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NEWS @ 9

9 GOUGH SQUARE

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Care Claims

Can the value of hospice care be recovered by the claimant?



Stephen Glynn

The facts: James Wilson died on 7th March 2007 aged 75 of asbestos-induced mesothelioma. He had worked as a boiler erector at Deptford power station in the 1950s and worked next to ladders who knocked off old asbestos insulation from adjacent pipework. Mr Wilson was told he had mesothelioma in September 2006 and thereafter his cancer took its usual and inexorable course, leading to his rapid decline and need for steadily increasing care and assistance from his adult daughters.

In fact, Mr Wilson's suffering was greater than most who suffer this cancer: He suffered from breakthrough pain, anxiety, fearfulness and marked depression. He lived alone, his wife having died some years before. He had a large and loving family from which he increasingly withdrew, becoming a virtual recluse in his final weeks.

The claimant, the deceased's youngest daughter, effectively moved in with him, providing a full range of care which included assistance with washing, bathing, dressing and cooking. She sat up during the night with him as his breathing became more difficult and which heightened his sleeplessness because of his fear of never waking up if he fell asleep.

On any view Mr Wilson suffered dreadfully. In the end despite the best efforts of his family, he was admitted to St Joseph's Hospice on 12th February 2007 where he remained for 23 nights until his death. Before his admission, he received weekly visits from the hospice's outpatient team to provide symptom control and medication intake advice, emotional support and assistance with his claims for both compensation and state benefit.





Care claims Can the value of hospice care be recovered by the claimant?

The claim: The estate claimed, in the conventional way, an amount to compensate the family for the gratuitous care which the deceased received from them and the Defendant agreed this head of claim in the sum of £11,000. Could anything be recovered though for the substantial cost incurred by the hospice in providing its care of the deceased which it did on a palliative basis? Could a claim be brought by way of analogy to the family care? This was the issue at stake in **Catherine Drake (PR of the estate of James Wilson, deceased) v. Foster Wheeler Limited** [2010] EWHC 2004 (QB).

St Joseph's Hospice, like many hospices, was funded in part by donations made by local Primary Care Trusts as well as from other grants, gifts, donations and legacies. The evidence was that 62% of the hospice's running costs were funded from these charitable donations. The hospice was able to provide evidence of the cost of its care based upon its management accounts and this showed that essentially £10,021 in costs had been incurred by the hospice in caring for the deceased, net of any NHS/PCT funding.

The basics: HHJ Thornton QC sitting as a Judge of the High Court in *Drake* considered that the claim brought by the estate on the hospice's behalf for the value of its care of the deceased was indeed analogous to the claim brought by the family for its gratuitous care. The Judge reminded himself that since *Hunt v. Severs* [1994] 2 A.C. 350 HL, it was now clearly established that although the "voluntary carer" has no cause of action of his own against the tortfeasor, the law recognised "the justice of allowing the injured claimant to recover the value of the services so that he may recompense the voluntary carer..." (Lord Bridge, page 363 B).

The type of care recoverable: The Court went on to consider that there were a number of previous cases which illustrated the breadth of the type and nature of care which the law recognised as warranting compensation through the agency of the claimant and that this included not just help with washing and dressing and the like but extended to nursing care. The judge noted for example *Hogg v. Doyle*, (unreported, C.A., 6.3.91, Kemp) in which the value of nursing care was recovered as a consequence of it being provided by the claimant's wife, who was herself a qualified nurse.

Who qualifies as a voluntary carer? A number of other authorities reviewed by the judge in *Drake* concerned care being provided by spouses, other blood relatives, informal relations and friends. No previous case though included claims by bodies such as charitable institutions like St Joseph's Hospice. The judge thought that there was no reason in law or policy to restrict such claims to individuals who fell into the category of family and friends. Clearly this category was not in itself readily capable of precise definition.

Moral obligation needed? The judge considered that it did not matter that there was no evidence of any moral obligation expressed by the deceased before he died to recompense the hospice, since recovery under *Hunt v. Severs* was not based on the need for the claimant to point to any contract or other obligation in existence before death, rather that the law recognised the need for the tortfeasor to compensate the carer as a matter of justice.

