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Lawyers Service Newsletter

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Editorial

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As we are now in the run up to Christmas it seems fitting that this LS Newsletter is something of a "bumper edition". It includes ***"AvMA's Outline of Legal Developments"*** with information on HSIB as well as fixed costs for low value clinical negligence claims and other relevant issues. There is also a questionnaire found here aimed at identifying your views on what might be considered "an improved process" – please do complete this as soon as you can, **ideally before 7th January 2019**.

The AvMA legal outline updates the position on extending the coroner's jurisdiction to include investigations into late term stillbirths, Counsel, **Dr Peter Ellis of Hailsham Chambers** has looked at the impetus for this change in his article **"Stillbirth Investigation: An Update"**. Peter has also written up the inquest touching the death of **Max Colley**, Max sadly died as a result of hypoxic brain damage contributed to by neglect; the case engaged Article 2 ECHR.

Still on the subject of inquests, funding for families attending inquests is another topic that has drawn attention over the latter half of this year, we are grateful to **Sarah and Pat Stephens** for allowing us to reproduce an article about AvMA from their blog **"Violet Skies"**, the article reminds us just how difficult the inquest process is for families; Violet was their 15-month-old daughter and evidently they are most grateful to their counsel **Judy Dawson of Park Square Chambers**. Grateful thanks are also given to **Dominique Smith of 1 Chancery Lane** who has written up the **inquest touching the death of Nigel Handscomb** where a series of significant failures in the management of his care amounted to a finding that neglect contributed to his death; **Tom Semple of**

Parklane Plowden Chambers, represented the family in the **inquest touching the death of Peter Hunt**. Mr Hunt was known to be suffering from dementia and had attended hospital for treatment of an ischaemic leg, again serious failings by nursing staff contributed to him leaving hospital unnoticed, another death contributed to by neglect.

Inquests are potentially a powerful forum for identifying what, if anything, went wrong with the healthcare provided. Coroners can use their powers to make a prevention of future death report (PFD) to highlight changes that are required to avoid ongoing risks to the public. Recently, AvMA has seen a tendency for some coroners not to follow up on or to try and evade their original decision to make a PFD. Some of you may remember **Caroline Wood's** case on the inquest touching the death of **Mr Sheffield** which appeared in the June edition of the Newsletter. Caroline is a barrister practising at **Park Square**, she has continued to assist the family by following up the coroner's decision to make a PFD, her article in this edition of the Newsletter provides details of the submissions she made to the coroner when he appeared to be swayed by representations made by the trust after the inquest that a PFD was not in fact necessary – it contains very useful tips for other practitioners who may find themselves in a similar situation.

On a related topic, it has long been recognised that there is a need for the formal introduction of Medical Examiners (ME) to be part of the system of examining deaths. The role of ME is expected to become compulsory in April 2019; some hospitals have taken the initiative and already introduced this post. **The University of Sheffield** has been looking at **Safety for Patients through Quality Review (SPQR)** and evaluating the role of the ME, they have kindly allowed us to publish their outline of this project which includes some key aspects of the ME's role.

Hospital triage systems have been under the spotlight in recent months. **Rajkiran Barhey counsel at 1 Crown Office Row** had cause to explore this in more detail when she represented the family at the **inquest into the death of Hubert Kelly**. Rajkiran's case review raises several interesting points including issues around the coroner's refusal to disclose certain documents and a letter from hospital staff indicating that they did not agree the findings of the trust's own root cause analysis. Unusually, the CQC was represented by counsel at this inquest. However, the Supreme Court decision in **Darnley** has really shone the light on the importance of representations made by hospital staff being accurate. Simeon Maskrey QC and **Jeremy Pendlebury both of 7 Bedford Row** represented Mr Darnley; many thanks to Jeremy for providing his short note on the Supreme Court's key findings in this case which will be invaluable to the busy practitioner.

Costs are central to any legal practice and whilst legal aid funding is no longer as relevant to clinical negligence cases as it once was the Legal Aid Agency (LAA) receives "sufficient queries and applications for payment of unrecovered costs to make this topic worthy of explanation", **Louise Ford** of the LAA addresses this issue in more detail in her article **"The very high cost case contract – What happens when the case wins but not all costs are recovered from the opponent?"**

Staying with the subject of costs, I have included **Philip Holt's** write up of his case of **Lister v Black**, a low value claim which went to trial in December 2017. No doubt this example of how defendant conduct can ratchet up costs in a low value claim will resonate with many, if not all of you! **Jenny Cawthorne** is a Chartered legal executive and costs consultant at **PIC**, she looks closely at the case of **Herbert v HH Law**, although this was a personal injury case, Jenny explores the dangers of clinical negligence lawyers not carrying out proper risk assessments on the success fees being charged to clients when entering into a Conditional Fee Agreement (CFA). Jenny's article **"Assess the risk or run the risk"** is a must read for all clinical negligence practitioners.

Andrew Roy is a barrister at 12 Kings Bench Walk his article **"Duce v Worcestershire Acute Hospitals – the limits of informed consent"** explores in detail why it is that cases based purely on the absence of consent are unlikely to succeed. The impact of the landmark case of Montgomery v Lanarkshire Health Board has also been examined by counsel, **Justin Valentine, barrister at St John's Chambers, Bristol** in his article **"A variation of the Montgomery principle: C v County Durham & Darlington NHS Foundation Trust"** – the case was based on the failure to inform the patient/claimant of a diagnosis of Crohn's Disease due to poor systems operating at the trust, it looks at what the reasonable patient would expect to be told and the significance of the information withheld.

Daniel Sokol is a lecturer, barrister, medical ethicist and author practising at 12 Kings Bench Walk, for what it's worth, he's a pretty good magician too! Our thanks to Daniel for allowing us to reproduce a chapter **"Doing the right thing"** from his most recent book **"Tough Choices"** Whilst acknowledging that it can often be easier said than done, Daniel reminds us that we all have a responsibility to do what is right.

Without prejudice meetings of experts, more particularly the apparently increasing practice of solicitors providing

experts with two agendas instead of one agreed agenda is an issue that Mrs Justice Yip is watching carefully. **Dr Simon Fox QC of No 5 and Exchange Chambers** has set out the warnings of cost consequences resulting from this practice in his article "**Experts' Agendas – a warning from the bench"**.

Last but certainly not least is **Victoria Frederico's** excellent article **"Special Educational Needs Law – Considerations for other professionals"**. Victoria is a solicitor and Head of Education Law at Access Legal and reminds us of the importance of seeking advice and input from a Special Education Needs (SEN) solicitor when acting for children who have suffered brain injury as a result of negligence; that input can add value to a medical negligence claim and the costs are recoverable.

You may remember **Rebecca Greenstreet's** article on wrongful birth in one of our previous LS Newsletters. Rebecca's book **"A practical guide to wrongful conception, wrongful birth and wrongful life claims"** is now available through Law Brief Publishing; Rebecca Greenstreet is a barrister at **Hardwicke Chambers**, with thanks to Moira Gwilliam for her review of the book which is included in this Newsletter.

We look forward to catching up with as many of you as possible at the AvMA Panel and the Christmas drinks that follow on 30th November.

Best wishes

AvMA's Outline Legal Developments

Fixed Recoverable Costs in clinical negligence:

The primary role of the Civil Justice Council (CJC) is to advise the Lord Chancellor, the judiciary and the Civil Procedure Rule Committee on civil matters. The CJC has been tasked with considering fixed costs in clinical negligence claims with a value of £25,000 or less.

The CJC clinical negligence fixed costs working group ('the working group') was convened in about April of this year, it is chaired by Andrew Parker a partner at DAC Beachcroft solicitors specialising in injury claims. Andrew is a former president of the Forum of Insurance Lawyers (FOIL) and a solicitor member of the Civil Justice Council he has worked on the Government's whiplash reform agenda as well as the fixed cost scheme for Noise Induced Hearing Loss.

The Vice Chair is David Marshall. David is managing partner at Anthony Gold. He is a past chair of the Law Society's Civil Justice Committee and was appointed as an Assessor to Lord Justice Jackson as part of his wide-ranging review of the civil litigation costs system.

Terms of Reference: Full details of the Civil Justice Council's terms of reference for the clinical negligence fixed costs working group can be found at: **https://www.judiciary.uk/related-offices-and-bodies/advisory-bodies/cjc/clinical-negligence-fixed-costs-working-group/**

The working group has been put together to consider and recommend an improved process for clinical negligence claims valued at £25,000 and under, having identified an "improved process" the working group is then to apply fixed recoverable costs to that process. The working group has also been asked to consider figures for the cost of expert reports and how expert reports should be commissioned and funded. This includes looking at the feasibility of single joint experts in some claims as part of the overall improved process.

CJC working party rules of engagement: The process is confidential in the hands of the CJC. The rules are:

- Issues discussed are confidential to the process although representatives of the working party can report back to their own organisations
- Confidentiality allows the Core group with their representative hats on to share the info with those in their representative groups and/or core groups whilst respecting the confidentiality of the process.
- Chatham House Rule prevails: Discussions are held under the Chatham House Rule which means that participants are free to use the information received but are not able to reveal the identity of the speaker.
- Papers circulated to the core group are confidential to CJC process

When is the working group expected to report? The original timetable had been for the working group to report by the end of September 2018, that time estimate was subsequently revised to December. At the time of writing this Newsletter it seems likely that the report will not be available until the first quarter of 2019.

How does the CJC fixed costs working group operate? The working party is made up of two specific groups, a wider stakeholder group comprised of about thirty members which meets every 3 months or so and a core group of about twelve claimant and defendant representatives including AvMA and members of the judiciary. The core group meets more frequently.

The CJC itself is an advisory body and cannot make decisions. The intention is that the core group discusses the issues in more detail and aims to achieve as much consensus as possible on changes to the process and establishing a fixed costs regime.

Managing contentious issues: Mediation is expected to form a part of the working group process to iron out some of the more contentious issues between the various representative groups involved in the working party. It is also intended that the core group draw up proposals and make decisions for discussion and ratification by the wider group.

What is the current position? The core group discussions to date have centred on exploring an improved process, it will come as no surprise that achieving a consensus on some of the topics discussed is easier said than done.

The process is intended to be used by all healthcare providers, not just NHS Resolution but private and primary care providers as well.

What sorts of improvements to the process are being considered? It is fair to say that whether the issues discussed are considered an improvement depends of whether you are a claimant or defendant representative. The consensus on some of the issues discussed is not clear and some of the issues will almost certainly need to be revisited.

A broad outline of the issues under discussion: The issues listed below have been discussed on more than one occasion, but the lack of consensus means they will need further discussion.

The figures: There has been discussion around the data sets available for analysis but as the improved process has yet to be designed or agreed on there has been no

discussion on the figures that are to apply to each stage of the process.

Consideration of type of expert report required: Several different types of reports have been considered including a brief overview report which contains enough information to allow the defendants to investigate the case whilst remaining cheap to commission - no more than a few hundred pounds, maximum.

How such a report might be used in litigation has been considered, including the impact of serving the same on a sequential but without prejudice basis. One suggestion has been that the party relying on the overview report is not bound by the contents of it.

A variation of the overview report is a report which addresses the key issues from a core bundle of medical records (put together by the claimant solicitor) the report would not be CPR compliant. However, there is no agreement about what status, if any a report of this nature might have in the post issue period if the claimant issues proceedings.

Could a report of this type offer any benefits given its uncertain status in the post issue phase? Is anything other than a full report commissioned at the outset going to be cost effective in the long run? Would experts even be prepared to write these types of reports?

It is important to emphasise that all these issues remain under consideration and no decisions have been made. It may be that this is one of those issues that is referred for mediation at the end of the process although that too remains to be seen.

Categories of case: It is expected that some types of case will fall outside of the fixed costs regime, see below under "**Exemptions**" for more information.

It has been suggested that cases that do not require any expert or counsel involvement could be treated differently, in a track of their own. Some of the data suggests that up to 25% of cases could be caught by this track. However, defining those cases at the outset is more challenging. Perhaps, "never events" that have occurred and give rise to claims should be a starting point for identifying these cases, however even cases involving never events may need expert reports on causation and or condition and prognosis.

Pre-issue exchange of expert and witness evidence: There is some support in principle for a scheme that looks to early disclosure of expert and witness evidence; the emphasis is on this information being disclosed sequentially and at the earliest opportunity in the pre-issue stage.

The rationale is that the early disclosure will ***"hold the defendant's feet to the fire,"*** that is, if the Claimant substantiates their claim at an early stage it will encourage early settlement which in turn will save costs.

Sequential versus simultaneous exchange of expert evidence: This envisages the Claimant serving their medical expert evidence first, potentially at letter of claim stage. If, following D's investigation of the claim, the claim does not settle then D should serve their expert evidence and witness statements with their Letter of Response. If that procedure were accepted, then it is envisaged that C would have a right to reply to that letter of response and C's expert can comment on D's expert evidence.

