He states:

> "I qualified with a MB BCh BAO from Queens University, Belfast, in 1995. I have a PhD from the University of Newcastle, Australia and an FRCS (General Surgery) from the Intercollegiate Specialty Board.
>
> I qualified as a Consultant General and Colorectal Surgeon in 2010. I initially worked as a Consultant Colorectal Surgeon (Locum) at St Mark's Hospital, Harrow from June 2010 until March 2011. Since April 2011, I have been employed as a General and Colorectal surgeon at the Royal Berkshire Hospital, Reading, where I still work.
>
> I also undertake private practice and between September 2013 and March 2019, I undertook private practice at the Berkshire Independent Hospital, where I treated Mr Healey.
>
> I first met Mr Healey in my NHS clinic at the Royal Berkshire Hospital on 27 July 2017. In Mr Healey's case, surgery (possibly followed by chemotherapy, depending on the histology) was the best chance of a curative option. Other available options, such as chemotherapy, radiotherapy, or any treatment which was non-surgical, would be non-curative. I explained this to Mr Healey, and we discussed the fact that since he was a younger patient, with very few other medical conditions, surgery was the best option for him.
>
> Mr Healey requested to undergo the surgery on a private basis, funded by his private health insurance. I confirmed that this was a possibility, and he was keen to pursue this. However, I explained to Mr Healey that there are risks involved in undergoing a procedure of this nature in a private hospital – mainly the absence of an Intensive Care Unit (ICU). However, Mr Healey was young, with few medical problems, and therefore I considered it was reasonable to perform the surgery privately."

16. Mr McGrath details the actions he took at every stage. He was, he states, duly vigilant about Mr Healey's condition and his deteriorating presentation, but despite his efforts, his patient "sadly died on 10 August 2017". His position in respect of liability evolved. He did not accept breach of duty in relation to his conduct on 4 August 2017, but did admit limited breach in respect of 5 and 6 August, accepting that

he should have arranged an X-ray to investigate a potential anastomotic leak. He denied liability by not admitting causation in his Defence and then denying causation in his Amended Defence. Mr McGrath issued his own Contribution Claim against Ramsay. In it, he asserts that Ramsay's nursing staff and the RMO, for whom it is said Ramsay is liable, owed Mr Healey an independent duty of care. He alleged this gives rise to an independent liability which is neither reduced or extinguished by Mr McGrath's actions. In the way that will be explained, a failure to follow certain important guidance is conceded by Ramsay.

Professor Schofield

17. Professor Schofield was instructed for the coronial proceedings by HM Coroner, but his expert report was admitted into evidence for the purposes of the main claim. The Professor is a Fellow of the Royal College of Surgeons of England and of Edinburgh, was Head of Division of Surgery, Professor of Surgery (Consultant Surgeon) at University Hospital, Queen's Medical Centre, Nottingham until October 2017 when he retired from NHS practice. Since that time he has continued his research interests alongside private and medicolegal practice. The critical passages from Professor Schofield's opinion include:

> "6. Anastomotic leak is the most feared complication after bowel surgery, as its presentation can be insidious and, if not detected promptly, the patient can become desperately sick and may occasionally die from sepsis and multi-organ failure. Thus, all responsible colorectal surgeons should have a high index of suspicion to detect this complication as early as possible and to treat it promptly (this almost always means re-operation).
>
> 7. Unfortunately, Mr Healey did develop an anastomotic leak which probably began around 4" August 2017 (with the benefit of hindsight), and the leak was not identified until 7" August, by that time Mr Healey had developed systemic sepsis. Despite surgery to wash out the sepsis and despite maximal ITU therapy, he went on to develop multi-organ failure and sadly he died on ITU 9 days after his cancer resection.
>
> 8. Anastomotic leaks may occur in up to 10% of elective colonic anastomosis, and most commonly occur in the pelvis. Right hemicolectomy where small bowel is joined to large bowel is regarded as slightly safer than a colorectal anastomosis as the small bowel has a very good blood supply. The leak rate after elective right hemicolectomy is said to be around or less than 5%.
>
> 16. It is notable in all of the entries that Mr McGrath has written in the postoperative period there is not any evidence of examination of Mr Healey's abdomen, which I would have thought was a fairly fundamental part of an assessment.
>
> 18. It may be that Mr McGrath didn't record negative findings. However, abdominal tenderness can be a useful indicator of potential abdominal sepsis.

22. … Mr Healey's early warning scores on the 3" and 4" were starting to go up from 2-6at 11 o'clock on 4" August. This led to the nurses on 4" August instituting their "deteriorating patient pathway".

