DEANS COURT CHAMBERS

Mark Bradley

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Education	Professional Associations
BSc (Hons) Chemistry	Personal Injuries Bar Association
PgDL	Association of Regulatory and Disciplinary Lawyers
BVC	Mental Health Lawyers Association

Areas of Specialism

- Clinical Negligence
- Inquests
- Personal Injury
- Professional Healthcare and Regulation
- Professional Discipline
- Court of Protection

Profile

Mark Bradley has a significant healthcare practice. He specialises in Clinical Negligence, Coroner's Inquests, Personal Injury, Professional Discipline / Regulation and Court of Protection.

Clinical Negligence

Mark has developed his Clinical Negligence practice alongside his Coronial Law practice, advising on claims involving a wide range of medical issues.

He has experience of cases concerning surgical and dental negligence as well as misdiagnosis and delayed diagnosis

He advises in relation to both liability and quantum in a range of clinical negligence cases against hospitals and GPs.

Mark has experience of dealing with clinical negligence claims involving:-

Inappropriate treatment of hydrocephalus resulting in cardiac arrest and associated health issues;

Failure to diagnose and treat lung cancer which resulted in metastases and premature death;

Complications following a complex percutaneous coronary intervention requiring further surgery and an inpatient fall leading to cerebral injuries;

Delayed diagnosis and treatment for osteoporosis resulting in a preventative fracture at T7;

Negligent treatment in the staged process limb lengthening procedure involving the Iliac Crest graft being harvested.

Inquests

Mark appears at inquests on behalf of families, local authorities, insurers and other interested persons.

He recognises that early, and skilled, involvement ensures that legal issues such as disclosure, representation, contact with the Coroner, expert evidence and legal arguments are all dealt with in a timely fashion, all of which may have a significant impact on the course and outcome of inquest proceedings

Personal Injury

Mark undertakes all aspects of personal injury work from multi-track trials to High Court applications, including high-value, complex or catastrophic injury and fatal accident claims.

He is regularly instructed on cases involving serious injuries, including brain injury, spinal cord injury and amputation cases and cases involving complex medical and other expert evidence.

He acts for both claimants and defendants and is regularly instructed by insurers in respect of fraudulent claims or claims in which policy cover is avoided by virtue of the insured's conduct.

A selection of Mark's recent cases are noted below:

Road traffic accident in which the claimant sustained injuries to his leg, amputation of his foot, and severe psychological injuries;

Employer's liability accident in which the claimant required lower limb fasciotomies, cuboid open reduction, lisfranc open reduction and talus open reduction

Professional Healthcare and Regulation

Mark has considerable experience of advising and representing healthcare professionals in General Dental Council and General Medical Council proceedings.

Court of Protection

Mark appears in the High Court instructed by the Official Solicitor, in cases involving the requirement for urgent medical treatment in persons with learning disabilities, and disputed capacity to consent to such medical treatment.

He also appears in the Court of Protection on behalf of local authorities, in cases involving welfare issues, including contact and capacity to consent to sexual relations.

Notable Cases

Inquest touching upon the death of JC

Practice Area: Inquest

Mark Bradley represents the family of a care home resident who was given an overdose of medication which contributed to his death.

Former chip shop owner John Collinson - known as Ricky - from Llanfairfechan in Conwy county died in August 2022, eight weeks after he was given 10 times more than his correct dose of medication over four days.

The 88-year-old lived at Kinmel Lodge in Kinmel Bay at the time, and had been mobile and physically active before the error was made, but afterwards became mostly confined to his bed.

The inquest heard the error had occurred as a result of a miscalculation after Mr Collinson's medication changed from being administered in pill form to being given in liquid form.

Inquest touching upon the death of KJ (Article 2 Inquest)

Practice Area: Inquest

Represented the family of the deceased who took her own life by injecting excess insulin.