There are strongly held views on the benefits of sequential exchange of expert reports versus simultaneous exchange.

Another possible option is that the letter of claim could be served with a confirmation/declaration that it has been drafted with the benefit of an expert report – the name of the clinician and the date of the report could be cited in the letter of claim. A similar declaration could be required of the Defendant in their letter of response, simultaneous exchange expert evidence could then take place shortly after service of the letter of response.

The arguments for simultaneous exchange of expert evidence point to the fact that there is no evidence that the present system does not work. Arguably, simultaneous exchange of expert evidence avoids the temptation for the D expert to report in a way that focuses on seeking to undermine the C expert report. It preserves the parties' respective positions and maintains a parity between them. It encourages the experts to look at the evidence and form their own robust and impartial views which in turn increases the chances of the expert producing a report which is independent and not influenced by the pressures of litigation.

By contrast, there is a view that sequential exchange encourages a tit for tat type response where the focus is on attacking what the claimant expert has written rather than forming an independent view of the evidence.

Exemptions: There is agreement that certain categories of case should fall outside of any fixed recoverable cost regime and there has been considerable discussion about the type of cases to be excluded. There appears to be consensus that cases requiring more than two experts ,one on breach and one on causation, would fall outside the scheme, similarly cases involving multiple defendants.

There is a view that cases involving stillbirths, fatal accidents, protected parties and Human Rights Act claims

should fall outside of the scheme too. That is not a view shared by all of the participants in the core group.

It is understood that the categories of exempt cases are to be revisited.

What will the post issue process look like? That will depend on what is agreed in the pre-issue stage, discussions around the process are ongoing but the post issue process could be as simple as a pretrial review (possibly by telephone) and then fixing the date for trial.

The aims of the process: NHS Resolution and other healthcare providers will understandably want to avoid being faced with a process that encourages a barrage of unmeritorious claims.

AvMA firmly believes that for claimants who have been injured as a result of clinical negligence the best lawyer to advise them is an experienced, accredited lawyer specialising in this field of work.

The emphasis must be on achieving a fair settlement for injured patients and identifying the breaches that pose a continuing risk to patient safety. For the process to be improved, healthcare providers must act on rectifying the breaches that gave rise to the claim in negligence.

The CJC terms of reference offer a unique opportunity to put patient safety and learning at the centre of the process. If this were to happen it could prove to be a truly "improved process" with the potential to make real cost savings in clinical negligence; in the longer term it could serve to reduce the number of claims and incidentally improve the patient experience as well as reducing the impact of litigation on the doctors, nurses and other healthcare providers. If the CJC commits to getting this right it could prove to be a real gamechanger for all parties involved.

Issues requiring discussion: There are still several substantial issues to be discussed. The big question of the level of fixed costs to be applied to the process will not be discussed until the process has been designed. Other significant areas requiring discussion include:

How are expert reports to be commissioned and funded?

There has been a suggestion that this aspect of the terms of reference invites discussion about whether After the Event (ATE) insurance premiums in clinical negligence cases should continue to be recoverable. There is division as to whether this discussion does fall within the scope of the CJC terms of reference and some strongly held views about whether it should or shouldn't be explored.

The question of whether you can reasonably put a cap on expert fees has also been raised. It has been noted that 77% of the respondents to the Department Health consultation were opposed to the suggestion of a cap of £1,200. Respondents pointed out that this step would result in a decreased pool of experts and the risk of claimants being unable to obtain appropriate expert evidence to allow them to properly pursue their claim.

It has been pointed out that previous attempts by external agencies/influences to manage the expert report market have failed; the Legal Aid Agency's attempt to depress expert rates has resulted in experts refusing to do legal aid work because the rates are too low.

It has also been pointed out that a cap on expert fees is likely to result in further deductions from client damages. In low value claims this is likely to be a barrier to accessing justice; the client's damages could be so severely reduced or wiped out such that it is no longer worth their while bringing a claim. Many solicitors will refuse to run such cases, regardless of the merits to prevent damaging their own professional reputation and/or entering into situations of potential or actual conflict with their client.

Discussion on how expert reports should be commissioned and funded continue.

Patient safety: Another key area requiring discussion. Improvements in patient safety is the cornerstone of better care and a reduction in the number of clinical negligence claims having to be brought and paid out on. A commitment to improving patient safety is the cheapest, most effective and most appropriate way of reducing costs and more importantly, reducing harm to patients and alleviating stress on clinicians and hospital staff.

The terms of reference have identified that one area of patient safety that needs improvement is how case outcomes are reported back for the purposes of learning. AvMA has already made public suggestions about how this could be tackled. If you are not already aware of our proposals, then further information can be found on the AvMA website at:

https://www.avma.org.uk/?download_protected_attachment=Briefing-Patient-Safety.pdf

Retention of client damages: Claimants are already susceptible to losing up to 25% of the value of their past losses and general damages to a success fee, additional sums may be deducted to reflect the difference between the contractual hourly rate set out in the CFA and what is recovered by way of fixed costs. If claimants are also faced with having to pay a contribution towards their experts' fees because of the effect of a capped expert fee,

or the cost of ATE premiums, it follows that their damages will be steadily eroded.

If claimants are unable to bring a claim because their award of damages after deductions is too low to make the stress of litigation worthwhile then this becomes an access to justice issue. This must be taken seriously and cannot be allowed to happen.

AvMA's work: AvMA is represented on both the wider and the core CJC working groups, we continue to maintain our work raising awareness of the impact fixed costs may have on access to justice and patient safety. This includes discussing the risk to low value claims with our delegation of patients' charities and what this may mean for their beneficiaries.

AvMA remains very mindful that whilst £25,000 is frequently referred to as a low value claim, a low value award can make a big difference to some injured people and/or their families. It can mean the difference between individuals and/or families being able to pay rent or mortgage arrears or paying off loans which were required to cover debt that accrued due to time off work. Compensation for an injury that attracts a so-called "low value claim" can make a vital difference and we must not lose sight of how important these awards can be, not just in monetary terms but in terms of learning and improving the care offered by the NHS and other healthcare providers to the public.

AvMA's focus is very much patient safety and access to justice. For there to be access to justice, funding must be available to service the cost of expert reports. Equally important is the need for any process to reward lawyers who have expertise and experience in clinical negligence claims so it is commercially viable for them to run these low value cases efficiently, robustly and fairly ensuring awards of damages are commensurate to the injuries and losses sustained by members of the public who find themselves in the unwanted situation of having to bring litigation to enforce their rights of redress.

It is therefore crucial that if fixed costs are an appropriate way forward that the costs awarded are commercially viable so ensuring experienced solicitors can undertake this sensitive and complex area of work.

AvMA Lawyers Questionnaire: The confidential nature of the CJC meetings is such that it is difficult for us to identify what our Lawyer Service members think about the proposals and most importantly whether in all probability they would be able to do the work at all.

With that in mind we have compiled a questionnaire seeking your views. The questionnaire is intended to be straightforward, quick and easy to complete although there are opportunities for you to comment on issues more generally if you wish to. The questionnaire can be accessed by clicking on the link below:

https://podio.com/webforms/21936688/1533893

We encourage as many of you as possible to respond to the questionnaire and submit it by **no later than Monday 7th January 2019** after this date we will start to collate your responses and communicate your views to CJC, and other relevant bodies.

Healthcare Safety Investigations Branch (HSIB)

As many of you know, HSIB became operational in March 2017 it has already undertaken several investigations many of which are still ongoing. Their investigations cover a wide range of issues from ***"Transition from Child and Adolescent mental health services to adult mental health services"*** to ***"Implantation of wrong prosthesis during joint replacement surgery"*** both investigations have now been completed and details are available from the HSIB website: **https://www.hsib.org.uk/**

Other HSIB investigations into issues such as ***"Ingestion of button batteries in children"*** to ***"Management of acute onset testicular pain"*** are ongoing.

HSIB is intended to be an exemplar of healthcare safety investigative practice and aims to embed a culture of learning across the NHS in England. It is meant to be ***"independent of the NHS and at arm's length from Government"*** it is to have ***"new powers that will enable it to discharge its investigation functions fully and effectively"*** [1]

The draft Health Service Safety Investigations Bill (the Bill) was published in September 2017 and makes clear that HSIB's function is to investigate qualifying incidents and is not to assess or determine blame, civil or criminal liability or whether further action against an individual is required by their regulatory body. Patients and their families are to be involved in HSIB investigations if and so far as is reasonable and practicable (S3 (3) the Bill).

The key parts of the Bill can be found at S28 which provides for a prohibition on HSIB disclosing to *"any person"* any information, document, equipment or other item which is held by it in connection with the investigation. The only exception to the prohibition on disclosure is where the High Court makes an order for disclosure.
At Sections 20 - 22 The Bill proposes allowing NHS Trusts to become accredited by HSIB to carry out both internal

1 *Draft Health Service Safety Investigations Bill; Foreword*

and external investigations. If this were to happen then accredited Trusts would be able to rely on the prohibition on disclosing information as set out at S28.

AvMA has been very clear from the outset that the prohibition on sharing information is contrary to the Duty of Candour and is not acceptable.

It should be noted that since April 2018, HSIB has also been tasked with carrying out maternity investigations although to date none of the maternity investigations have been completed. Unlike other HSIB investigations the maternity investigations are carried out under the Duty of Candour principle. We understand that HSIB Directions are to be amended to make clear that safe space principles do not apply to maternity investigations. In December 2017 AvMA received written assurance from the Department of Health (DH) that the change of emphasis in maternity investigations intended that families were provided with relevant information and that there should be a move away from protecting certain information from disclosure.

The DH also made clear that their more open approach to maternity investigations did not mark an acknowledgment that so called "safe space" was not appropriate for first level investigations.

AvMA's Involvement

AvMA has put considerable effort into lobbying against Sections 20 - 22 the draft Bill, resisting the proposal that 'safe space' be applied to local trusts' investigations. As well as work with mainstream and social media and briefings 'behind the scenes', Peter Walsh provided both written and verbal evidence in front of the Joint Select Committee considering the Bill.

The Joint Committee

The Joint Committee on the Draft Bill produced their final report on 2nd August 2018. There is good and bad news. The good news is that the joint committee report described AvMA's evidence as ***"compelling"*** and strongly recommended getting rid of the proposal that NHS Trusts could be accredited by HSIB to carry out their own internal and external investigations – the committee report is very much against the extension of safe space to local investigations.

However, worryingly the joint committee has recommended that the safe space protection be extended to cover any information and material disclosed to HSIB. That recommendation, if accepted, creates considerable uncertainty around how HSIB maternity investigations will be handled – presumably maternity investigations will also fall under the umbrella of safe space NOT duty of candour!

The Committee recommended that maternity investigations be taken away from HSIB and given to NHS Improvement. Whilst this would mean they would not be subject to 'safe space', many people feel it is impractical to ask NHS Improvement to develop the same level of investigation expertise as HSIB, as well as NHS Improvement not being independent.

HSIB Maternity Investigations

To give the joint committees proposals context it is worth looking at HSIB's current remit when it comes to maternity investigations.

HSIB is being funded by DH to carry out specialist independent investigations into maternity incidents; this is part of a national strategy to improve maternity safety. HSIB aims to bring a standardised approach to maternity investigations without attributing blame or liability. Currently, the investigations are being rolled out slowly across England but the aim is for HSIB maternity investigations to be fully functional by April 2019 covering about 1,000 investigations per annum with the assistance of fourteen maternity investigation teams. AvMA understands that once fully functional there will be three HSIB maternity teams in the South East, three teams in London, four teams in the Midlands and East Regions and four teams for the North.

HSIB will undertake maternity investigations that meet Each Baby Counts criteria (the criteria apply to all births that occur at 37+ weeks' gestation) and the defined criteria for maternal deaths, this will include investigations into the following:

(i) Intrapartum stillbirths – that is where the baby was believed to have been alive at the start of labour but was born with no signs of life.
(ii) Early neonatal deaths – when the baby dies within the first week of life
(iii) Severe brain injury – where the brain injury was diagnosed at birth or within the first seven days of life and where the baby was diagnosed with a Grade III hypoxic ischaemic encephalopathy (HIE) OR was therapeutically cooled OR where baby had decreased tone AND was comatose AND had seizures of any kind – Babies whose outcomes were considered to be the result of congenital abnormalities will be excluded.

(iv) Maternal deaths: where the mother dies while pregnant or within forty two days from the end of her pregnancy from any cause related to or aggravated by the pregnancy; direct deaths resulting from complications of the pregnancy, labour and puerperium; indirect deaths from previous existing disease or diseases that developed during the pregnancy which were aggravated by the physiological effects of pregnancy in the perinatal period. Suicides are excluded.