23. It does not seem that Mr McGrath was particularly concerned on 4" August, despite the fact that the white count was elevated and the CRP was significantly elevated at 607.

24. In my view, this was a very significant and unexplained rise in the CRP on 4 August (normal range, less than 40). Most surgeons find CRP is a useful and sensitive indicator of acute inflammation following abdominal surgery. A CRP of 607 is massively elevated and it should have rung alarm bells for Mr McGrath - in my view this result in a patient who was not making the expected progress after a laparoscopic hemicolectomy mandated an abdominal CT scan.

26. In my opinion, the sudden rise in CRP on 4" August was probably indicative of intra-abdominal sepsis- at least gut bacteria in the peritoneal cavity.

27. In Mr McGrath's statement he notes that the CRP had risen on 4" August to 607 but thought this was "a consequence of ileus" – I strongly disagree as an ileus would not cause a CRP of this magnitude.

28. Mr McGrath's statement also comments that on 4th there was rise in creatinine "suggesting an acute kidney injury" - It is my opinion that an acute kidney injury should have rung alarm bells as, although in the presence of a severe ileus, fluid shifts into the gut may occur, an acute kidney injury is commonly associated with intra-abdominal sepsis.

29. Mr McGrath does not seem to have been concerned as to the cause of Mr Healey's ileus, just accepting it as consequence of intestinal surgery, but given that after laparoscopic colectomy most patients do no experience an ileus, and that they usually go home 2-3 days after bowel resection, his lack of concern seems odd.

32. Being sweaty is not generally consistent with an ileus, though I accept that abdominal distension would be seen in an ileus. Again, all experienced colorectal surgeons would be questioning why the patient had an ileus 5 days after an uneventful right hemicolectomy.

34. On admission at the Royal Berkshire Hospital Mr Healey was already showing signs of severe systemic sepsis."

18. Professor Schofield concludes:

"42. Although I am critical of the delay in recognizing the possibility of anastomotic breakdown around 4" August, my concern in this case is that alarm bells should have been ringing for Mr McGrath on 4" August that there was a real risk of the dreaded complication of anastomotic failure.

> This was overlooked until the X ray on 7" August showing free gas, and I am convinced that this delay has played a significant part in the sequence of events which followed.
>
> 43. Although Mr Healey had relatively minor faecal contamination at operation on 8" August and again on 10" August, he clearly had a lot of bacteria in his peritoneal cavity as a result of the leak of fluid and air and the fibrinous peritonitis seen at post-mortem, indicating that he had a considerable bacterial load in his peritoneal cavity. A delay in diagnosis has probably resulted in his death from what was probably otherwise a salvageable condition with surgery on the 4th, 5th or even 6th August."

Mr Cundall

19. Mr Jeremy Cundall is Consultant in General/ Colorectal Surgery and Executive Medical Director, County Durham and Darlington NHS Foundation Trust. His expert report states:

> "The Deceased underwent a routine laparoscopic right hemicolectomy for a colorectal malignancy with curative intention. This was performed at the Second Defendant's Berkshire Independent Hospital.
>
> Within 3 days of the procedure, it became clear that the patient was unwell. This was indicated by persistent pain, markedly abnormal NEWS scores and massively raised CRPs. Despite this, the risk of an anastomotic leak was not considered by Mr McGrath until 7 days postoperatively.
>
> This delay meant that the Deceased did not undergo serial lactate measurements and a CT scan. When the Deceased was transferred to the Royal Berkshire Hospital a CT scan was performed. This indicated an anastomotic leak and the Deceased underwent a laparotomy. At the laparotomy, the anastomosis was not taken down which would have been optimal care but instead it was patched and the bowel was defunctioned proximally.
>
> This procedure did not control the sepsis and he, therefore, underwent a further laparotomy and washout the next day. Despite this, he, unfortunately, succumbed to overwhelming sepsis.
>
> The delay in diagnosis of the leak and the incorrect surgical technique used to treat the leak in my opinion, on the balance of probabilities, caused the Deceased's demise."

Ms Botting

20. Ms Lucy Botting is an Advanced Nurse Practitioner Nurse Tutor, District Nurse and Independent Nurse Prescriber, Epsom and St Helier University Hospitals NHS Trust, St Helier Hospital, Surrey. She found in respect of the conduct of Ramsay's nursing staff:

> "failings in the escalation policy in accordance with the Royal College of Physicians (RCP) NEWS Guidance. Nursing staff failed on occasion to always inform the RMO when the patients NEWS score increased (or remained consistently high) and from the evidence provided, failed to undertake observations in accordance with the NEWS guidance. However I also acknowledge that Ramsay Healthcare are not an acute provider and the nurses were working to a management plan set out by Mr McGrath and the RMO, however the documentation or rationale for not informing the RMO should have been more explicit. And, as such this standard and policy needs to be more clearly set out by Ramsay Healthcare."