KJ was a type 1 diabetic who required insulin as a form of management. At the time of her death, KJ used a hybrid closed loop system to manage her diabetes which delivered insulin to her automatically. KJ was well known to the

mental health system and the local treatment teams were aware that she had visited hospital and been admitted to the ICU as a result of a previous overdose prior to her death.

The cause of death was hypoglycaemia caused by excess insulin.

The Coroner concluded suicide with a concurrent narrative that, at times, KJ's risk of suicide, as opposed to accidental death was not properly identified and/or managed by NHC Trust mental health services in the community. Additionally, that KJ was wrongly prevented from accessing long term mental health support within LMHT and NH mental health teams responsible for KJ's overall risk management and care failed to ensure that full and robust multi-professional meetings were held to identify and share risk pertinent information and agree a co-ordinated future plan of care and these factors probably more than minimally, negligibly or trivially contributed to KJ's death.

Inquest involving deaths due to failing eyesight

Practice Area: Inquest

The government is under pressure to change its driving licence system following an inquest which highlighted how people continue driving on the UK's roads after being told not to do so by professionals due to failing eyesight

The inquest, which investigated the deaths of four people killed by drivers who had been told they were unsafe, heard estimates that around 2% of drivers would currently fail the present driving eyesight test – which would equate to around 750,000 drivers a day, and 4,250 journeys every day on the M25.

Mark Bradley appeared on behalf of the families of the victims, instructed by Hudgell Solicitors

Read more about this case:-

https://lnkd.in/eZsctBm3

https://lnkd.in/euVQr7mP

Covid-19 Inquiry

Practice Area: Inquiry

Represented the core participants UK CV Family, Vaccine Injured Bereaved UK and Scottish Vaccine Injury Group in Module 4 of the UK Covid-19 Inquiry with Leading Counsel.

Inquest touching upon the death of SH

Practice Area: Inquest

Represented the family of the deceased who was killed in the course of his employment. The deceased was a HGV driver who had gone to pick up a delivery of steel. Whilst the steel was being moved by a forklift truck driver, the steel fell from the forklift truck and knocked the deceased to the ground thereby killing him.

The inquest dealt with training and systems of operation in place at the deceased's employer and the accident location with respect to the safe unloading / loading of materials and whether these were followed.

Inquest touching upon the death of AF

Practice Area: Inquest

Represented the family of the deceased who died after a failure by the Trust to carry out an ECG despite the

deceased's history of chest pain, shortness of breath and tachycardia during ED attendances.

There was a further failure by the Trust to note or act upon the significance of the deceased's history of collapse and CPR, and a failure to consider a diagnosis of pulmonary embolus.

A narrative conclusion with a neglect rider was provided.

Inquest touching upon the death of HS

Practice Area: Inquest

Represented the organisers of a college rugby trip.

The inquest focused on the circumstances of how the deceased was found to have died in a lake, the precautions and risk assessments that were made with respect to the planning of the visit, the necessary documentation and the precautions and risk assessments which took place with respect to supervision and monitoring of the deceased and the other students at the lake.

Inquest touching upon the death of JP

Practice Area: Inquest

Represented the company that provided treatment to the deceased for his substance abuse issues.

The deceased had suffered a decline in his physical and mental health and had suffered a number of episodes of disturbed mental state, often associated with the use of substances and / or a flare up of his auto-immune disorder. The deceased, whilst under the influence of alcohol and drugs, jumped from his apartment.

A narrative conclusion was provided.

No adverse findings were made against the substance abuse treatment provider.

Inquest touching upon the death of LM

Practice Area: Inquest

Represented the family of the deceased who underwent an elective pacemaker implantation procedure at the Trust. During the procedure he suffered a pneumothorax and a haemothorax, which are recognised complications. These conditions were not identified on an x-ray taken that afternoon, but were observed when the x-ray was reviewed the following day. To treat the collapsed lung once identified, a chest drain was inserted as an emergency to stabilise the condition. He subsequently developed a hospital acquired pneumonia and suffered a heart attack. He continued to deteriorate and was placed on an end of life pathway until his death.