Currently NHS Trusts are expected to carry out serious incident reports into the above incident types, however if HSIB investigations have already been introduced in the region where the serious incident has taken place then the investigation will fall to HSIB. Where HSIB carries out a maternity investigation, that investigation will replace the need for the Trust to carry out a SIR.

If HSIB maternity investigations have not yet been introduced in a particular region then the trust will continue to be responsible for conducting a SIR.

If HSIB maternity investigations go to plan then HSIB investigations should be available throughout the country by April 2019. In any event, it is understood that trusts will continue to be responsible for completing the initial STEIS reporting, the seventy-two-hour report and compliance with the Duty of Candour.

It is clear that HSIB maternity investigations will cover a broad spectrum of maternity and neonatal deaths. Given that HSIB maternity investigations are intended to replace the need for NHS Trusts to carry out their own investigations, the importance of ensuring that HSIB maternity investigations remain subject to the duty of candour principle and not the Bill's proposal to extend the prohibition on disclosure of information is apparent.

What happens now?

The Department of Health and Social Care (DHSC) is due to respond to the Committee's report and clarify its intentions before the end of the year. Obviously, if maternity investigations stay with HSIB then AvMA will continue to fight to ensure that these investigations do not become subject to 'safe space'.

The current position is that both HSIB and DHSC agree that HSIB maternity investigations should not be subject to 'safe space'; the HSIB Directions have been amended accordingly. If you would like more information, then you may find the AvMA news item on HSSI Bill of interest, details are on our website or click on the **here**:

Early Notification Scheme

NHS Resolution introduced the Early Notification Scheme (ENS) in April 2017. It only applies to NHS hospital trusts where a pregnancy has reached 37 weeks and where the trust has reason to believe that a maternity incident has occurred. Where this has happened the trust is required to complete a standard report form and send this in the first instance to their legal department; in any event the incident must be reported to NHS Resolution within 30 days of the incident having occurred.

A maternity incident used in the context of the ENS refers to those maternity cases where a baby is diagnosed either **at birth or within the first 7 days** of its life with a potentially serious brain injury.

The Trust will be required to complete an Early Notification report form if a baby has:

(i) Been diagnosed with a Grade III Hypoxic Ischaemic Encephalopathy (HIE);
Or had
(ii) Undergone therapeutic cooling.
Or has
(iii) Decreased central tone and has experienced seizures and is comatose.

What happens next?

An investigation should be carried out either by HSIB where HSIB has already been rolled out in that region or the investigation should follow the Serious Incident Reporting (SIR) Guidelines.

We understand that simultaneously, NHS Resolution will be carrying out their own review of the medical records to identify whether the facts of the case require that they should admit liability at an early stage. NHS Resolution have recruited at least two consultant Obstetricians, Tim Draycott and Rebecca Wilson-Crellin to assist with this aspect of the process.

NHS Resolution say they are committed to admitting liability at the earliest stage possible, they have three designated case handlers dealing with ENS cases to promote this. Overall NHS Resolution want the ENS process to help identify learning and share the learning at a national, regional and local level; improve the experience for both the families and staff affected; and reduce formal litigation in the courts and the associated legal cost.

AvMA has been in discussion with NHS Resolution about how families can and should be supported once they are

advised that an Early Notification Report has been completed and an investigation should be undertaken.
It is still early days, but we would be pleased to receive details of your clients' experience of the ENS process.

Extending the jurisdiction of the coroner's court:
Currently, a stillbirth is only recorded if the foetus has attained a gestational age of 24 weeks or more. The fact that Coroners in England do not have the power to investigate stillbirths is a controversial issue for many families affected by this type of loss, as well as for lawyers and coroners. However, it may be that this is about to change: **The Civil Partnerships, Marriages and Deaths (Registration etc) Bill** proposes that The Coroners and Justice Act 2009 be amended to allow Coroners to investigate late term stillbirths – it has been suggested that a stillbirth that occurs from 36 weeks gestation would qualify as a late term stillbirth. AvMA would certainly welcome such a change which we consider to be long overdue.

The Bill passed the report stage and third reading on Friday 26th October and will now be referred to the House of Lords for its first reading.

Legal Aid Funding for Inquests
As many of you may be aware, during the summer, the Ministry of Justice (MoJ) put out a call for evidence as part of their review of legal aid for inquests. The review is said to be aimed at considering what might need to be changed to the existing legal aid process, to ensure that families are able to fully understand and properly participate in inquest proceedings.

AvMA's response included several recent case studies from our Inquest Service. The cases were included to illustrate the difficulties that families faced with an inquest into the death of a loved one must routinely overcome. Details of our response can be found **here**

Following on from our submission AvMA were invited along with others to meet with the MoJ to discuss our views and concerns regarding the current system of funding. The meeting took place on 1st November but it is far from clear what changes, if any are going to be made. The MoJ told us that there is limited funding to make changes to the system.

What motivates patients to bring a claim?
You may be interested to know that NHS Resolution has now published the views from its Behavioural Insights Team (BIT) on **"Behavioural insights into patient motivation to make a claim for clinical negligence"** See **here**.

The report is dated August 2018 although was only published on 22nd October. It has been prepared in response to observations made by the Public Accounts Committee at the end of 2017 that the NHS needed to glean a better understanding of the factors that give rise to patients making claims.

The BIT report has been compiled with reference to surveys completed by 728 past claimants (this represents 7% of the total number of claimants approached by BIT) and on information obtained from twenty one-hour telephone interviews.

Although the BIT conducted its work streams between January and August 2018, the period when the negligence occurred is not clear; in 42% of the cases the incident began before 2013, 22% occurred in 2013 and 36% pertained to the period 2014 – 2017. Neither is the type of injuries sustained identifiable although the report does say that orthopaedics and general surgery were the two specialities where most care incidents had occurred.

The key motivating factors have been identified as falling into two distinct categories; first "External Motivations" which includes factors such as advertising. The second is described as "Personal or intrinsic motivations" these include issues such as the claimant wanting to prevent similar things happening to others; wanting an apology and/or accountability as well as frustrations with poor incident or complaint handling. The wish for financial compensation also falls within this category.

In AvMA's view the report does not identify anything new. Missed opportunities to avoid claims being made include better complaint handling; correcting the mistakes made; assurance that the same mistakes would be avoided in the future; better apologies and explanations following investigation; more honesty and transparency; better communications skills including being shown compassion and humanity.

Many of these points and more have been identified previously, certainly the Clwyd/Hart report **"Review of the NHS Hospitals Complaints System Putting Patients back in the Picture"** published in October 2013 identified some of these key themes; that report was compiled with the benefit of 2,500 testimonials from patients and their families and friends. See **here**.
Clwyd/Hart identified that some of the reasons why people complained were lack of information about their con-

dition, prognosis and expected treatment; a lack of respect, compassion and sympathy; not being treated with dignity and care and a need to ensure that lessons had been learnt. Five years later the same points are identified as motivational factors in making a legal claim.

The real question is: What, if anything is going to be done in response to the BIT's latest report? AvMA believe change is both possible and necessary but it will require funding and commitment to make the changes. More especially it will require a fundamental shift in culture and greater openness and transparency to make this happen, but if it does happen it is almost certain that it will result in huge savings in litigation costs.

MBRRACE – UK: Saving Lives, Improving Mothers' Care
On 1st November, MBRRACE published their most recent UK maternal report. The full report and the lay summary are available **here**

MBRRACE is now seeking proposals for new confidential enquiry topics for **severe maternal morbidity, and perinatal morbidity and mortality**. The confidential enquiries involve review of cases against national guidelines and standards to assess the quality of care women and their babies received. The deadline for topic submission is **30th November 2018**. Anyone (public and professional) can propose a topic for consideration. More information about how the confidential enquiries are conducted and guidance on how to submit a topic is available on the MBRRACE-UK website: **https://www.npeu.ox.ac.uk/mbrrace-uk/topics**

Stillbirth Investigation: An Update

PETER ELLIS
HAILSHAM CHAMBERS

Background

In 2016 the UK's stillbirth rate was 3.93 per 1,000 total births, a fall from 4.20 per 1,000 total births in 2013[1]. Over the same period the neonatal death rate fell from 1.84 to 1.72 deaths per 1,000 live births. However, for the Trusts and Health Boards which care for the most complex pregnancies and deliveries, the neonatal mortality rates show a wide variation, between 1.78 and 3.52 per 1,000 live births in those with level 3 Neonatal Intensive Care Units (NICUs).

Although gradually falling, UK stillbirth and neonatal death rates nevertheless remain high compared with many similar European countries. An area of particular concern is that about 70% of all stillbirths and neonatal deaths occur preterm, with about 40% at less than 28 weeks gestation.

In 2015 the Secretary of State for Health announced an ambition to reduce stillbirths and neonatal deaths in England by 20% by 2020, and 50% by 2030[2]. This coincided with the publication of the National Maternity Review 'Better Births', a 5 year plan to improve NHS maternity services in England[3].

In October 2016 the Department of Health launched the Safer Maternity Care action plan[4], which set out the improvements to maternity services that were expected to 'make a difference in each and every maternity and neonatal service across the country' by 2018.

In 2017 NHS Improvement launched the Maternal and Neonatal Health Safety Collaborative[5], led by its Patient Safety Team, covering all maternity and neonatal services across England. The aim was to improve the safety and outcomes of maternal and neonatal care by reducing unwarranted variation, and providing a high quality healthcare experience for all women, babies and families across maternity and neonatal care settings in England. This was intended to contribute to the ambition, set out in Better Births, to reducing the rates of maternal and neonatal deaths, stillbirths, and brain injuries that occurred during or soon after birth.

Multi-disciplinary clinical investigation: the Perinatal Mortality Review Tool and the RCOG Each Baby Counts programme

Although pathology plays a vital role in the determination of the cause of death,[6] there are many factors which are not identified by pathological examination alone. Within the NHS, it is now recognised that a multidisciplinary approach is required, to ensure that all factors and events are reviewed in a constructive and educational way.

Earlier this year, a collaboration led by Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries across the UK ('MBRRACE-UK') was appointed by the Healthcare Quality Improvement Partnership ('HQIP') to develop and establish a national standardised Perinatal Mortality Review Tool ('PMRT').

This built on the work of the Department of Health, and the Stillbirth and Neonatal Death Society[7] ('SANDS') 'Perinatal Mortality Review Task and Finish Group'. The PMRT has been designed with user and parent involvement, to support high quality standardised perinatal reviews on the principle of 'review once, review well'.

1 *https://www2.le.ac.uk/offices/press/press-releases/2018/june/latest-report-on-stillbirth-and-neonatal-death-rates-for-local-populations-and-individual-nhs-trusts-and-health-boards-across-the-uk-in-2016*

2 *https://www.gov.uk/government/news/new-ambition-to-halve-rate-of-stillbirths-and-infant-deaths*

3 *https://www.england.nhs.uk/wp-content/uploads/2016/02/national-maternity-review-report.pdf*

4 *https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/560491/Safer_Maternity_Care_action_plan.pdf;*

https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/662969/Safer_maternity_care_-_progress_and_next_steps.pdf

5 *https://improvement.nhs.uk/resources/maternal-and-neonatal-safety-collaborative/*

6 *Evans MJ. Perinatal pathologists have a vital role in stillbirth review. BMJ 2017. 359:j5620*

7 *https://www.sands.org.uk/about-sand*

The aim of the programme is to introduce the PMRT to support standardised perinatal mortality reviews across NHS maternity and neonatal units in England, Scotland and Wales. The tool facilitates:

- Systematic, multidisciplinary, high quality reviews of the circumstances and care leading up to and surrounding each stillbirth and neonatal death, and the deaths of babies who die in the post-neonatal period having received neonatal care.
- Active communication with parents to ensure they are told that a review of their care and that of their baby will be carried out and how they can contribute to the process.
- A structured process of review, learning, reporting and actions to improve future care.
- Coming to a clear understanding of why each baby died, accepting that this may not always be possible even when full clinical investigations have been undertaken; this will involve a grading of the care provided.
- Production of a report for parents which includes a meaningful, plain English explanation of why their baby died and whether, with different actions, the death of their baby might have been prevented.
- Other reports to identify emerging themes across a number of deaths, to support learning and changes in the delivery and commissioning of care to improve future care, and prevent the future deaths which are avoidable.
- Production of national reports of the themes and trends associated with perinatal deaths to enable national lessons to be learned.
- Parents whose baby has died have the greatest interest of all in the review of their baby's death. Alongside the national annual reports, a lay summary of the main technical report will be written specifically for families and the wider public. This will help local NHS services and baby loss charities to help parents engage with the local review process and improvements in care.