Similarity of care: HHJ Thornton QC considered that there was a broad similarity between the care rendered by the family and that provided by the hospice, although clearly the hospice care involved qualified nursing and medical care in contrast to that provided by the family. The nature of the care though appears not to have been an issue in previously decided cases, as is evident from the case of *Hogg* above (where in fact the claimant's wife was compensated for the care which she gave her husband and which was thought in fact to be the equivalent of employing two nurses).

Was it right and just that the defendant pay for the hospice care? Had the hospice been willing to charge the deceased for the services then clearly such a charge would be recovered from the defendant in principle but the hospice, for charitable reasons, imposed no such restriction on who would receive palliative care. The judge noted that under the Injury Costs Recovery Scheme set up under the provisions of the Social Care (Community's Health and Standards) Act 2003, which came into force on 29th January 2007, a tortfeasor must compensate the NHS for the cost of NHS treatment including ambulance charges incurred in connection with the consequences of the injury (although of course this scheme excludes the victims of industrial disease). Nevertheless, clearly this scheme is entirely consonant with the principle that the tortfeasor pay.

Overlap with charitable donations and PI claims: The judge in *Drake* recognised that the claimant did not seek to recover that proportion of the hospice's costs which were funded by the NHS. This would clearly not be recoverable. The judge also recognised that the claimant may keep, without deduction from the damages that would otherwise be awarded, any sum paid to him by a private individual, company or charity as a mark of sympathy that assistance ought to recover medical and related expenses. Where the donor expects however, whether as a result of a condition of the donation or as a moral obligation, the donation to be refunded if it is recovered as damages from a tortfeasor, the Court would otherwise award that sum but impose a trust of in favour of the donor. The distinction between charitable gifts and the case at hand was that the charitable gift, as it were, comprised actual care as opposed to any advance of money and no such distinction had hitherto prevented the voluntary care giver from being compensated on the *Hunt v. Severs* basis.

The award: The judge concluded that the defendant ought to pay £10,021 to the claimant who was directed to hold it on trust for the hospice and pay the sum and interest directly to the hospice. He directed that the hospice provide the estate with a copy of St Joseph's receipt of the payment and that the order should provide for liberty to the estate to apply to the Master for directions if the defendant failed to provide that receipt to the estate. The defendant suggested that the hospice's claim would open the floodgates. The Judge disagreed. He thought that claims for hospice care would be infrequent. In any event, mesothelioma claims are likely to decline in the future rather than stay level or increase. The judge thought that recovery of hospice care would otherwise be entirely consistent with established principles. The Defendant has applied for permission to appeal.

Stephen Glynn



Hildebrand Rules (Not) Ok!

In 2 conjoined appeals, *Tchenguiz & Others v Imerman and Imerman v Imerman* [2010] EWCA Civ 908, the Court of Appeal recently examined the use within ancillary relief proceedings of documents obtained unlawfully or clandestinely by one spouse from the other.

Practitioners have for years advised their clients that, provided that force was not used, it was both legal and good practice to access confidential documents belonging to the other spouse, copy them and rely upon the copied documents (but not the originals) within ancillary relief proceedings. This practice was based up on the so-called "Hildebrand rules" established in *Hildebrand v Hildebrand* [1992] 1 FLR 244.

The facts of the instant appeal were as follows: the husband Mr Imerman shared an office and computer system between 2003 and 2009 with his wife's brothers, the wealthy property developers Robert and Vincent Tchenguiz. Cracks started to appear in the marriage in the summer of 2007. Mr Imerman was reported to have said to his wife and her brothers on various occasions from the autumn of 2007 onwards that she would never be able to find his assets as they were so well-hidden. Mrs Imerman petitioned for divorce in December 2008. Unbeknownst to Mr Imerman, in early 2009, the Tchenguiz brothers made copies of various emails and other documents that were stored on the office server. Their motive in

obtaining this information in a clandestine manner was in order to protect their sister's interests.

Mr Imerman sought and obtained an injunction preventing the brothers and various others (including his lawyers) from disclosing any information within the documents to third parties (including Mrs Imerman), restraining them from copying or using the documents and requiring them to hand over all documents to Mr Imerman. The husband also obtained an order against his wife requiring her to return the 7 files of material she had been given by her brothers in order that he could determine which documents he was claiming privilege for. Those two decisions were then subject to appeal.