The Trust subsequently admitted breach of duty and causation and the civil claim was settled.

Inquest touching upon the death of LZ

Practice Area: Inquest

Represented the GP who was involved in consultations with the deceased prior to her death.

The deceased's death from chronic malnutrition was precipitated by adverse psychological responses to complications of bariatric surgery on a background of EUPD. The surgery was a triggering organic event that unveiled and brought to the fore negative aspects of her underlying EUPD. Over the following years and in a fluctuating manner, these included the deceased experiencing chronic pain likely of a non-organic source – as a result she developed a chronic dependency on opiates likely to have had a negative impact on her immune system. Critically, after two episodes of surgery she developed EUPD and an aversion to food and sometimes fluid to the

extent that her nutritional intake was severely and chronically reduced, leading in turn to severe and chronic malnutrition. By the time of her final admission to hospital, the evidence confirms that the extreme nature of the deceased's physical condition, deconditioning and vulnerability to new infection as a direct consequence of malnutrition was such that her death became inevitable.

Prevention of Future Death Reports are being considered for the Trust responsible for the bariatric surgery and the Specialist Mental Health Trust.

No adverse findings were made against the GP.

Mark Bradley represented the family of an 18 year old girl who tragically died two weeks after receiving her first Covid-19 'jab'.

Practice Area: Inquest

The deceased, an 18 year old student paramedic, died two weeks after receiving the Astra Zeneca Covid-19 vaccination, having received the vaccine early due to being a 'front line worker'.

A narrative conclusion was provided by the Coroner who recorded the cause of death as being cerebral venous thrombosis brought on by Vaccine Induced Thrombocytopenia and Thrombosis (VITT) as a result of the Astra Zeneca Covid-19 vaccination.

The Coroner confirmed there was a missed opportunity to identify the cerebral venous thrombosis.

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AB and MA v BTH Trust

Practice Area: Clinical Negligence

Represented the family of the deceased in a claim involving the failure to report abnormalities in a CT Head Scan that was reported as normal and effect and consequences of the failure to identify a tumour, hydrocephalus and / or intercranial fluid / bleeding and / or other abnormality resulting in a delay with treatment.

The claimant instructed a consultant paediatric neurosurgeon, consultant neuroradiologist and professor of paediatric oncology.

The claim settled for £100,000.

MI and GI and GS v IG and MIB

Practice Area: Personal Injury

Represented the MIB in claims for personal injuries (including a fatality) following a road traffic accident.

The three claimants were in a vehicle being driven by the first claimant who was performing a u turn in the carriageway when the accident took place. The second claimant passed away as a result of the accident.

The first defendant, who was travelling at excessive speed, attempted to overtake a number of vehicles travelling in the same direction and collided with the claimants' vehicle whilst it was performing the u turn.

Accident reconstruction expert evidence was utilised and arguments around contributory negligence raised.

The claims were pleaded in excess of £750,000 and settled for £295,000.

DJ v GS and NT and MB

Practice Area: Personal Injury

Represented the second defendant who had been instructed by the first defendant to undertake electrical work in the claimant's property.

The claimant suffered personal injury in a fire at his property. The claimant claimed that the fire was caused by an electrical fault at the circuit supplying an immersion heater.

The third defendant had been contracted to fit a new bathroom and immersion heater element.

Expert electrical engineers were instructed by the parties.

The claim was pleaded up to £330,000 and settled for £200,000 at a Joint Settlement Meeting.

SH v B and RMS

Practice Area: Personal Injury

Representing the family of the deceased in a civil claim for damages on behalf of the estate and dependency claim.

The deceased was killed in the course of his employment as a HGV driver who had gone to pick up a delivery of steel. Whilst the steel was being moved by a forklift truck driver, the steel fell from the forklift truck and knocked the deceased to the ground thereby killing him.

The claim raises issues around the training and systems of operation in place at the deceased's employer and the accident location with respect to the safe unloading / loading of materials and whether these were followed.