Mr Roy

21. Mr Rajahshi Roy is Consultant Clinical Oncologist, Hull University Teaching Hospitals NHS Trust, Hull Royal Infirmary. Mr Roy's expert opinion was sought in respect of causation. His view is that:

> "The post-operative histology had shown high-risk caecal cancer staged as pT4bN2aM0 with vascular invasion and clear resection margins.
>
> But for the post-operative complications, the Deceased would have received 6 months of adjuvant chemotherapy and his 3 year relapse-free survival probability would have been 55%. This is a well accepted surrogate for long-term survival in colon cancer and his chance of cure therefore would have been 55%."

22. Ramsay also filed nursing evidence from seven members of its staff.

§V. Issue 1: Fault

23. Both defendants have admitted liability. Therefore, there must be as a matter of logic some proportion of liability attributed to each of them. The court takes into account all the evidence. I found the evidence of Professor Schofield and Mr Cundall particularly persuasive. Mr McGrath has not filed any expert report in response. Indeed, he has not filed any other evidence in response in the Part 20 proceedings.

24. Professor Schofield and Mr Cundall are entirely independent and reach very similar conclusions separately that are critical of Mr McGrath's failure of act. He did not examine Mr Healey's abdomen, or if he did on the first two occasions he claims, which remains doubtful, he did not record his examination or his findings. This in itself is a cause of concern, and indicative of his defective approach to the treatment of Mr Healey which ultimately significantly contributed to his death. Mr McGrath admits that he was negligent on 5 and 6 August 2017 in failing to arrangement an X-ray to investigate a potential anastomotic leak.

25. Professor Schofield termed anastomotic leak with some justice "the most feared complication". It is not necessarily the prevalence rate, occurring in less than 1 in 20 hemicolectomies. It is the fact that patients can become "desperately sick" and "may occasionally die". It is the fact that leaks following such surgery may lead to sepsis,

and that internal poisoning is very difficult to arrest and may cascade out of control and result in multiple organ failure.

26. Mr McGrath was the consultant surgeon in charge of the treatment of Mr Healey. It was Mr McGrath's responsibility to devise the treatment plan to ensure his patient received. The critical treatment delay here was as a result of the failures of both defendants. But I have no hesitation in concluding that the prime fault lay with Mr McGrath. He was responsible for more than 50% of the fault, but not 100% of it. Mr McGrath's failures were very serious. Professor Schofield makes it clear that the failure of Mr McGrath to be sufficiently attentive to the signs of Mr Healey's failure to recover from the surgery and his failure to be sufficiently alert to the risk of an anastomosis leak were the principal failures.

27. In the evaluation of relative proportion, these matters must be weighed against the failure of nursing staff to request more frequent reviews and carry out more frequent observations. But the nursing failures are dwarfed in comparison to the failures of the consultant surgeon Mr McGrath. As Professor Schofield states, but for the "delay in diagnosis" (Mr McGrath's responsibility) death resulted from a condition that was "probably otherwise … salvageable".

§VI. Issue 2: Causative contribution

28. Professor Schofield states "I am convinced that [Mr McGrath's] delay has played a significant part in the sequence of events which followed." It is important to be clear about the mechanism of death in this case. It was caused by sepsis. The sepsis was caused by the anastomosis leak. Once there was a leak following the surgical intervention, it needed to be repaired and the peritoneum cavity washed out to reduce the poisoning from material that should have been removed or excreted from the body. It was necessary to arrange diagnostic imaging to either confirm or exclude the leak. Mr McGrath failed to do that. This failure was the direct cause of Mr McGrath's death.

29. The causative contribution of the nursing failures was limited by comparison. The nursing staff were constrained to request the diagnostic interventions that ultimately were taken, but too late. When Mr McGrath failed to act appropriately, the nursing staff could have considered, as Mr Weitzman put it, "going around" the recalcitrant Mr McGrath. But ultimately the crucial delay was predominantly attributable to the failures of Mr McGrath. Thus the breach of duty by Mr McGrath was more causative of Mr Healey's death.

§VII. Conclusion on contribution

30. To properly evaluate the overall responsibility, it is necessary to combine the two elements of Hobhouse LJ's rubric. The court has identified the mechanism that led to Mr Healey's death. Mr McGrath was very substantially at fault for the failure. His breach of duty significantly exceeds that of D2. The second defendant submits that the just and equitable apportionment is 75:25 in favour of Ramsay. The court agrees.