The Court of Appeal held that there was no legal basis for the so-called "Hildebrand rules", which had been misinterpreted by both practitioners and courts over the years. The narrow rule in *Hildebrand* remains good law: as Lord Neuberger MR sets out, "*Hildebrand* is authority only as to the time when copies obtained unlawfully or clandestinely should be disclosed to a spouse", in other words no later than at the

normal disclosure stage at the time of service of the questionnaires.

However, on the wider issue the Court of Appeal was clear and unequivocal: "*It follows that nothing in the so-called Hildebrand rules can be relied upon in justification of, or as providing a defence to, conduct which would otherwise be criminal or actionable, whether in tort or in equity, nor as providing any reason why the relief...which would otherwise be available should not be granted.*"

Practitioners need to be aware that, following *Tchenguiz & Others v Imerman and Imerman v Imerman*, the absence of a defence under the *Hildebrand* rules applies as much to the professional advisers who receive the "stolen goods" as it does to the light-fingered spouse who pinched them in the first place.



Oliver Millington

Pressure mounts on the Lord Chancellor...

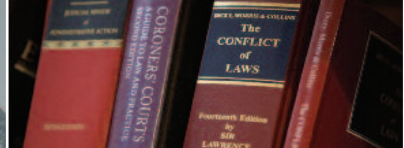
Section 1 of the Damages Act ("DA") 1996 empowers the Lord Chancellor to fix the rate of return which is deemed to be made on any lump sum award. The Lord Chancellor exercised this power and fixed a standard rate of return of 2.5% in June 2001. This rate of return remains in place today.

Unfettered by section 1 DA 1996, Jonathon Sumption QC sitting as the Guernsey Court of Appeal judge in the case of *Helmut v Simon* (unreported, 15th September 2010) has called into question the appropriateness of the 2.5% discount rate. In a judgment awarding probably the highest ever personal injury award within the British Isles of £13.7 million, the judge extensively reviewed current economic and investment trends and concluded that the appropriate rates of return in the present case were -1.5% (yes, minus 1.5%) for earnings-related and 0.5% for non-earnings-related future loss.

Whilst these rates might not be entirely appropriate in relation to claims brought in England and Wales, the judgment makes it abundantly clear that the 2.5% rate set under the DA 1996, is now manifestly wrong and far too high.

It remains to be seen whether the Lord Chancellor (see back page) will take notice!

Lycia Parker



"Bloodgate"

Sports Medicine in the spotlight



Esther Pounder

The facts of the "Bloodgate" scandal that rocked the rugby world are now as familiar as they are striking. During the quarter final of the 2009 Heineken Cup against Leinster, Harlequins wing Tom Williams suddenly began bleeding quite dramatically from his mouth allowing his team to substitute Nick Evans, a specialist kicker. The blood turned out to be fake: from a blood capsule bought in a joke shop in Clapham and the substitution didn't help Harlequins' cause as Evans' kick missed and his team lost the match.

Suspicious, however, were aroused and in the locker room Williams entreated Dr Wendy Chapman, the team doctor, to help him by cutting his lip. Dr Chapman agreed, making a small incision in his lip which she would later claim, when asked about the incident, was caused by a loose tooth.

The truth came out and, following an investigation, Tom Williams and Dean Richards (the Harlequins' Director of Rugby) were both banned from the game for 4 months and 3 years respectively. The physiotherapist Steph Brennan who purchased and provided the fake blood capsule to Williams was suspended for 2 years. Meanwhile Dr Chapman who was initially suspended by the GMC for 12 months was, after a full hearing, given a warning and allowed to return to practice. During the course of the hearing before the GMC she accepted that she administered the cut because the player wanted to demonstrate a 'real injury'. She contended that she had been placed under extreme pressure by the club to behave as she did. At the conclusion of the hearing the chair of the GMC panel said "Normally such misconduct could be expected to result in a finding of impaired fitness to practise.. However, the circumstances of this case are wholly exceptional in that the expert medical evidence suggests that in the absence of depression you would have not acted in this way." The Panel found that at the time of the incident Dr Chapman's fitness to practice was impaired but that "looking forward" her fitness to practice was not impaired.