Each Baby Counts[8] is the RCOG's national quality improvement programme, launched in 2016 to reduce the number of babies who die, or are left with severe disability, as a result of incidents occurring during term labour. Each Baby Counts has an ambitious aim to reduce by 50% the incidence of stillbirth, neonatal death and severe brain injury as a result of incidents during term labour by 2020.

Stillbirths, neonatal deaths and brain injuries occurring due to incidents in labour are initially investigated at a local level. In each maternity unit, these incidents are rare, and it is often difficult to see clear patterns or best ways to avoid them. The Each Baby Counts programme brings together the results of these local investigations to understand the bigger picture and share the lessons learned. The Each Baby Counts programme also utilises a multidisciplinary approach which also provides an opportunity to learn from parents, midwives and doctors.

Legal investigation by coroners and procurator fiscals: the current regime

Investigation of stillbirth is not currently within the jurisdiction of coroners in England & Wales, and procurators fiscal in Scotland. Babies who are stillborn are not considered to have an independent life. Thus coroners and procurator fiscals have, to date, only been involved in cases where there was doubt as to whether a baby was stillborn or born alive.

In 2016, of a total of 1,028 term stillbirths, less than 7% of cases were discussed with a coroner or procurator fiscal, and only 12 cases (1.2%) underwent a coronial post-mortem. Assuming that all term stillbirths were accepted for investigation and post-mortem by English and Welsh coroners this would have a major impact on their workload.

Investigation of neonatal death is part of the remit of the coroner where the cause of death is unknown, or there are specific concerns that the death may have been unnatural. Of the 465 term neonatal deaths that occurred in the UK in 2016, 58% (270) were discussed with the coroner or procurator fiscal, and almost half of these (132) were accepted for post-mortem examination and investigation.

In Northern Ireland, which has separate legislation, the position is different. In 2013, the Northern Ireland Court of Appeal held that the coroner did have jurisdiction to carry out an inquest on a child born beyond the legal limit for viability (24 weeks) that had been capable of being born alive[9].

8 *https://www.rcog.org.uk/en/guidelines-research-services/audit-quality-improvement/each-baby-counts/ See also the NHS Resolution Early Notification Scheme https://resolution.nhs.uk/services/claims-management/clinical-claims/clinical-negligence-scheme-for-trusts/early-notification/*

9 *Siobhan Desmond v The Senior Coroner for Northern Ireland [2013] NICA 68*

Proposed reform

Amending the Coroners and Justice Act 2009

In January 2014, Tim Loughton MP introduced a private members' bill: The Civil Partnerships, Marriages and Deaths (Registration Etc) Bill 2017-19[10]. The Bill is currently progressing through Parliament, and has reached its first reading in the House of Lords. The Bill has Government and Opposition support at present.

The Bill could pave the way for coroners to have jurisdiction to investigate stillbirths. Clause 4(1) of the Bill would require the Secretary of State to 'make arrangements for the preparation of a report on whether, and if so how, the law ought to be changed to enable or require coroners to investigate stillbirths.'

At the Public Bill Committee, Gareth Thomas MP tabled an amendment to the Bill which would have required the Secretary of State to examine how the law should be changed, rather than whether it should be changed. However, this was withdrawn on objections from Victoria Atkins MP that this would prejudge the findings of the report.

Clause 4(2) of the Bill states that the term 'stillbirth' is to have the same meaning as in the Births and Deaths Registration Act 1953: 'a child which has issued forth from its mother after the twenty-fourth week of pregnancy and which did not at any time after being completely expelled from its mother breathe or show any other signs of life'.

Clause 4(4) of the Bill enables the Lord Chancellor, after the report has been published, to create regulations amending Part 1 of the Coroners and Justice Act 2009 to 'enable or require coroners to conduct investigations into stillbirths', and to 'specify the circumstances in which those investigations are to take place (including by limiting the duty or power to investigate to certain descriptions of stillbirths').

The explanatory notes to the Bill suggest that this provision could be used 'to provide that a power or duty to investigate stillbirths only applies to stillbirths of more than a specified gestation'; in other words, investigate a narrower range of stillbirths than the post-24 weeks prescribed by the Births and Deaths Registration Act 1953.

Finally, Clause 4(5) of the Bill confirms that the Bill may not 'create any offence' or 'confer any power to make a provision of a legislative character', other than by applying modifications to the Coroners and Justice Act 2009.

10 *https://services.parliament.uk/bills/2017-19/civilpartnershipsmarriagesanddeathsregistrationetc.html*

In May 2017, SANDS issued a position statement supporting 'calls to broaden the jurisdiction of the coroner so that they are able, at the request of parents, to investigate a stillbirth'[11].

Health Services Investigation Branch and the Medical Examiner Scheme

In response to these calls for reform, and the Government response to the Morecambe Bay Investigation[12], and in anticipation of possible legislation, the Secretary of State for Health made a statement to the House of Commons in November 2017, that the then newly formed Healthcare Services Investigation Branch[13] would investigate every case of stillbirth, neonatal death and suspected brain injury notified to the Each Baby Counts programme. He also stated that he would work with the Ministry of Justice 'to look closely into enabling, for the first time, full-term stillbirths to be covered by coronial law' [14].

In response, the President of The Royal College of Pathologists, Professor Jo Martin, agreed that this would be an important step in helping parents to get answers to what happened, and also enable the NHS to learn where mistakes may have been made, and to improve future care[15].

However, once the new Medical Examiner scheme has been introduced, she thought that all cases of stillbirth should initially be reported to a medical examiner for review, who would then decide which cases should be referred to the coroner for further investigation.

The national network of medical examiners is due to be introduced from 2019 to provide independent scrutiny of deaths not reported to the coroner, initially working independently across hospital Trusts, with their role also extending to examination of deaths in the community.

Pilot schemes showed that medical examiners were ideally placed to identify trends relating to deaths and highlight areas for further investigation, giving relatives the answers they deserve and improving care for future patients. The Morecambe Bay Investigation into the deaths of 11 babies

11 *https://www.sands.org.uk/professionals/professional-resources/position-statement-coroners-inquests-stillbirths*

12 *https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/408480/47487_MBI_Accessible_v0.1.pdf*

13 *https://www.hsib.org.uk/*

14 *https://www.gov.uk/government/news/new-maternity-strategy-to-reduce-the-number-of-stillbirths*

15 *https://www.rcpath.org/discover-pathology/news/college-response-to-secretary-of-state-s-announcement-investigating-stillbirths.html*

at Furness General Hospital, recommended that the role of medical examiners should be extended to include review of stillbirths.

New criteria for reporting deaths to coroners

In his 2016 Report[16], the Chief Coroner observed that the notes for doctors attached to the Medical Certificate of Cause of Death stated under 'When to Refer to the Coroner', that there was no statutory duty to report any death to a coroner. The notes, therefore, did no more than encourage doctors to adopt the criteria for registrars, and report any death which should be referred to the coroner by the registrar of births and deaths. But this was no requirement or instruction, and doctors were not bound by it. There was therefore a lacuna in the law.

He concluded that doctors needed clear statutory guidance for reporting deaths to the coroner as soon as possible. At the same time statutory criteria would also guide local coroners. It would preclude them from promoting their own policies for reporting deaths locally. At that time there was inconsistency of practice amongst senior coroners. Some requested doctors to report all stillbirths and all child deaths. There was no legal basis for that approach and a neighbouring coroner area might have no such policy.

It would be a matter for Parliament in regulations to decide what types of death should be reported. In England and Wales Parliament had envisaged that the Lord Chancellor could make regulations 'requiring a registered medical practitioner, in prescribed cases or circumstances, to notify a senior coroner of a death of which the practitioner is aware'[17].

There were two possible routes for this. When the Medical Examiner scheme was implemented, draft Death Certification Regulations were ready to be brought into force. Alternatively, freestanding regulations could provide the necessary criteria.

16 *https://www.judiciary.uk/wp-content/uploads/2016/09/chief_coroner_report_2016_web2.pdf*

17 *Section 18 of the Coroners and Justice Act 2009*

Max Colley Inquest: Neglect contributed to death of second twin from hypoxic brain damage

PETER ELLIS
HAILSHAM CHAMBERS

The inquest into the death of Max Colley was heard in the Douglas Courthouse, Isle of Man, on 29 May 2018 to 1 June 2018, and on 4 June 2018, by Coroner of Inquests Mr Needham. The Coroner had previously ruled that Article 2 of the ECHR was engaged.

Mrs Colley was admitted to the maternity ward at Nobles Hospital on 10 July 2016, for induction of labour for a twin pregnancy. Due to a previous miscarriage, and conception by fertility treatment, the pregnancy had been categorised as high risk.

Labour was induced during the evening of 10 July 2016 using a prostaglandin pessary, Propess 10. During the consultant ward round at 09:10 hours on the morning of 11 July 2016, the plan was for continuous CTG monitoring, and assessment of labour 24 hours after the insertion of the Propess if there had been no developments sooner.

Spontaneous rupture of membranes occurred just before 10:00 hours, and although there were some difficulties with continuous CTG monitoring of Twin 2, Max, there were no concerns about fetal hypoxia for either twin during the day.

At 16:45 hours Mrs Colley was transferred to a delivery room, and an anaesthetist was asked to attend in order to site an epidural. The anaesthetist left the room at about 17:48 hours.

At 18:00 hours the attending midwife realised that the second sensor on the CTG machine was not working, and the sensor was changed. In the meantime, the on-call middle grade Speciality Doctor in Obstetrics had already been bleeped and asked to attend, in order to perform an ultrasound scan to locate twin 2.

After performing the ultrasound scan, the doctor left the room at 18:10 hours. At this stage the cervical dilatation was 5cm. According to the Coroner's independent experts in obstetrics and midwifery, Mr Tufnell and Ms Walker, the fetal heart rate traces for both twins became abnormal from 18:20 hours.

The fetal heart rate trace for twin 1, Sophia, showed a rising baseline, little or no variability, clear decelerations, and no accelerations. The trace for twin 2 showed a normal baseline and variability, but there were decelerations, some of which were prolonged. Although there were two midwives in the room caring for Mrs Colley, these abnormalities were not initially recognised.

At about 19:10 hours the Speciality Doctor attended the labour room. There was a conflict of evidence as to whether this was in response to a different midwife at the central monitoring station noticing what she believed were non-reassuring fetal heart rate traces, or whether the doctor had planned to attend of her own volition.

The doctor performed a repeat vaginal examination which confirmed that the cervix was fully dilated, twin 1 had a cephalic presentation, and was at station +2. Her review of the CTG traces recorded: '... Twin 1 – 150 bpm, twin 2 – 170 bpm. Variability > 5 in both...'.

When giving evidence, the doctor was unable to account for failing to recognise the lack of variability in both traces, and accepted that it was 'really obvious'. Furthermore, no review of the traces back to 18:20 hours was performed, which the Coroner described as a 'significantly deficient review and interpretation.'

In addition, the Speciality Doctor, who had joined the Hospital about six weeks earlier, was not familiar with the Hospital's Multiple Pregnancy Guidelines, in particular the requirement that a consultant obstetrician should be present at the delivery.

Thus although a locum consultant obstetrician was present on the delivery suite from time to time during the evening, the Speciality Doctor did not inform him, as she thought the CTG traces were not worrying, and because she also thought that she would be in charge at the delivery. Furthermore, a senior midwife also told the locum consultant that he was not needed, and he accepted this advice, as he was also unfamiliar with the requirement in the Guidelines that he should be present at the deliveries.

From 19:20 hours until the birth of Sophia at 20:11 hours, the attending midwives thought that both fetal heart traces were non-reassuring. In fact, according to the independent experts, both traces showed significant late

decelerations, and periods where it was possible that only one twin was being monitored. Urgent delivery of both twins, if necessary by Caesarean section, should have been considered from 1820 hours onwards.

The Speciality Doctor returned to the room at about 19:40 hours, and due to the fetal heart traces appearing similar, a decision was taken to apply a fatal scalp electrode. The Coroner found that there was an undue delay in applying the FSE until 20:00 hours. The first attempt was then unsuccessful, and although an attempt was made to reapply the FSE, Sophia was delivered naturally at 20:11 hours, in good condition.

After Sophia's delivery, no steps were taken to expedite the birth of Max, by administering a Syntocinon infusion, in breach of the Multiple Pregnancy Guidelines. There was also no effective monitoring of the fetal heart rate trace, although this was showing significant late decelerations between contractions, which should have prompted an emergency delivery, if necessary by Caesarean section.

The Coroner accepted Mrs Colley's evidence that no urgency was being shown by the people in the room, and the management of the delivery appeared chaotic. The Coroner concluded that 'there was an obvious failure to expedite Max's birth.'

Unfortunately, it was not until 40 minutes after Sophia's birth that Max was delivered naturally, at 20:51 hours. He was pale, floppy, not breathing, and no heartbeat could be detected. The first heart rate was obtained at approximately 3.5 minutes of age. At 21:02 hours Max was transferred to the neonatal intensive care unit.

