10 - 11 Bedford Row
London WC1R 4BU
DX 1046 London / Chancery Lane
Telephone: +44 (0) 20 7269 0300

3 Orchard Court, St. Augustines Yard
Bristol BS1 5DP
DX 78229 Bristol 1
Telephone: +44 (0) 117 930 5100

Naomi Rees

Call: 2006
Clerk: Paul Adams
Email clerk: adams@oldsquare.co.uk
Tel:
Email:

Profile

Naomi Rees is a clinical negligence and personal injury specialist within chambers. Her practice encompasses all elements of litigation and advisory functions, but additionally related aspects including inquests, court of protection, regulatory law and costs.

Naomi has extensive trial experience, where she has developed effective witness handling and advocacy skills. She is comfortable with cases involving multiple experts. Naomi is also a skilled negotiator, whether a case concludes at JSM or at the door of court.

Naomi's written advocacy is considered robust with an analytical understanding of the issues involved. She is familiar with drafting and responding to complex schedules of loss.

Naomi is ranked in the Legal 500 2017 edition and is referenced as being "very congenial and meticulous". Her client care skills mean that she is often called upon to advise in sensitive matters, where she provides straight-forward advice with empathy and with a detailed understanding of the facts and the law.

Recent and current work

SH v A NHS FT

The Claimant was caused injury to her accessory nerve during routine parotidectomy surgery. During that treatment the Claimant's sternomastoid flap was raised but it was unlikely that the accessory nerve was either preserved and/or checked during this part of the procedure.

Even though the Claimant was seen some 3 weeks post surgery and attended with a tender and weak shoulder the injury was not detected. She felt a burning pain across the front of her chest and down the back of her shoulder. She also experienced shoulder function deficit in the initial weeks following the surgery. There was further delay by the treating surgeon to realise that injury had been caused and ,other than rehabilitative physiotherapy, no treatment to remedy the nerve damage was considered.

The Claimant was left with a scapula which was in a prominent position and with a permanent restriction of movement in the shoulder which prevented the Claimant from raising her hand above shoulder height. There Claimant also continued with altered sensation over the area of the supraclavicular nerve and deep tenderness within the levitator scapulae and rhomboids.

The restrictions and pain that the Claimant suffered were life-long injuries that would deteriorate with age.

Whilst reinnervation treatment was a possibility, the experts were guarded regarding the prognosis of such challenging surgery.

The results, in any event, would not have any real functional benefit, but would reduce pain by one level. The case therefore required detailed analysis of what could be appropriately claimed and supported in the schedule of loss.

Matter settled in favour of the Claimant after exchange of expert evidence.

KJ v A NHS Trust

The Claimant suffered from a leg injury and was initially treated at A&E. Later, during her attendance at the fracture clinic the Claimant was admitted for open reduction and internal fixation of her fracture. Following discharge from hospital the Claimant suffered from a large pulmonary embolus, leading to urgent re-admission.

The Claimant's disputed case was that following surgery, because of the risk of thromboembolic complication, and on account of risk factors specific to the Claimant, she should have been provided with thromboprophylaxis until her mobility was no longer compromised. The Claimant disputed appropriate risk assessment was carried out as to whether prophylaxis was required and the Claimant was not informed for the risks of failure to provide her with the same. Montgomery informed consent was therefore also in issue.

There was considerable debate between the Claimant and Defendant experts regarding the interpretation of the NICE Guidelines on the use of prophylaxis.

Furthermore, the Defendant indicated that the decision not to treat the Claimant with thromboprophylaxis had no causative effect upon the Claimant ultimately suffering from thromboembolic complication and that it was an unfortunate but recognised complication of surgery.

Most elements of breach of duty were in issue, as well as the entirety of causation, condition and prognosis.

The claim was settled in favour of the Claimant despite a defence which denied causation in its entirety.

H v A NHS FT

The Claimant was suffering with age-related wet macular degeneration (Wet AMD). There was a failure by the Ophthalmology Department to refer the Claimant for treatment (in the form of Lucentis injections) within period specified by the Royal College of Ophthalmologists.

The Defence was based upon resource allocation and the Defendant's case was that whilst the guidelines were something to aim for, they were not something that had to be complied with strictly – they were standards of best practice.

Had the treatment been carried out in accordance with the guidelines, the Claimant would have achieved stabilisation at a good functional level. However, the Claimant's vision deteriorated such that she had no useful vision remaining the affected eye. The case required consideration of sympathetic ophthalmia and risk of total blindness. There was a further and discrete issue between the parties over the principle of provisional damages and application of s.51 County Courts Act 1984.

The matter was litigated and the case was settled at a six figure sum, with a sizeable future care claim to meet the Claimant's needs in the future, and in accordance with the risks.