The scandal brought into sharp relief the potential for conflict between a sports doctor's role as a physician: whose only concern is the

welfare of his patient, and the employee engaged to help protect their employer's assets and serve their purposes. Quite unlike their colleagues in a hospital or surgery, doctors employed by clubs or teams often work alone and without the support of other doctors. Similarly while hospital doctors or GPs are turned to by lay people for their expert advice and treatment, and accordingly are generally treated rather reverentially by their patients, at the very least "Bloodgate" shows us that plainly the same cannot be said of sports doctors. In this environment they are junior members of a team employed for their ability to get results. They are often required to make quick and potentially life-changing decisions in a highly charged and emotive environment, sometimes under the watchful eye of many thousands of fans in the stadium or at home watching on television. How difficult must it be in that situation to make clear and informed decisions? Should, for example, the player who has knocked his head be allowed to continue playing? Has the player lying on the grass broken his neck?

In addition, doctors practising in sports medicine inevitably face pressure from clubs to protect their expensive assets but also to allow individuals to continue, or return to, the field as quickly as possible. Players also may want to be treated in a way which facilitates their early return to the game even if that means they risk future medical problems. The doctor meanwhile has a duty to look after the long-term health and wellbeing of the individual player or athlete. This raises interesting questions in the clinical negligence context.

Notwithstanding the apparent "perfect storm" combination of high adrenalin urgent pitch-side decision making, the potential for external pressure (real or imagined) and the likely high value if things go wrong, there are few examples of UK clinical negligence cases examining the role of doctors in sports medicine. As medical staff have become part of all professional sport, and particularly following "Bloodgate", it seems likely that there will be a greater volume of such cases in the future.

One unusual example of the extent of a doctor's duties when treating professional sportsmen can be found, however, in the field of contract law in the case of *West Bromwich Albion Football Club Ltd v. Medhat El-Safty* [2006] EWCA Civ 1299. A footballer (P) injured his knee in training. He was referred to and subsequently treated by the Defendant, a consultant orthopaedic surgeon specializing in sports injuries and arthroscopic surgery but not employed by P's club. D negligently advised that P required reconstructive surgery. It was common ground that if the injury had been treated conservatively then P would have been fit again in about 4 months. As it was he never returned to professional football.

West Bromwich Albion (W), the player's club, sued D on the basis that an express contract was made between W and D when W's in-house physiotherapist Mr Worth arranged an appointment for P to see D. They claimed it was implicit in that contract that W was the contracting party that would be responsible for D's fees and in return would be owed the duties of care that would go along with D's obligations to render his advice to W. Alternatively they argued that even if D's contract was with P, the facts were that W relied on his advice and D should have known that, and should have appreciated the important financial interests that were involved in the adequacy of that advice, in a situation so akin to a contract, so it was just and equitable for him to be responsible to W for the financial consequences of his negligence.



The Court of Appeal did not agree, however, finding that there was no contract, and it was not necessary to imply one, under which an orthopaedic surgeon owed a duty to a football club to advise the club in respect of his treatment of one of its players and about its financial affairs. Similarly the surgeon owed no duty of care in tort in respect of any foreseeable economic loss to the club resulting from the negligent treatment. Although it was reasonably foreseeable by D that W would suffer financial loss if his medical treatment was negligent, and there was a proximity of a sort between him and W, it was not such that it would be fair, just or reasonable to impose such a duty on D.

Lord Justice Rix in his judgment commented upon the potential conflict of interest in such cases, noting that *"the immediate interest here is medical, not financial. W is interested, but principally as a good employer not as an investor in player contracts, and it appears on the scene, in the person of Mr Worth, in the form of a referring health professional, and not in a managerial or business context. Moreover, the question of conflicts of interest arises here again to emphasise that [D]'s concern is, or ought to be not only primarily, but exclusively, with his patient's well-being, and not with the Club's financial circumstances...the dominant relationship is that of the doctor and his patient, and the dominant context is that of [P]'s health, not his employer's financial security"*. One wonders, of course, whether their Lordships might have come to a different conclusion if D had (like Dr Chapman) been directly employed by the club in question?

Plainly there is nothing to prevent players themselves who have been injured by the negligence of club doctors from bringing clinical negligence claims, and potentially recovering significant sums for lost earnings. More interesting questions arise where such doctors (as in the case of Dr Chapman) accept that that they acted not in their patient's best interests but claim that they only did so as result of the pressure put on them by their patients or their employers.