Soon after birth a diagnosis of hypoxic ischaemic encephalopathy was made, from which Max died on 11 April 2017, aged nine months.

The Coroner recorded a narrative conclusion: *'The Deceased died in hospital at the age of 9 months from gastrointestinal and respiratory failure arising as a result of severe hypoxic ischaemic encephalopathy secondary to perinatal asphyxia. Max suffered an acute and profound episode of cerebral hypoxic ischaemia during the majority of the interval of 40 minutes between the birth of his sibling and his own birth. The risk of Max suffering hypoxic brain damage through his birth was heightened due to it being a multiple pregnancy. Despite that known risk and the abnormal features consistently displayed in the results of the monitoring of fatal heart rates during active labour, repeated opportunities were missed to expedite the delivery of the twins, most likely through Caesarean section. Guidelines were not followed, inter-alia, as to the need for a consultant obstetrician to be present at the delivery of the twins, and for there to be the prompt administration of oxytocin to the mother immediately following the birth of the first twin, so as to expedite the delivery of Max. The factual reasons for these missed opportunities involved both individual and systemic failures and, in combination, such failures amounted to neglect.'*

The Coroner also made a number of recommendations to prevent future deaths including that:

- A laminated checklist be distilled from the Multiple Pregnancy Guidelines containing the various steps specific to intrapartum care, and such be introduced for use by both obstetric and midwifery staff at all stages of labour and delivery of twins.
- The systems in terms of recruitment of locums should be reviewed to ensure that they are sufficiently robust, so that intranet access to important policy documents is not just obtained, but that there is an audit trail established, so that a locum can be held to account that they have received such access, and are able to utilise it.
- The standard of contemporaneous record keeping specific to intrapartum care planning and decision-making within the obstetrics and midwifery team should be regularly audited, so as to ensure records are comprehensive, accurate and written in a timely fashion.
- Subject to manufacturer's guidance on testing, there should be a standard procedure introduced for midwives to undertake, that in addition to routine daily checks, in the case of twins both CTG transducers are checked by the midwife to ensure that both are working at the time they are first attached to the mother, and that such satisfactory testing is recorded in the notes.
- The obstetrics and gynaecology management should continue to closely audit the recording of the application of the 'fresh eyes' principle, to ensure it is being utilised where continuous CTG monitoring is occurring.
- The Isle of Man Department of Health should ensure that its corporate memory as to what went wrong in Max's case, and the steps it had identified to better ensure that such does not happen again, should not get forgotten or displaced because of shrinking budgets, cost-cutting measures, the replacement of staff, or through the simple effluxion of time.

Dr Peter Ellis was instructed by Quinn Legal on behalf of Mr and Mrs Colley

Violet Skies - Life after child loss

SARAH AND PAT STEPHENS

Violet playing with her balloon the morning of the day she died.

AVMA A VIRTUALLY UNKNOWN CHARITY

Most people have never heard of an amazing charity called AvMA – Action Against Medical Accidents, probably because until the worst happens you have no need to seek them out.

We were introduced to this organisation by the Manchester coroners office, when we were first informed that there would be an inquest into our daughter Violet's death at Manchester Children's hospital.

The coroners team said it was highly likely that the Manchester NHS trust would employ their own barrister for the hearing, when it finally happened, and that they wanted us to feel supported, as though someone is on our side. They said they didn't want us to be bullied by the trust's representatives and that an organisation called AvMA might be able to help.

You may now ask "well what about legal aid?" It turns out that no matter what your financial situation in this circumstance legal aid is not available for an inquest hearing. Can you imagine the additional heartbreak and stress for anyone who is grieving a loved one and believes their death might be because of negligence or an accident but has no free legal support? We were quoted upwards of £1000 by several solicitors to pay for legal advice and support for the inquest.

You may ask "what about no win no fee" though but this also isn't available for a coroner's inquest as this hearing looks solely to find the cause of death not to apportion blame or result in any type of compensation. In order to get a pay out you would have to have a separate legal proceeding in front of a judge rather than a coroner and this would be after the inquest and is a separate legal action entirely.

AvMA provides free independent advice and support to people affected by medical accidents (lapses in patient safety) through a specialist helpline, written casework and inquest support services. They can put patients in contact with accredited clinical negligence solicitors if appropriate. They also work in partnership with health professionals, the NHS, government departments, lawyers and, most of all, patients to improve patient safety and justice.

For us it meant having a trained barrister examine all the documents associated with Violet's death and care whilst in Manchester Children's hospital. This proved invaluable to us as she requested certain things we hadn't noticed were missing, such as when we asked for a copy of Violet's medical records the hospital hadn't included any of her X Ray results, of which there were many. We then had time to request them ahead of the hearing.

Judy, the barrister that volunteered her services to us, was amazing. We had a conference call with her a few weeks before the inquest and were pleased to see that she'd pulled together a list of her main concerns that all tallied with ours. She had done extensive research, including combing through not just the post mortem report but also the medical reports and all of Violets notes (that we couldn't bring ourselves to sift through again). She also consulted various medical professionals she knew to get their advice on things.

At the inquest itself both Julia the representative from AvMA and Judy our barrister were amazingly supportive. Judy asked all the questions we wanted and cross examined some of the witnesses, the various specialists and consultants responsible for Violets care while she was in the hospital. We passed Judy notes from the table behind with any additional questions that came to us while they were giving evidence, and before the coroner

had finished with a witness, Judy always double checked with us that there was nothing else we needed to ask.

I was originally instructed by the coroner to read out the police statement I had given immediately after Violet died and Judy said she could ask for me to be excused from doing this because I was heavily pregnant and the additional stress it would cause. We didn't even realise this was an option and the coroner said he would admit the statement to the records as a printed document instead. This saved me having to undergo further emotional distress on the day.

Ultimately the inquest couldn't bring Violet back and we got some answers but not really the resolution we wanted. However I'm not certain we would have received these same answers if we hadn't have had AvMA and Judy helping us. It was a traumatic day with lots of tears, so I doubt we would have had the strength or wherewithal to ask so many questions ourselves. Their help and support at what was an extremely vulnerable time for us proved to be priceless.

Judy and AvMA only invoiced us for their expenses, which totalled less than £200, including travel costs from London and an overnight stay, so when you consider the thousands a barrister would normally charge this was a bargain. We've since given a larger donation to the charity too, so we can help them to help someone else like us who find themselves in an impossibly heart wrenching situation.

AvMA operate as a charity offering support to parents and families like us whose loved ones have died or been seriously injured because of what might have been a medical accident. This will be the hardest most traumatic time in their lives and as a result they are certainly in need of support, especially around something that could result in answers, justice and in the case of proven negligence, when someone is seriously injured, later on a possible future financial payout too, that could make the difference to quality of life.

I know this charity isn't as attractive or as immediately heart tugging as a animal, Children's charity or a cancer cause but rest assured they can make a huge difference to people's lives at a time when their world has just ended. When they are already struggling to deal with the grief and shock of losing someone, in our case our 15 month old daughter.

You never think this type of thing will happen to you. That one day your perfect little life bubble could burst and you lose a child or someone close to you but if this happens then you certainly need legal support from someone like AvMA as life at this time is overwhelming and devastating enough without adding a looming inquest to the list.

If you can afford to donate to this amazing charity, even if a small one, then please do so as you could help someone like us who has said goodbye to their child. If you're a legal professional and would like to donate time or expertise to work with the charity to help someone like us then please do take a closer look as we're so grateful to Judy for giving up her time and expertise to help us.

Judy explained to us that she understood a little of what we had gone through with Violet, as her daughter had been premature so she had spent lots of time with her in hospital and luckily she was healthy now but she knows how scary it can be to be a parent of a sick child. She said she can't begin to imagine then losing them and then the stress of the coroner deciding to launch an inquest into what happened too. After reading our case she felt compelled to help us. A truly wonderful lady and we will be eternally grateful to her for her help and compassion.

The Violet Skies Blog can be found **here**

Inquest into the death of Nigel Thomas Handscomb

DOMINIQUE SMITH
1 CHANCERY LANE

Nigel Handscomb was a 65 year old gentleman with a history of bipolar disorder, which was managed well with lithium. On the 18th August 2017, Mr Handscomb visited his GP surgery, presenting with a history of dysphagia and vomiting which had lasted several days. Later that evening, he was not contactable and his family raised the alarm. He was taken to the Accident & Emergency Department of University Hospital Lewisham, where he was diagnosed with pneumonia and a possible stroke. He was transferred to a ward on the 19th August 2017 to continue treatment.

Mr Handscomb sadly passed away on the 21st August 2017. The investigations that followed his death revealed a series of failures in the management of his care by both the hospital staff and his GP. The Coroner concluded that neglect had contributed to Mr Handscomb's death.

Background

Mr Handscomb had a history of bipolar disorder. He managed his condition well with lithium, which he had been prescribed for a number of years.

Mr Handscomb visited his GP surgery on the 7th July 2017, following a blood test. Dr Neve noted that his lithium level was slightly raised and his renal function had deteriorated. Dr Neve subsequently reviewed Mr Handscomb on the 7th August 2017. His lithium level remained unchanged, albeit still slightly raised, however his renal function had returned to its previous level. Mr Handscomb's lithium dosage was subsequently reduced.

On the 18th August 2017, Mr Handscomb saw Dr Gramsma at his GP surgery. He presented with a history of severe dysphagia, which had resulted in him bringing up fluids and "giving up" with solid foods. Dr Gramsma prescribed lansoprazole and advised Mr Handscomb to return on the following Monday.

Later that evening, at approximately 22:15, paramedics attended Mr Handscomb's residence due to his family's concerns that they were unable to reach him. Mr Handscomb was discovered by the kitchen sink with his head resting on the tap, immersed in cold water. He was transported to the Accident and Emergency Department of University Hospital Lewisham in an unwell and confused state. He was recorded as having a history of vomiting over the previous few days. He was diagnosed with pneumonia and concerns were raised as to a possible stroke. Treatment in the form of IV Amoxicillin, oral lansoprazole and oral clarithromycin was given.

Prior to his admission to a ward, Mr Handscomb should have been placed on a list of patients for a Consultant to see him in the post-take ward round. As a result of an error by a junior doctor managing patient admissions, this was not done. Mr Handscomb was therefore not reviewed by any doctor until his death on the 21st August 2017.

Mr Handscomb was transferred to Laurel Ward on the 19th August 2017. No observations of Mr Handscomb were taken by the nursing staff after his admission for a period of 11 hours. Once observations were taken, no referral to the outreach team and senior nurse was made when his NEWS (National Early Warning System) scores reached the appropriate level for intervention. Thereafter, his NEWS scores were incorrectly recorded.

Mr Handscomb was determined to be nil by mouth by the nursing staff following a swallow assessment. Fluids were prescribed to him by a doctor, however the doctor wrote the prescription without ever reviewing Mr Handscomb. At numerous nursing handovers, it was not identified at any point that Mr Handscomb had not been seen by a Consultant. Further, as Mr Handscomb took lithium for his bipolar disorder, Trust policy indicated that his lithium levels should have been taken upon his arrival at the hospital. No lithium levels were ever taken, and therefore, it could not be determined whether Mr Handscomb was suffering from lithium toxicity prior to his death.

Mr Handscomb was discovered in the early hours of the 21st August 2017 in cardiac arrest. He could not be successfully revived. A post-mortem later indicated that the cause of death was:

1(a): aspiration pneumonia;

1(b): bronchopneumonia;

2(a): ketoacidosis.

The Inquest

The inquest was heard in Southwark Coroner's Court before Assistant Coroner Philip Barlow over two days. Evidence was heard from the family, Mr Handscomb's general practitioners, and the clinicians and nurses involved in Mr Handscomb's care at University Hospital Lewisham.

It transpired in the course of the inquest that the nursing staff had determined shortly after his admission to Laurel Ward on the 19th August 2017 that Mr Handscomb could not swallow effectively. His oral medication, including clarithromycin, was stopped. No referral was made to any clinician to notify them that the medication for Mr Handscomb's pneumonia had been stopped, nor were any questions raised as to how the clarithromycin could be administered in any other way. Mr Handscomb's pneumonia was therefore ineffectively treated until his death two days later.

It further transpired that Mr Handscomb's GP, Dr Gramsma, was not properly recording the outcomes of patient consultations following appointments. These records of his consultations were being produced some time later, and subsequently, a number of crucial details (including in this case whether Mr Handscomb had been physically examined), were omitted.