Allen (Salford City FC)

Practice Area: Fraud

The Claimant, Richard Allen, was a passenger in a road traffic accident in Preston on 3 January 2017. Breach of duty was admitted. The matter proceeded in relation to quantum only.

Allen was a semi-professional footballer at the time of the accident and played more than thirty times during his injury prognosis period. The Salford City Football Club website confirmed the various matches in which Allen had played during this prognosis period. Despite this, Allen told the medico-legal expert that he had difficulty lifting items and his shopping activity was severely restricted. He also informed the medico-legal expert that he was unemployed at the time of the accident and made no mention of the fact he had played semi-professional football on numerous occasions from the accident date to the date of his examination. Allen continued to play semi-professional football until June 2018.

Allen provided evidence that he self-administered steroids and painkillers and continued playing semi-professional football despite the pain in his neck, shoulder and back because he had no other option. This was his source of income so he could not stop playing football. Allen played more than 30 football matches during his prognosis period of eleven months.

At a trial at Preston County Court, Recorder McLoughlin observed that:

There was no argument by the Defendant that there was anything other than a straightforward accident.

Breach of duty had been admitted.

Prior to the date of the Defence, Allen had been examined on 17/9/17 by a medical expert.

Allen wanted to rely on the report and said it was accurate.

The Defendant served a Defence which set out in plain terms their position.

Allen's witness statement was prepared after service of the Defence and stated he was playing football rather than being unemployed.

Payments made to Allen by Salford Football Club were provided and they showed a regular pattern of payment including payments in the off-season.

The Court found it remarkably unconvincing how Allen explained his role at Salford Football Club and concluded he had downplayed his role.

Video footage was obtained of the matches taking place.

The Court did not consider it acceptable that Allen considered himself to be unemployed. A and E notes noted his occupation at that stage as a professional footballer. This was a contradiction. He was being paid 52 weeks per year. There were inconsistencies as to whether he told the club about the accident. Allen had been caught out. He had represented unemployment to a doctor.

The Court considered it flew in the face of common sense and beggared belief that there were no restrictions when attending semi professional football and yet there were significant restrictions with lifting and shopping.

There was video footage from 25 February 2017 with Allen shooting, scoring, and celebrating without restriction, but yet he was having difficulties with shopping.

The medical records were considered. The Judge considered there was inconsistency in the reporting of symptoms. There was a detailed A and E note in which Allen presented with neck, lower back and left scapula pain – a further inconsistency. Of more significance, the pain score in the A and E notes was 2 (mild). In contrast, the medical report at 8.5 months post-accident referred to severe pain.

The Court concluded that Allen had consciously and deliberately exaggerated his symptoms and fundamentally misled the medico-legal expert.

As to fundamental dishonesty:

The Judge considered section 57 of the Criminal Justice and Courts Act 2015 and London Organising Committee of the Olympic and Paralympic Games v Sinfield [2018] EWHC 51 (QB).

The Judge made clear he was unimpressed by Allen's evidence. Allen did not disclose his taking of steroids to the doctor at the medical examination.

It was found that there had been 'a lack of candidness by Allen and the contrary nature of the restrictions was significant'.

The Judge concluded that the doctor had been misled regarding employment, treatment and the nature and extent of the injuries.

The Judge found the Claimant was unreliable and had not been prepared to be open and honest with medico-legal professionals.

Applying the test in section 57 and the guidance in Sinfield, the Judge was satisfied on the balance of probabilities that Allen had acted dishonestly regarding his primary claim. The Judge accepted that Allen had suffered some injury of a very modest level, transitory in nature, with mild pain such that he was on the substitute bench on 7 January 2017 and played on 21 January 2017. The Judge valued PSLA at £1000. There was no award for special damages.

Accordingly the entire claim was dismissed and Allen was ordered to pay £6000 for the Defendant's costs after set off of £1000 damages.

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