This proportion reflects the very serious and pivotal nature and quality of Mr McGrath's failures to act and consequence breach of duty.

§VIII. Issue 3: Claimant's costs

31. Ramsay has settled and paid the costs of the main claim. It is unarguable but that Mr McGrath as being chiefly responsible for the breaches of duty causatively linked to death should pay the appropriate contribution of 75%.

§IX. Issue 4: Ramsay's main claim costs

32. Ramsay seeks an order that Mr McGrath pay a proportion of its costs in defending the main claim. Ramsay submits that the appropriate proportion is 75%. This issue, as distinct from the costs payable to the claimant and costs recoverable from contribution proceedings, was considered by this court in *Mouchel Ltd. v Van Oord (UK) Ltd (No.2)* [2011] PNLR 26 at 535-50, (see particularly [53]-[60]). The facts of that case need brief exposition for the decision of the court to be properly understood.

33. The dispute was about the construction of a power station in Lincolnshire that had gone wrong. Kier ("K") subcontracted to the parties. M provided advice; VO's role was construction. There were two principal breaches of duty by M (1) using unsuitable sand; (2) the placement of scour rock around water cooling structures. VO was only involved in the second breach. Using approximate figures, M settled with K in the sum £100,000 damages; interest was £18,000; litigation costs et cetera £400,000. Only £24,000 of the £100,000 damages was attributable to the scour rock (second breach). Of that, VO's contribution was 35%. Thus, VO was liable for £8,500 in damages. VO was not involved in the main proceedings until very late.

34. The case was heard by Ramsey J. He concluded that there was a discretionary power to order a defendant's costs defending the main action, not under the CLCA but under the general s.51 SCA discretion. His reasoning was as follows:

> "53 The provisions of the 1978 Act make it clear that what is being granted is a right to contribute in respect of a party's liability to a third party. As set out above that liability can include liability to that third party for costs. However, I see no grounds upon which a party can seek a contribution in relation to its own costs because that does not form a liability to a third party in respect of damage. It is a liability of the party itself in relation to proceedings brought by the third party, but that does not make it a liability to the third party for damage. In those circumstances I do not consider that there is a claim by Mouchel under the 1978 Act for the costs that Mouchel incurred in the main action.
>
> 54 There is however, it is common ground, a general discretion under ss.51(1) and 51(3) of the 1981 Act and if there is any claim by Mouchel for costs against Van Oord I consider it has to establish that claim under those provisions.

> 55 In cases where the third party proceedings consist of a claim which is passed through to the third party, then depending on the outcome of the third party proceedings, if the third party is liable to a defendant and the defendant is liable to the claimant then the third party may have a liability to pay the defendant's costs which would include costs which the defendant had incurred in defending the claim by the claimant.
>
> 57 As is clear from the issues between Mouchel and Kier they were confined to issues relating to Mouchel's liability to Kier, rather than anything to do with primary liability of Van Oord to Kier. Indeed in this case Van Oord was not involved in the proceedings until a late stage in June 2008. In those circumstances I find it difficult to see the basis upon which the court should exercise its discretion and make an order that Van Oord should contribute to Mouchel's costs in defending proceedings to establish Mouchel's liability, in such circumstances.
>
> 58 In terms of CPR r.44.3(2) the court would generally follow the rule that the unsuccessful party will be ordered to pay the costs of the successful party. In the context of contribution proceedings, that rule applies as between Van Oord and Mouchel in respect of the costs of the third party proceedings. But it is difficult to see how, by Mouchel incurring costs in defending the claims by Kier up to the time of settlement, it can be said that the costs of Mouchel should be borne by Van Oord as being the unsuccessful party.
>
> 59 Equally considering the matters to which the court has to have regard under CPR r.44.3(4) I find it difficult to see that there are circumstances in this case which would lead to it being just to make an order that Van Oord should pay some of Mouchel's costs. There does not appear to me to be any conduct by Van Oord to justify such an order. And this is borne out by considering the various matters included as conduct in CPR r.44.3(5). The fact is that Van Oord were not involved until very late in the main action and then by way of contribution proceedings and I do not see that there is anything in that conduct which justifies making an order that Van Oord should pay some of Mouchel's costs. In particular, in the context where Van Oord's overall liability to contribute is only a small percentage of the overall settlement so that it cannot have been a material factor in Mouchel deciding whether to settle or not and where the costs of the third party proceedings will reflect matters as between Van Oord and Mouchel, I do not consider that it is appropriate to exercise my discretion and award Mouchel a contribution for its costs of defending the claim by Kier."