The Conclusion

The Coroner provided a short form conclusion with narrative elements. He considered that several opportunities to escalate Mr Handscomb's care were missed. He found that there were gross failures to provide care to Mr Handscomb, who was in a dependent position. He noted that the evidence of Dr Aitken was that if Mr Handcomb's care had been escalated, he would have been reviewed and likely a candidate for intensive care. As such, on the balance of probabilities, he would have survived.

The Coroner was satisfied that University Hospital Lewisham had made important changes since Mr Handscomb's death and did not consider a Prevention of Future Death report in respect of the hospital was appropriate.

The Coroner was however critical of Dr Gramsma's record keeping. He noted that the records referred to in the course of the inquest were made several hours after Mr Handscomb's consultation. They did not record that he performed a chest examination, nor that Mr Handscomb had not been able to take his lithium for several days, contrary to the evidence of Dr Gramsma. The Coroner noted that it was a significant finding that Mr Handscomb could not swallow, yet there was no record of this in the medical record entry recorded by Dr Gramsma. No record was made that the medication prescribed to Mr Handscomb during that consultation was not to be taken in accordance with the instructions written on the medication packaging.

The Coroner accepted that the care offered by Mr Handscomb's GPs did not have a causative impact, however thought that the concerns could be highly significant in another case. Consequently, he considered a Prevention of Future Death report in respect of Dr Gramsma was appropriate.

Comment

Following the decision of the High Court in *R (Parkinson) v HM Senior Coroner for Kent [2018]* EWHC 1501 (Admin), families will face challenges in demonstrating that Article 2 ECHR is engaged, as cases have to be considered exceptional and go beyond mere error or medical negligence. In this case, the Coroner did not consider that Article 2 ECHR was engaged; rather, it was a case that fell into the category of errors of care, coordination and delay. Despite this, the Coroner was nonetheless critical of the care Mr Handscomb received, leading to a finding of neglect.

Inquest into the death of Mr Peter Hunt

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Peter Hunt was born on 4 February 1933 and had been living in sheltered housing in Kendal. He had been diagnosed with memory problems in 2013, but this had developed into dementia by late 2016. He attended Royal Preston Hospital ('Preston') on 5 December 2016 with an ischaemic leg. However, upon being admitted to the ward, serious failings by the nursing staff were found to have contributed to him leaving hospital unnoticed.

Mr Hunt was subsequently found walking along a country road at night in the rain, 40 miles from the hospital, where he was struck by a motorist. He died from his injuries on 9 December 2016. The Coroner concluded that the failures of the nursing staff amounted to neglect.

Background

In light of Mr Hunt's memory problems, his daughter was given Lasting Power of Attorney in August 2015. She was also named as his next of kin.

On 4 December 2016, Mr Hunt was taken to Royal Lancaster Infirmary ('Lancaster') complaining of pain in his knee. He was found to have an ischaemic leg and the plan was to transfer him to Preston for vascular surgery input. He was admitted to EDU at Preston initially and it was decided that his leg could be treated conservatively. He was therefore admitted to one of the wards on 6 December 2016.

The nurse accepting Mr Hunt onto the ward did not carry out a formal risk assessment, including whether Mr Hunt's mental state required enhanced care measures to be put in place. Further, the electronic system had not been updated to show that the patient who had been in the bed prior to Mr Hunt had been replaced. At the end of the morning shift, the nurse then failed to do a formal handover of her patients to the afternoon shift.

The afternoon shift therefore were not aware of whom Mr Hunt was, why he had been admitted and what assessments had yet to be carried out. The electronic system still recorded the previous patient as the occupant of the bed.

Mr Hunt then left the ward. The time of his departure was not clear, but by the time the hospital staff had noticed, he could not be found on the premises. A police investigation found that Mr Hunt had taken a bus to Leasgill, Cumbria. He then walked along an unlit road in the rain. A collision occurred with a passing motorist and Mr Hunt sustained multiple injuries, including large contusions and a fractured right forearm. The police and paramedics attended and made contact with Mr Hunt's daughter. Prior to this, she had been completely unaware that Mr Hunt had attended both Lancaster and Preston, unaccompanied and without her being given the opportunity to provide input into his care.

Mr Hunt was taken back to Lancaster where he was initially admitted to the Acute Medicine Unit. He was transferred to the Acute Frailty Unit in the early hours of 9 December 2016, following which he went into cardiac arrest. He tragically died that morning. The post-mortem evidence concluded that the injuries caused by the road traffic accident put too greater strain on his heart, which was already damaged due to pre-existing cardiac disease.

Mr Hunt's family were understandably concerned as to how he had been allowed to leave the hospital ward at Preston unnoticed. Further, his daughter had not been contacted, despite her details having been given to Lancaster on previous hospital attendances with Mr Hunt. She had been denied the opportunity to provide valuable input into Mr Hunt's care. The family instructed AvMA's pro bono inquest service to ensure these issues were fully explored.

The Inquest

The inquest was heard in Kendal Coroner's Court before Assistant Coroner Robert Chapman over 3 days. Evidence was heard from Mr Hunt's sister, staff from both hospitals, the police and witnesses to the road traffic collision.

The Coroner heard evidence regarding persistent staffing issues for the ward to which Mr Hunt was admitted. On 6 December 2016, the ward was short-staffed to the extent that the senior nurse in the afternoon shift thought it was

unsafe, but no one had thought to escalate the issue to senior management.

The morning shift nurse admitting Mr Hunt to the ward was unable to attend the inquest for medical reasons. However, her colleagues all gave evidence as to the importance of doing risk assessments on admission and in carrying out handovers to the following shift. One described the handover as the "basic safety standard" and none were able to recall another occasion where a staff member had failed to do a handover. As far as they were aware, Mr Hunt was the patient who had previously occupied the bed and had been well enough to be discharged. They had no reason to suspect that he had memory problems or potentially needed enhanced care. It even transpired that the previous patient's medical notes had been left by Mr Hunt's bed, adding confusion over what observations were made of Mr Hunt before his departure.

The Coroner also heard evidence from the police and the motorist involved in the road traffic accident. It was clear from all accounts that, at the time of the collision, Mr Hunt was very difficult to see and there was little that could have been done by the driver to avoid the collision.

Since Mr Hunt's death, the Coroner was advised of an increased focus on improving staffing levels on the ward at Preston. Whilst recruitment remained an issue, staffing levels have since improved. The nurses on the ward felt the situation now was much better than in December 2016. Furthermore, the failure to contact Mr Hunt's daughter was due to Lancaster's failure to update Mr Hunt's electronic records. Corrective measures had been implemented to ensure the same mistakes were not repeated.

The Verdict

The Coroner concluded that Mr Hunt died as a result of the injuries sustained in the road traffic accident late on 6 December 2016. However, this had been contributed to by neglect on the part of Preston. He considered that the failure to risk assess Mr Hunt and carry out a handover to the afternoon shift "fell way below the professional standards of a nurse."

In assessing whether there was a direct causal link with the neglect and the death, he considered that this had been established. Had an assessment or handover been done, the afternoon shift would have known:

1. Who Mr Hunt was;
2. That he had memory problems at the very least;
3. That he was an 83-year-old, frail gentleman;
4. That he was not happy about being in hospital and did not know what was happening;
5. That he was far from home and without any support from his family; and
6. That he ought to be supervised to prevent him from walking out.

He further commented that, because of the failure of Lancaster to adequately update the next of kin details, both Lancaster and Preston were deprived of the opportunity of contacting Mr Hunt's daughter. In giving evidence, she advised that she would have warned the hospitals of Mr Hunt's dementia and she would have attended Lancaster to provide support prior to his departure. It is noteworthy that the Coroner identified the fact that Mr Hunt was isolated as a factor affecting his subsequent departure from the ward.

Comment

To find neglect in a medical context, a Coroner must conclude that there has been a gross failure to provide or procure basic medical attention for someone in a dependent position. Further, there must be a clear and direct causal link between the neglect and the death. There must have been an opportunity of rendering care that would have prevented the death, rather than possibly making a difference. It is a high threshold and families ought not to confuse neglect with common law negligence. A negligent hospital is not necessarily going to be found to be guilty of neglect at an inquest.

A declaration that someone's death has been contributed to by neglect should therefore be very sobering for the institutions implicated. It should also provide reassurance for families wanting to highlight poor standards of care and instigate corrective action. Whilst not establishing civil liability, neglect certainly emphasises significant shortcomings in the care provided. Mr Hunt's death was the tragic outcome of basic safety standards not being met and the hospital was held to account. Lessons will be learned.

The family was informed at the inquest that the nurse involved no longer practises.

A trust's attempt to avoid a PFD Report following conclusion of an inquest

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The inquest touching on the death of Mr Sheffield, reported in the previous June edition of the newsletter, appeared to have concluded on 31st January 2018 with the Coroner indicating that a PFD (Preventing Future Deaths) report would follow addressing the concern of essential equipment being lost or misplaced in a ward to ward transfer. The family were pleased with the outcome and were grateful for the support from AvMA and counsel.

Responding quickly, and prior to the publication of the PFD report, the hospital made further changes to their ward to ward transfer document requiring a computerised box is checked confirming that all essential equipment is available, checked and ready to use at the time of arrival on the ward.

Unknown to the family, on 7th February 2018, the trust wrote to the Coroner, indicating that the PFD report was no longer required because it would have no practical effect and the Coroner's duty to make a PFD report was no longer engaged.

In the meantime the family chased the Coroner's Office for updates as to when the PFD Report would be published. On 22nd March 2018, almost 2 months following conclusion of the inquest, the Coroner wrote to the family to say he would no longer be making a PFD report, because it would be otiose, citing The Chief Coroner's Guidance number 5 paragraphs 5 and 24 as being applicable. The letter from the Coroner to the family was accompanied by trust's letter dated 7th February 2018, which the family saw for the first time. There was no invitation for the family to make submissions of their own in response.

Nevertheless, submissions were made as follows by Counsel on behalf of the family to challenge the Coroner's decision not to make the PFD report: -

a) Once a duty under Schedule 5, S 7(1) Coroners and Justice Act 2009 "Action to prevent other deaths" has been engaged, as it was at the inquest, there is a duty to make the PFD report and there is no discretion or scope for retrospective withdrawal;

b) The sending of letters to the Coroner's Office following conclusion of the inquest is not recognised as part of the procedure under the 2009 Act or at all;

c) The Chief Coroner's Guidance number 5 "Reports to Prevent Future Deaths" applies to the inquest, not to letters sent after the inquest has concluded. Furthermore the Guidance cannot over-ride the duty under the Act;

d) The steps taken by the trust prior to the inquest to avoid equipment being lost were inadequate because further steps were taken after the Coroner indicated a PFD was warranted. The basis of the request to withdraw the PFD was not because the PFD was made in error but because the trust had complied with what would have been written on the PFD. In any event the decision in R (Dr Siddiqui and Dr Paeprer-Rohricht) -v- Assistant Coroner for East London[1] seems to support that, even if the PFD report were made in error in absence of the full facts, the decision to make a PFD cannot be challenged, at least not by Judicial Review and, by analogy, not by informal correspondence sent after conclusion of the inquest.

e) Informal letter sending after the inquest has concluded and without the knowledge of other interested parties is not consistent with transparency in the coronial process;

f) Taking such letters into consideration sets a dangerous precedent and offends the finality of the inquest;

g) There are procedures that must be followed to challenge the decision of the coroner, neither of which were followed here;

h) The deadline for any further steps to be taken by the family was not clear as the inquest appeared to informally progress in private without the knowledge of the family. Implicitly, this was a reference to potential Judicial review proceedings.

The Coroner responded quickly, taking on board the representations made on behalf of the family and the PFD report was duly provided.

1 *A full transcript was not available*

Safety for Patients through Quality Review (SPQR)

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Background

The SPQR study has been commissioned to evaluate the role of the Medical Examiner and how this can best work together with Structured Judgement Review (SJR) to identify deaths due to shortcomings in care. The SJR method is now being implemented across the NHS through the national Mortality Case Record Review Programme. However, the workload implications are such that 'pre-screening' is likely to be necessary to select cases for review. The role of the Medical Examiner (ME) was created to review the recorded cause of death and ensure appropriate referral to the coroner, but has developed to address patient safety by identifying clinical governance issues. ME assessment could be used to pre-screen deaths for SJR.

What will the SPQR study do?

- Qualitative interviews with MEs to explore what their assessment involves, how judgements are made and identify common themes and variations in practice.
- Examine discordant judgements from ME assessment and SJR to determine how each process might be improved and work alongside each other.
- Thematic analysis of ME and SJR reviews to determine the relative strengths and weaknesses of ME assessment, and gain insights that can be used to improve quality of care.
- Implementation analysis to model different scenarios for implementing ME assessment alongside SJR and to determine the resource implications of implementation.

We have completed some of the interviews with MEs and report some of our preliminary findings below.