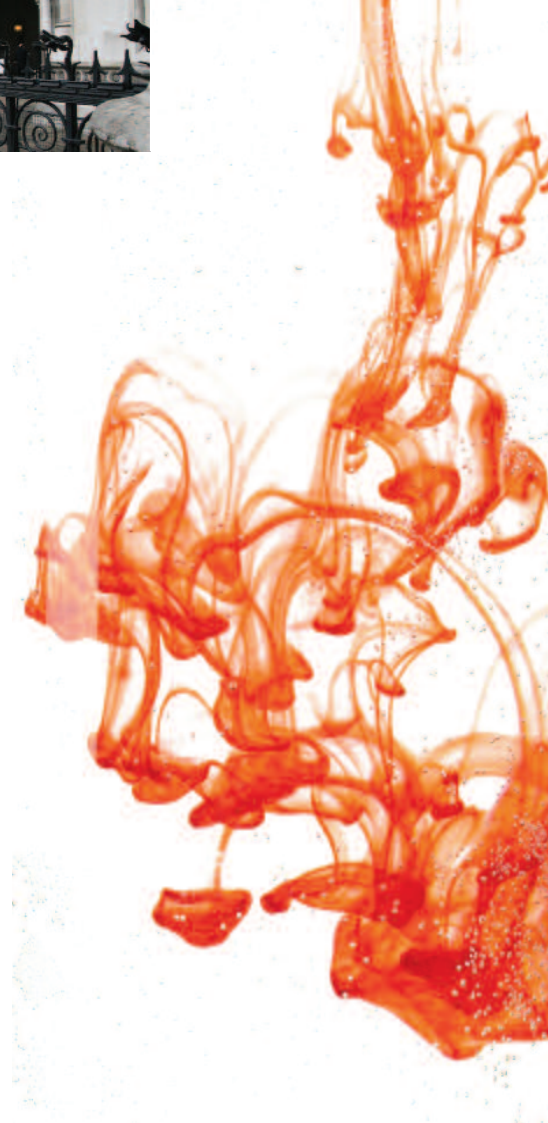
Finally it's perhaps worth considering other potential issues for medical professionals employed in the world of sport: in particular those of consent, confidentiality and cheating. The same general ethical and legal issues

regarding consent apply to doctors involved at sporting events and treating sportspeople. As in all other areas of medical care, doctors need to obtain the patient's agreement in advance when providing examination or treatment. Consent can be verbal, written or signaled by the willing agreement of a person who understands what will be undertaken. Specific consent is also needed for the disclosure of confidential information to coaches or managers of the player.

As discussed above, doctors employed by sports teams or clubs may have problems with conflicting loyalties, real or perceived, between the team or club as their employer and the player as their patient. This is particularly pertinent in terms of confidentiality. The World Medical Association's (WMA) **Declaration on principles of healthcare for sports medicine** states that: *"In sports medicine, as in all other branches of medicine, professional confidentiality must be observed. The right to privacy over medical attention the athlete has received must be protected, especially in the case of professional athletes"*¹

Plainly the interest in the information is significant in cases involving professional sportspeople as coaches, management, the press and the public will all want to access that information. The British Medical Association (BMA) are firm in their view that: *"a doctor being a salaried employee of the sports club gives no other employee, including the coach of that club, any right of access to the athlete's medical records or to details of examination findings. With the athlete's consent, the coach may be advised of any relevant information relating to a specific matter on a strictly need-to-know basis, the significance of which the athlete clearly understands. If the athlete refuses to allow any information to be provided to the club or to the coach, the doctor must not breach confidentiality, unless, for example, it puts the health or safety of the athlete or other players at risk. The fact that the athlete may be in breach of their contract as a result of the refusal to share the information is a matter for the athlete, and is not a reason for the doctor to breach confidentiality"*²

The issue of cheating is also a potential minefield for medical professionals involved in sport. Whenever sportsmen or women decide to cheat by medical means (for example: with performance enhancing drugs or blood doping),



doctors are likely to be involved behind the scenes. Again, when faced with this issue the doctor's primary concern should be the long-term interests of his or her patients. In addition they should operate, and be seen to operate, within the law. There are, of course, however many drugs freely available over the counter or on prescription which are banned by the rules and regulations of various sporting bodies. Doctors treating professional sportspeople (including GPs) should of course be alive to the possibility that they could unwittingly become a conduit for cheating. In addition there may be serious clinical negligence issues arising if doctors do agree to provide drugs or procedures for non-medical purposes in sport and complications arise.