JM v A Hopsital NHS Trust

The Claimant suffered a fall from height whilst at work and was taken to the Defendant hospital, where it was suspected that he might have suffered spinal fracture. The Claimant's pelvis was x-rayed, but there was no MRI nor x-ray of his spine. He was discharged home.

The Claimant continued in extreme pain and developed urinary complications and neurological deficit whilst he was at home recuperating.

The Claimant re-attended approximately 2 weeks later, given the worsening symptoms, and following an MRI scan, it was found

that he had suffered from a burst fracture of T12 with a 60% anterior vertebral body height loss and retropulsion of the posterior aspect into the spinal canal, which was compressing the lower spinal cord and nerve roots. There was also subluxation of T11-T12 facet joints bilaterally. The Claimant thereafter underwent emergency surgery. The Claimant's fracture had become worse in the time over which he was sent home from hospital and the degree of angulation could not therefore be corrected during the surgery.

The Claimant received an apology from the Chef Medical Officer from the Trust in respect of the breach, but causation was in issue between the parties.

The Claimant's avoidable symptoms were that of significant weakness in both legs, restriction of movement and difficulties with micturition. The Claimant also has a chance of requiring vertebrectomy and cage reconstruction in the future in order to provide full stability to the thoraco-lumbar spine.

The Claimant was a labourer and was limited in his future work and suffered from a disadvantage on the open labour market.

B-K v A Bank PLC

The Claimant lived in a flat which was on the first floor, above a bank. On her flat roof there was a skylight structure into the bank below. The Claimant was gardening on her roof when she fell into the bank below, though the window. It was a Sunday and so there was nobody in the bank below, but the alarms sounded, and thankfully the Claimant was rescued. Issues of breach surrounded the safety of the skylight on the flat roof, adequate barrier and whether the structure itself was suitable or sufficiently strong.

The main issue though was that of the injury. The Claimant suffered from an open book pelvic fracture which required both internal and external fixation by plate. The Claimant further from significant and extensive scarring, multiple fractures of the lumbar spine and psychological injury.

The matter was litigated and, following joint statements, the parties were opposed as to the causation of injury. The Claimant's case was that the entirety of her present and future needs were on account of the accident whilst the Defendant's expert was of the view that the majority of symptoms were on account of the Claimant's constitutional background and obesity.

The matter was settled at JSM.

BO and JR v FCC

Two school children attended a residential course which took place at a farm. During their visit they carried out many farm-related activities, including changing the animal bedding and feeding.

A day after the course both children began to feel unwell, with vomiting and high temperatures and both were taken to hospital. They were diagnosed as suffering with campylobacter infections.

The expert instructed for both Claimants suggested that both children were suffering from post-infective IBS, that may have been a life-long condition.

However, both of the children had very similar constitutional matters in their background which the Defendant suggested were more likely to be the cause of their on-going symptoms.

Child 1 had suffered from urticaria pigmentosa in his childhood which had caused, inter alia, a number of bowel symptoms in his childhood. The Defendant's case was that the bowel symptoms could not be distinguished from the post-infective IBS symptoms and in the circumstances, on balance, the Claimant could not prove his case on the on-going symptoms.

For Child 1 therefore the case involved a detailed chronology and history regarding the historic interrelation between the urticaria and the bowel symptoms with the Claimant's expert.

Child 2 had suffered with allergies to various foods during his infancy and the Defendant's case, again, was that it was those

allergies and his constitutional make up that were likely to be contributing to the on-going bowel symptoms, rather than the post-infective IBS. Again, the Claimant's medical records underwent foresntic analysis with the Claimant's expert in conference to understand the differences in the symptoms previously observed and those now being suffered by the Claimant.

Both matters were eventually settled on behalf of the Claimants.

However, a further issue arose as to approval of the settlements. The Claimant's expert advised that whilst the post-infective IBS would not deteriorate from its current state, that it could nevertheless be permanent (there was a chance that it would improve). There was a significant length of time for the prognosis given in the expert reports.

If there was any significant prospect that the post-infective IBS could be permanent (which there was) it was unlikely that the Court would approve the settlements before the end of the prognosis period, although, of course, both cases would have to be stayed to take this into consideration which would have meant very prolonged litigation and the Claimants losing out upon the interest that otherwise they might have achieved on their settlements during that period of time, if those settlements were eventually approved.

Therefore, the cases were settled on the "worst case" scenario basis which allowed the Claimant to quantify the matter on the basis that the children would suffer, indefinitely, at the same level. This allowed the Court to be satisfied that there was no risk of under compensation.

The case also considered educational impact upon the injury for the both of the children given the time they had away from school and the impact of the symptoms on their day-to-day disruptions.