Things to consider in setting up an ME service

- It requires a dedicated office space located near the bereavement office (IT and phone access, quiet).
- ME experience, seniority, communication skills and confidence are important to deal with challenging questions and decisions, as well as sensitive conversations with relatives.
- Understanding the coroner's role and what the coroner requires is important. The coroner needs to trust that MEs are making appropriate referrals.
- ME officer and bereavement staff support are important to ensure MEs can focus on key aspects where their expertise is required and provide continuity where the ME function is rotated across different people.
- An oversight role is needed to ensure a degree of consistency across different MEs.
- Timeliness of access to records is important. This can be problematic if covering more than one site and there are paper records.

Key aspects of the ME role

- As well as focussing on improving death certification, governance issues are becoming increasingly prominent.
- The ME screening process is not a forensic review. It identifies 'red flags' or concerns, for coroner or SJR referral.
- It has an important educational aspect in training junior doctors to do better death certification.
- Speaking to relatives is highly valued, but delays in making contact (e.g. due to delayed notes) is undesirable.
- There is variation in processes and systems at different sites. All deliver key aspects of the ME role but there is local variation in how this is achieved, including recording and communication (e.g. who speaks to relatives).

Relationship with SJR

- The relationship between the ME and SJR function varies according to how long an SJR process has been in existence. MEs receive minimal or no feedback on SJR referrals. Issues for consideration include whether

MEs should be involved in the SJR process and appropriate feedback.

Concerns and issues to consider

- Variation in how ME services are funded and concerns around reliance on cremation fees.
- How should the impact and success of the ME role be assessed?

Get involved in this research

If you would like to find out more information about this study, to take part in the Medical Examiner interviews or to become a participating site, please contact:

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Inquest into the death of Hubert Kelly

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On 14th November 2017, Mr Hubert Kelly died at Russells Hall Hospital ("RHH") in Dudley. Care home staff had called an ambulance as Mr Kelly had refused food and drink and appeared lethargic. The paramedics attended and noted his observations were generally normal. However, they suspected a chest infection and recommended admission. He arrived at RHH Emergency Department on 13th November at approximately 10:15pm. He was triaged and, around an hour later, his bloods were taken. He was placed in a corridor to wait. At approximately 1:00am his family requested that he was moved into the waiting room as he was cold. It was noted that he was alert. He fell asleep. At approximately 3:50am a disturbance occurred in the waiting room and staff noticed that, unusually, Mr Kelly did not react. A nurse came over and checked on Mr Kelly. She could not find a pulse. He was pronounced dead at 04:06am. He was 86 years old.

Following his death, no post-mortem was carried out. The death was reported to the Coroner's Office on 15th November 2017 but, based on the information available, the Assistant Coroner took the decision that no investigation was required. A death certificate was issued by Mr Kelly's GP, which stated: *'I(a) Old Age. II Hypertension, Aortic Stenosis, Bullous Pemphigoid.'*

The Executive Director of RHH wrote to the Coroner's Office on 19th January 2018 to advise them that a Serious Incident review was being undertaken in relation to Mr Kelly's death. On 9th March 2018 the Coroner received the Root Cause Analysis report and decided to investigate.

The family attended an initial hearing unrepresented. However, they were subsequently able to obtain representation through AvMA. Counsel attended the next hearing which was intended to be the inquest hearing. However, upon realising the complexity of the issues, the Coroner decided to hold a Pre-Inquest Review and scheduled the inquest for September.

Interested Parties

Alongside the family and the Trust, the Coroner decided to make the Emergency Department Consultant who was on call on 13th – 14th November an Interested Party. This decision appeared unusual, given that there was no indication that the Consultant had been called on that night and failed to attend, or any similar sort of criticism. However, it stemmed from a letter which had been sent by medical staff in response to the Root Cause Analysis report. The letter indicated that staff did not accept all the findings of the Root Cause Analysis. Given the potential for an opposition of interests between the Trust and the Consultant, the Coroner advised him to obtain legal representation.

Disclosure

Prior to the inquest, the Trust did not disclose Mr Kelly's medical records. In addition, they did not disclose any of the Trust's policies, including their triage policy. This was despite repeated written requests from AvMA and the Kelly family. AvMA wrote to the Coroner asking her to order disclosure but no action was taken. The issue was raised at the start of the inquest, and the Coroner promised to keep it under review, but no further disclosure was ordered. As readers can imagine, this made it somewhat difficult to conduct the inquest. However, the family were keen to press on with the proceedings.

Care Quality Commission

Another slightly unusual aspect of the inquest was the involvement of the CQC. Following Mr Kelly's death in November 2017, the CQC carried out a routine inspection in December 2017. The Urgent and Emergency Services department was given an inadequate rating (report is available **here**)

A follow-up inspection took place in March 2018 which maintained the rating of inadequate (report available **here**) and raised a number of serious concerns. A further inspection was then carried out in June 2018. The CQC continued to rate the hospital inadequate and placed conditions on the registration of the hospital. This report (available **here**) was particularly damning and was published on 6th September 2018, one week before the inquest.

Each report raised a number of concerns relevant to Mr Kelly's case, mainly around the triage system. In particular, there were concerns about staff members' understanding of the system and monitoring of patients after they had been triaged. On the first day of the inquest, the Coroner stated that she had made the CQC an Interested Party but indicated that they did not intend to be represented or ask questions.

The inquest hearing

From Monday 10th September 2018 to Wednesday 12th September 2018, the inquest into the death of Hubert Kelly resumed at Black Country Coroner's Court in front of Assistant Coroner Laura Nash.

At the outset, the Coroner indicated that she would defer a decision on Article 2 but that she would approach proceedings as if it were an Article 2 inquest.

On the first day, the inquest heard evidence from Mr Kelly's son, his GP, two triage nurses, the Clinical Site Co-Ordinator and a registrar. Mr Kelly's son, Mark, explained that Mr Kelly was admitted to the hospital, they (Mr Kelly, his wife and Mark) waited in the waiting room, and then he was found to have passed away in the early hours of the morning.

Mr Kelly's GP provided evidence as to his background medical condition, noting that he had deteriorated quite significantly in the past few months. She stated that their surgery had been contacted by the Coroner's Office to provide a cause of death and she felt that, given the circumstances of his death, his age, rapid deterioration, and co-morbidities, that 'old age' was the most appropriate cause of death.

The first nurse to give evidence was the nurse responsible for triaging Mr Kelly upon his arrival. Given the lack of hospital policies and the lack of medical records, she was asked a range of questions to try and establish what the hospital's triage system was and how it was applied in Mr Kelly's case. She had been employed at RHH for many years and gave evidence that, throughout her time there, a modified Manchester triage system had been in use. She explained the five categories which essentially were (1) the patient required immediately life-saving intervention (2) the patient's condition was just below life threatening (3) the patient could wait in order of arrival and (4) minor injury or illness and (5) redirect to other service. She explained that none of Mr Kelly's observations were particularly concerning and therefore she considered that he was capable of waiting. She stated that she did not recall being told by the paramedics that they suspected a chest infection and that Mr Kelly's triage notes did not record this. She was asked what system was in place to monitor and/or check on patients who had been triaged and were waiting. She confirmed that, at the time, no definitive system was in place but that staff tried to carry out 'quality rounds' i.e. they tried to check up on waiting patients and offer them drinks. There was no policy as to how frequently these rounds took place.

The second nurse to give evidence interacted with the Kelly family at approximately 3:00am. She had carried out a 'quality round' on the night which consisted of offering drinks to patients. It did not include taking observations. She noted that, on the night, she offered Mr Kelly's wife and his son a drink but that they declined on Mr Kelly's behalf as he appeared to be asleep. She also concurred with the evidence of the first nurse, namely that the triage system in place was a modified Manchester triage system. She also confirmed that there was no formal system in place to monitor patients who were waiting to be seen following triage.

The nurses' evidence as to triage conflicted with the findings of recent CQC inspections and the Root Cause Analysis which both stated that the ESI system of triage was in use at the hospital. A representative of the CQC stated that they were concerned that they had been told incorrect information and that the oral evidence did not match the documentary evidence that they had been shown. I took this as an opportunity to raise to the Coroner yet again the difficulties caused by the lack of disclosure and urged her to order disclosure of the Trust's policies. She refused, stating that she was confident that subsequent witnesses would be able to clarify the position on triage.

The registrar who pronounced Mr Kelly's death also gave evidence. He stated that he could not say how long he thought Mr Kelly had been dead when he saw him and that he also could not say what his cause of death was likely to have been.

On the second day, the CQC instructed Counsel. One of the attending paramedics gave evidence, followed by the Deputy Director of Operations and the on-call ED Consultant. The paramedic evidence was that Mr Kelly's observations were generally normal, with some slightly unusual findings. Given his history, however, they thought it was appropriate to bring him into hospital. The evidence of the Deputy Director of Operations focused on staffing levels and bed shortages.

Finally, the on-call ED Consultant gave evidence. He talked at length about the unprecedented pressures that A&E departments are facing across the country and stated that RHH was no exception. He gave evidence, however,

that on that particular night he felt that the ED department had sufficient staff. As to the triage system, he stated that the system in place was a hybrid between the Manchester triage system and the ESI, hence why it was known as a modified Manchester system. He was very clear, however, that there was only ever one triage system in place at the hospital.

He gave evidence in relation to death certificates. As noted, Mr Kelly's death certificate unusually listed 'old age' as the cause of death. The Consultant indicated that he often felt that the ED medical staff were not best placed to provide medical causes of death as they only saw the patient very briefly. Instead, he preferred professionals such as GPs to give the medical cause of death as they tended to know the patient's medical history.

At the PIR, the Senior Coroner had refused to instruct an expert to assist on causation, stating that the ED Consultant would be able to give his view. He was initially reluctant to express any view given that he did not treat Mr Kelly, but ultimately he came to the view that it is unlikely that earlier treatment would have made any difference to his condition.

The inquest also heard evidence from the Executive Director of RHH as to the changes which the Department has made as a result of Mr Kelly's death and subsequent CQC inspections. In particular, he stated that the triage system had been changed and staff had received training on the new system. Furthermore, he stated that a more robust system had been set up for checking on patients who had been triaged and were waiting for treatment. He stated that a medically trained member of staff was permanently in the waiting room in order to monitor patients.

The Coroner made a point of asking the Medical Director if staff received training on completing Notification of Death forms because, in Mr Kelly's case, important information had been omitted which led the Coroner to conclude no investigation was necessary. It was only several months later, when the Executive Director wrote to the Coroner's Office to inform them that investigations were taking place into Mr Kelly's death that the Coroner realised an inquest was merited.

On the final day the inquest heard evidence from a senior doctor at another Trust who had been asked to conduct an independent Root Cause Analysis into Mr Kelly's death. She gave evidence that she had recommended the wholesale implementation of the ESI triage system but that, even with that triage system, it could not be said that the outcome would have been different. She ultimately agreed with the causation evidence of the ED Consultant.

Conclusions

Given the causation evidence the Coroner came to the conclusion that Article 2 was not engaged. She also concluded that no finding of neglect could be made. As to triage, she found that the decision as to which triage category to place an individual into is invariably somewhat subjective. Furthermore, although it was arguable that Mr Kelly should have been placed into a higher category and there was evidence that this may have led to a quicker clinical assessment, there was no evidence as to what would have happened to Mr Kelly thereafter.

She returned a narrative conclusion finding that Mr Kelly arrived at hospital at 10pm where he was triaged and blood tests were taken. She found that he was then left with his family in a corridor before being moved into the Emergency Department waiting room. After waiting 4 hours Mr Kelly was found to have passed away in his wheelchair.

She also made a Prevention of Future Deaths report relating to the triage system in place at the hospital, and in particular accountability and monitoring of patients.

She indicated that the Senior Coroner would write to the hospital concerning the Notification of Death Report Form.

Whilst it was a difficult experience, the Kelly family were grateful to have had the opportunity to find out more about what happened to a loved husband and father. Many of the staff, particularly the triage nurses, were visibly upset by what had happened and used the inquest as an opportunity to express their condolences to the family. It is testament to the grace and kindness of Mrs Kelly that she embraced the nurse who had triaged Mr Kelly and assured her that she was not to blame for the tragic circumstances in which he died. It was an absolute privilege to be able to represent the Kelly family.

Since the inquest, a further CQC report was published on 17th October 2018 – accessible **here** – based on an inspection in August 2018. Key findings included: *"Patients presenting to the emergency department still did not always receive a robust assessment of their clinical presentation and condition during the triage process."* and *"There was still a lack of accountability for the safety of patients pre and post triage who were located within the waiting room."*

Note on the Supreme Court Judgment in Darnley

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The Supreme Court, per the judgment of Lord Lloyd-Jones (with whom Lady Hale and Lords, Reed, Kerr and Hodge all agreed), allowed the appeal by Michael Darnley from the dismissal by the Court of Appeal of his appeal from the dismissal of his claim by the trial judge. Mr. Darnley will now recover damages for the devastating brain damage he suffered, consequent upon the progression of a bleed on the brain he suffered in an assault on the afternoon of 17 May 2010.