It is perhaps curious given all of the above that, to date, very few clinical negligence claims seem to have arisen from the involvement of doctors in sport. Perhaps in the aftermath of "Bloodgate" lawyers, as well as doctors, may be paying closer attention to this interesting area of work.

1. World Medical Association Declaration on principles of healthcare for sports medicine. Adopted at the 51st WMA General Assembly Tel Aviv, Israel, October 1999. Available at www.wma.net/e/policy/h14.htm

2. British Medical Association Board of Science: "An information resource for doctors providing medical care at sporting events", www.bma.org.uk, 9th January 2009.



Primus Inter Pares: Disabled employees the first amongst unequals?

As of 1 October 2010 discrimination law in England and Wales has, to a large extent been codified in the Equality Act 2010 (“the Act”)¹. Over the past 30 years, the hard fought gains to protect the vulnerable and the different in workplaces throughout England and Wales has seen its crescendo in this piece of legislation and in what must be seen as a significant legacy of the previous Labour Government.

Of all the aspects to discrimination affected by the Act changes to the protection of disabled people are set to be the most significant for employers and employees alike.

More generally the Act consolidates existing concepts and introduces novel ones to the discrimination legal landscape:

Direct discrimination: less favourable treatment because of a protected characteristic or by their association with someone who has a protected characteristic.

Discrimination by association: already covered by existing legislation but firmed up in relation to disability. New protection is offered for discrimination by association with those who are gender reassigned or on the basis of their sex. This is classed a form of direct discrimination somewhat confusingly.

Perception discrimination: now extended to cover disability, gender and sex.

Indirect discrimination: again whilst already covered by existing legislation it is now further extended to disability and gender reassignment. A policy, condition, rule or practice in an organisation that applies to everyone but disadvantages people with a protected characteristic will only be justified in circumstances where it is a proportionate means of achieving a legitimate aim.

Harassment: the Act extends protection to those that find behaviour offensive even if not directed at them and importantly, there is no need for the complainant to show that they possess the protected characteristic.

Third Party harassment: ensures that employers now have a codified duty to protect employees from harassment by those not employed by the employer. The scope of liability is however restricted to acts that have occurred twice before, the employer being aware of these acts and not having taken reasonable steps to prevent it from happening.

PROTECTION WIDENED FOR THE DISABLED AT WORK

The changes brought in by the new Act are most pronounced in relation to disability-related discrimination: now termed discrimination ‘arising from a disability’ which will be introduced with an additional ability to claim indirect disability discrimination.

Discrimination ‘arising from a disability’ is the unfavourable treatment of an employee because of something arising as a consequence of their disability. The employer must know, or be reasonably expected to have known, that the employee in question has a disability.

The definition of ‘disability’ remains based on the current definition in the Disability Discrimination Act 1995 (“DDA 1995”). There is no longer the requirement to prove that one of a list of ‘capacities’



¹. Only partially in force



has been affected. As under the DDA 1995, certain conditions as listed at Schedule 1 of the Act are automatically regarded as disabilities.

Most important of all and in a response to the decision in *L B Lewisham v Malcolm* [2008] IRLR 700 HL (the relevant comparator for a disabled employee was a non-disabled employee who is otherwise in the same circumstances), under the new provisions of the Act there is no relevant comparator. The employee has to simply establish that they have experienced 'unfavourable' treatment and that this is because of something connected with their disability. There is no longer the requirement to prove 'less favourable' treatment.

Employers will still be able to defend such claims if they did not know, and could not reasonably have been expected to know that the employee was disabled, or if they can establish that the treatment was a proportionate means of achieving a legitimate aim. Tribunals will have to consider the legitimacy of any business objectives identified by the employer; whether the employer has met those aims in a fair, balanced and reasonable way, or could reasonably have been expected to achieve those aims using less discriminatory methods. This is a more stringent test than was previously needed to justify disability-related discrimination.