35. Ultimately, the judge refused to grant the order applied for. That was a fact-specific decision, based on the late involvement of VO and its limited contribution to the breaches of duty that resulted in the overall level of damages. The judge proceeded to state at [60]:

> "Whilst there might be cases which would make it just for a contributing party to make payment of some of the other party's costs of defending

> proceedings against a third party, there is nothing in this case to suggest that this is appropriate here."

36. Therefore, the decision leaves open the possibility of cases where it would be appropriate to exercise the discretion in favour of such a defendant. Is Ramsay Health Care one such defendant who should be entitled to a contribution in costs from Mr McGrath in respect of the *main* claim? There are a number of relevant matters, involving the nature of the claims and the conduct of parties, both relevant CPR factors:

    (1) Mr McGrath was involved from the start as the surgeon in charge of Mr Healey's treatment;

    (2) The role of the nursing staff for whom Ramsay is liable is very much subordinate to Mr McGrath. He devised the treatment plan. They could not. They were entitled to rely upon his experience and expertise to arrange a safe treatment pathway for Mr Healey. But Mr McGrath did not do that and his failures were the substantial contributory cause of Mr Healey's death;

    (3) While Ramsay was realistic enough to compromise the claim brought by Mrs Healey, Mr McGrath did not. That is why Ramsay brought contribution proceedings.

    (4) Having reviewed the papers carefully, and especially in light of the expert evidence from Mr Cundall and Professor Schofield, it is difficult to understand how Mr McGrath's defence was tenable. In fact, it was fundamentally flawed;

    (5) His failure to compromise the main claim with Mrs Healey mirrored closely his limited engagement in the contribution proceedings leading to summary judgment being entered. Thereafter his almost complete non-participation culminated in his failure to attend trial. While this latter conduct relates to the Part 20 proceedings, it reveals a course of conduct by Mr McGrath that is unsatisfactory, unrealistic and uncooperative.

    (6) The apportionment levels in this case are markedly different from *Mouchel*. There VO was liable for approximately 8.5% of damages, limited to a lesser breach of duty. In this case, Mr McGrath is liable for 75% of damages and his conduct and negligent failures were the principal causative element leading to death.

37. Under the SCA, the court has a necessarily wide discretion. I conclude that for these reasons, it is just for Mr McGrath to contribute to Ramsay's costs of defending the main claim. On one view, Ramsay is 100% responsible for its own negligence. But I regard that as too simplistic a characterisation in this case, and one that is unfair to Ramsay. Its nursing staff were heavily dependent on Mr McGrath's expertise, experience and medical leadership. His negligence set in train a sequence of ultimately catastrophic events. I judge that it is just for Mr McGrath in these specific circumstances to make a contribution to Ramsay's costs. I find that the 75% contribution claimed is excessive and disproportionate. Mr Weitzman in his

submissions realistically observes that the court may feel in its discretion appropriate to award a lesser proportion. It does. On what is before the court, I assess that the fair contribution to Ramsay's own main claim costs that Mr McGrath should pay is one third. That takes into account that Ramsay's negligence did not occur in a vacuum, but arose as a result of circumstances initially caused by Mr McGrath's serious and ongoing breaches of duty. Chiefly, Ramsay's staff members failed to respond to the results of Mr McGrath's negligence in the ways that Ms Botting has identified.

38. The question then becomes what is the just proportion. I step back and look at the overall picture. In doing so, I also look ahead to Issue 5 and weigh that the court will also grant Ramsay's application for its Part 20 costs. The global picture is that Mr McGrath must make a 75% contribution to damages; he must pay 75% of the claimant's costs and 100% of Ramsay's Part 20 costs. In those global circumstances, the fair proportion of Ramsay's main claim costs Mr McGrath should pay is one third.

§X. Issue 5: Ramsay's Part 20 costs

39. In the Part 20 contribution claim, Ramsay is the successful party and Mr McGrath is the unsuccessful party. There is no reason not to follow the general rule that costs follow the event. Mr McGrath must pay Ramsay's costs to be assessed on a standard basis if not agreed.

§XI. DISPOSAL

40. In summary, the orders of the court are as follows, all costs to be assessed on a standard basis if not agreed:

(1) Mr McGrath to pay Ramsay 75% of the agreed damages compromised for £1,200,000;

(2) Mr McGrath to pay Ramsay 75% of the £417,500 costs paid by Ramsay to the claimant;

(3) Mr McGrath to pay Ramsay one third of Ramsay's costs defending the main claim;

(4) Mr McGrath to pay Ramsay 100% of its Part 20 contribution proceedings costs.