Some simple worked examples of the benefits of the new provision are as follows:

- A has long absences from work as a result of being treated for cancer and was dismissed. Under *Malcom*, A would have to have shown she was treated less favourably as compared to a person without a disability and with the same level of work absence. Under the new Act it is clear that A has suffered unfavourable treatment through her dismissal, therefore it is for the employer to provide an objectively reasonable justification for the unfavourable treatment, otherwise A would succeed.
- B receives an offer of promotion and shortly after informs his employer that his wife has had a stroke and will need significant levels of care provided by him. Provided B can prove the unfavourable treatment was on the grounds of his association with his wife (i.e. a person with a protected characteristic), B has a valid claim for disability discrimination. This codifies the judgment *Coleman v Attridge Law* (C-303/06 – ECJ) and extends protection to those who are not disabled themselves and/or those that are perceived to be disabled but are not.

This whistle-stop tour through the Act has sought to highlight the additional protection offered to disabled employees. Updates to this article are sure to follow following the Act's full implementation.



Ed Lamb

9 GOUGH SQUARE



And finally...

At the recent 9 Gough Square / R Costings Autumn Reception, over £13,000 was raised for the Spinal Injuries Association. The SIA are a Charity particularly close to our heart and we are thrilled to have beaten the target of £10,000 by a considerable margin. Thank you to all our clients for their attendance and generosity.



The Golden Rule Survives

1 A recent case heard by Mr Justice Briggs in the Chancery Division served as a clear reminder that compliance with the Golden Rule remains an essential step in the avoidance or limitation of probate disputes.

2 The substance of the Golden Rule is that where a solicitor is instructed to prepare a will for an aged testator or for one who has been seriously ill, he should arrange for a medical practitioner to satisfy himself as to the capacity and understanding of the testator and to make a contemporaneous record of his examination and findings.

3 In *Key v Key* [2010] EWHC 408 (Ch) instructions were accepted from an 89 year old testator (D) whose wife of 65 years had been dead for no more than a week. Neither was there an assessment of the testator's capacity nor a contemporaneous attendance note of the meeting with the testator.

4 The result after hearing expert and lay evidence was that the Court concluded that the testator lacked testamentary capacity and the will was therefore invalid.

5 The testator died in July 2008 at the age of 90. His wife had died about eighteen months previously in November 2006. They had been married for 65 years and were survived by

four children; two sons and two daughters. The sons had worked with their father and by 2006 had taken over the running of the family farming business. One daughter lived locally to her father and the other lived in the USA.

6 A week after the testator's wife's death, his solicitor attended the family home in order to take instructions on a new will. One of the testator's daughters was present throughout this meeting. Two days later the same daughter took her father to the solicitors office to execute the new will. Under D's 2006 will the majority of his estate was divided between his two daughters.

7 The sons challenged the validity of the 2006 will on the basis that D did not have testamentary capacity and that he did not know and approve the contents of the will. The brothers' challenge was successful on the first ground and therefore the Court did not need to consider the second ground. However it had been argued by both parties and therefore the Court held that it would have found against the will on this ground.

8 The Court found that the death of D's wife so shortly before the execution of the will could impact D's testamentary capacity, and reminded practitioners that the "Golden Rule" is very much alive and well. When a will is drawn

for an aged testator or one who has been seriously ill, it should be witnessed or approved by a medical practitioner, who ought to record his examination of the testator and his findings.

9 This decision does not chart new ground on the issue of testamentary capacity, but serves as a useful reminder of well-established principles. The leading case on this subject continues to be *Banks v Goodfellow* (1870) LR 5QB 549 in which it was held that the Court must be satisfied that the testator must (1) understand the nature of his act; (2) understand the extent of property of which he is disposing; (3) comprehend and appreciate the claims to which he ought to give effect; and (4) not be subject to any disorder of mind as shall "poison his affections, pervert his sense of right, or prevent his natural faculties."



Tim Parker



Ken Clarke

Former member of chambers Ken Clarke, from the days when 9 Gough Square were at 2 Dr Johnson's Buildings in the Temple, writes on his appointment as Lord Chancellor:

"As you have probably gathered, the appointment came as a genuine surprise to me, but it is no less an honour to serve in this fascinating job.

I have now begun to absorb myself back into the once familiar field of law and criminal justice with great enthusiasm. I don't suppose I will get away with calling myself a novice, but these are difficult times and the task of delivering a fair and effective system at a time of financial frugality is a great challenge."