Mr. Darnley attended the A&E department of the Mayday Hospital, Croydon on the evening of 17 May with his friend Mr. Tubman and informed the receptionist of the assault and head injury and that he was feeling unwell and needed to see someone. He was wrongly told the wait would be four to five hours – he should have been told he would be seen by a triage nurse within 30 minutes. He waited for 19 minutes and then went home before being seen, because he felt so unwell that all he wanted to do was take some painkillers and go to bed. Whilst at home he suffered a deterioration, caused by a progression of the bleed, and despite prompt surgery he suffered permanent serious brain damage.

The Supreme Court held: -

(i) the factual circumstances of the case came within an existing category of a duty of care between a hospital and a patient; and hence the Mayday hospital owed Mr. Darnley a common law duty of care;

(ii) that common law duty included the giving of reasonably accurate information as to waiting times;

(ii) that it was negligent of the receptionist (the employee of the Mayday Hospital) to inform Mr. Darnley that he would have to wait for up to four to five hours before being seen, in the circumstances that the receptionists knew that the correct information was that he could expect to be seen by a triage nurse within 30 minutes;

(iii) on the findings by the trial judge, the Supreme Court held that causation of damage was therefore established, the findings being: -

(a) that had Mr. Darnley been given the correct information, he would have remained within the hospital setting; and

(b) that it was reasonably foreseeable that someone, who had been told that he/she might have to wait four to five hours before being seen, would leave a hospital and might foreseeably suffer an injury in consequence; and

(c) that Mr. Darnley's decision to leave the hospital was at least in part made on the basis that he had been told that he would have to wait up to four to five hours; and

(d) that Mr. Darnley would have suffered his collapse around 21:30 that evening in a hospital setting; and would have been transferred to St. George's Hospital and would thus undergone surgery sooner, in which case he would have made a very near full recovery.

The Supreme Court rejected the judgment of the majority in the Court of Appeal (Jackson and Sales LJJ) and the submissions of the Trust; and held:

(i) that the factual circumstances were not "novel", in that there was a hospital / patient relationship between Mr. Darnley and the Trust;

(ii) thus there was no requirement to establish that it was fair just and reasonable to impose that duty of care;

(iii) the duty of care of the Trust included the duty to take reasonable care not to provide misinformation to patients;

(iv) that to impose such a duty of care upon the Trust would not add a new head of liability for NHS trusts;

(v) that it was inappropriate, in terms of the imposition of that duty of care, to distinguish between clinical and non-clinical staff;

(vi) that the contention that to impose the duty of care would place an unreasonable social cost upon society at large was misplaced;

(vii) given the trial judge's findings of fact, Mr. Darnley did not break the chain of causation by deciding to leave the hospital after 19 minutes.

This judgment illustrates some important points: -

(i) the tendency in some courts to elide breach of duty / scope of duty issues with the concept of a duty of care (as had the majority in the Court of Appeal and the trial judge) was identified and rejected;

(ii) it will only be necessary for a claimant to establish the third limb of Caparo ("fair, just and reasonable") where the duty of care contended for is of a novel category;

(iii) the status of an employee of an organisation is not relevant to whether the organisation owes a duty of care (as distinct from the status of that employee being a factor to take into account when considering whether there has been a breach of that duty);

(iv) notwithstanding the unique nature of a publicly funded organisation such as the NHS, it does not enjoy any special status in terms of owing common law duties of care;

(v) causation of damage should be assessed by reference to the breach, not independently of that breach (as the majority in the Court of Appeal had done, in concluding that Mr. Darnley's decision to leave had broken the chain of causation).

Jeremy Pendlebury (of 7BR) together with Simeon Maskrey QC represented Mr. Darnley in the Supreme Court and in the Court of Appeal (instructed by Deborah Blythe of Russell-Cooke); and Jeremy Pendlebury represented Mr. Darnley in the trial at first instance in the QBD.

Legal Aid for clinical negligence

LOUISE FORD – SOLICITOR
LEGAL AID AGENCY
CLINICAL NEGLIGENCE TEAM LEADER

The Very High Cost Case Contract - What happens when the case wins but not all costs are recovered from the opponent?

Background

Where a case is funded under a VHCC contract (i.e. where the costs exceed £25,000) and there is a partial costs recovery, whether by Court Order or agreement, you as the provider make a choice at the end of the case, to take your costs from the LAA or from the other side. The default position is that you cannot claim costs from the other side and the LAA. The intention behind the contract operating in this way is to protect public funds, and to shield the client's damages from the operation of the statutory charge in cases where the provider will benefit from the recovery of costs at inter partes rates.

Claims for unrecoverable costs in a successful case arise in only a relatively small proportion of publicly funded clinical negligence cases and in specified circumstances. We see it arise more frequently in judicial review proceedings where it is more common for a percentage costs order to reflect success in some grounds of the claim and dismissal of others. There may also be more willingness to make such claims in public law claims as there is no detriment the client. However, the Clinical Negligence Team of the LAA receives sufficient queries and applications for payment of unrecoverable costs to make this a topic worthy of some explanation, a run through of the circumstances where it is most likely to arise, and the information you will need to provide to the LAA for an application to be considered.

If your client is successful in their legally aided claim, most of your costs are likely to be paid by the NHS at inter partes rates. When you report the outcome to the LAA, the finance team will recoup any monies paid to you from the Fund during the lifetime of the legal aid certificate. There are circumstances under the terms of the VHCC contract where, if there is a shortfall in costs, you may be entitled to claim some, or all, of your unrecovered costs from the Fund. If we agree to this, the equivalent sum would be deducted from the client's damages (at legal aid rates) via the operation of the statutory charge.

How does the VHCC contract treat unrecoverable costs and can these be claimed from the LAA?

The contract specification is on the MoJ's website and can be found by following this **link**. The relevant clauses are 5.3 – 5.11 under Final Payment Choice.

In general terms, if you seek to make a claim from the LAA for unrecoverable costs, in a case where a VHCC contract is in place, you should provide evidence to the LAA of the following:

- There is an 'issues-based' costs order or agreement between the parties;
- The costs are unrecoverable **in principle**;
- The work was clearly authorised by the LAA (usually in a case plan or Clinical Negligence Funding Checklist) and was reasonably carried out;
- The client has been informed in advance of the potential operation of the statutory charge and has consented to the work being carried out.

You cannot, under a VHCC contract, claim a shortfall of your costs from the LAA simply because the Defendant does not agree to pay all your costs because they believe them to be excessive or unreasonable, even if the client consents. Furthermore, these terms are not intended to cover costs incurred in obtaining funding from whatever source, or corresponding with the LAA or preparing a Claim 1, as this is more properly to be described as an overhead. If all information required by the Funding Checklist is provided at the end of each stage, correspondence can be minimised and bill preparation simplified. This is probably the most effective way of keeping these costs which may be unrecoverable to a minimum.

When might a claim for unrecoverable costs arise?

Circumstances where we typically see issues-based costs orders or agreements in clinical negligence cases

are following the issuing of proceedings against 2 or more Defendants, and your client wins against one but loses (or abandons the case) against the other(s); or where the investigation results in you abandoning, for example, allegations of negligent failure to deliver the baby by way of a caesarean section, but you continue successfully to settlement with the remaining allegations of the mismanagement of labour. Alternatively, it might be a reasonable argument to say that unrecoverable costs following an overall win, but where there has been a failure to beat a (reasonably rejected) Part 36 offer, would fall within circumstances where the LAA could pay the relevant part of your costs. For a claim to be made you must be able to evidence that any shortfall in costs obtained from the other side is a direct result of the failure of a specific issue within the case.

These are no more than examples and are intended as a guide to what might be considered within the clauses covering final payment choice. The implications of these clauses are part of the reason why the LAA might seek further information from you at the beginning of a case if there are multiple potential Defendants or lines of investigation. Anecdotally, I would say that some firms do not claim costs from the LAA even where it is open to them to do so as, where damages are recovered, the additional sums will be paid for by the client rather than the LAA.

What payment rates apply?

Whether the costs claimed from the LAA are payable to you at 'risk' rates (i.e. £90 or £50 ph for Counsel and £70 ph for Solicitor) or prescribed rates plus enhancement, would depend on which stage of the case the costs were incurred. If they were incurred within the 1st £25,000 of authorised costs then you can claim prescribed rates plus agreed enhancement. If they were incurred after the 1st £25,000 has been spent then your costs and counsel's fees would be payable by the LAA at risk rates. Any expert's fees would be unaffected and will be paid at the codified rate, or higher if you have a prior authority. For example, if you incurred costs instructing an obstetrician in the investigative stage (within the 1st £25,000) and these costs were unrecoverable because you replaced that expert with another, or abandoned that aspect of the case, then you could claim prescribed rates. If, on the other hand, you instructed a care expert after £25,000 had been incurred under the certificate, and these costs were unrecoverable because you replaced that expert with another, then you would claim risk rates for associated work of solicitor and counsel. If unrecoverable costs arise due to the replacement of one expert by another then you will need to evidence that you had LAA approval for that step.

If the unrecoverable costs were incurred both pre- and post- £25,000 we would need to look in more detail at the case plan/Funding Checklist and reach an agreement as to the proportion of costs to be paid at non-risk rates. In any event any claim for unrecoverable costs is made with the agreement of the LAA so we would discuss any application which was not straightforward to ensure that a fair decision was reached. We will endeavour to take a common-sense and proportionate approach, usually by agreeing a percentage sum.

How should I apply?

Any application under the VHCC contract must be referred to the Exceptional and Complex Cases Team (formerly the Special Cases Unit), as the case manager with responsibility for funding the case makes the decision as to whether the terms of the contract apply to the circumstances of your application for payment of costs. If the case manager agrees that the criteria are satisfied they will authorise the bill-paying team to pay the solicitor a specified sum under the VHCC contract. Although final decisions are almost always made at the end of the case, a preliminary decision can be given at any point and you are able to make representations to the clinical negligence case managers for a preliminary decision to advise your client in relation to the statutory charge. The application will generally be straightforward if you are clear as to the criteria that need to be satisfied, and we would rarely need to see a detailed bill to make a decision.

I would suggest that any application for costs is supported by the following:

- A covering letter explaining the circumstances.
- The original application requesting legal aid cover for the investigation and/or pursuit of the relevant issue or Defendant. This will probably be your original Clinical Negligence Funding Checklist but it might be a subsequent case plan or letter or APP8.
- The costs order or agreement. It must be clear that the reason for the non-recovery of the relevant costs is directly related to a specific issue.
- Evidence that your client has been advised of the operation of the statutory charge and understands why this sum will be deducted from their damages.

We would generally expect to reach an agreement on costs based on Funding Checklist principles where possible. However, if you have any other queries please feel very welcome to write to any of the case managers in the clinical negligence team who will be happy to advise you or discuss further.

The views expressed are the author's own.

Lister v Black

Carlisle County Court

27th November – 1st December 2017

Before: His Honour Judge Peter Hughes QC

PHILIP HOLT - PARTNER
STONE ROWER BREWER LLP

In this matter we acted for the Claimant, the Widower of the Deceased in a claim against her GP for Clinical Negligence. The Claimant brought the claim both on his own behalf as a dependant of the Deceased, Margaret Lister, and on behalf of the Deceased's estate, against Dr Black.

The facts: The Deceased had telephoned her GP's surgery on 23 June 2010, suffering symptoms of constipation. She had not opened her bowels for a week and was in increasing discomfort. She was examined on 23 and again on 24 June 2010 by a District Nurse who advised her to take or continue to take Movicol (a laxative), which the Deceased did, as instructed.

At the Claimant's demand, the Deceased was then visited by Dr Black on 25 June 2010, who diagnosed constipation and advised she take Senna. There was a factual dispute as to the presentation of the Deceased on 25 June 2010.

On 26 June 2010 the Deceased was visited by an out-of-hours doctor [Dr M], who suspected bowel obstruction and arranged for the Deceased to be admitted to hospital urgently. The Deceased underwent surgery on 27 June 2010 which confirmed a diagnosis of a perforated bowel. By this time there was sepsis and the beginnings of multiple organ failure. The Deceased went into a coma, and died on 5 July 2010.

Liability, causation and quantum

Were all in dispute. In relation to breach, there were issues as to the clinical presentation of the Deceased on 25 June 2010, whether Dr Black took a sufficient history, whether Dr Black made a sufficient examination of the Deceased, and whether Dr Black ought to have arranged for the Deceased's admission to hospital.

As to causation, the Court was invited to determine whether, had the Deceased been admitted to hospital immediately following Dr Black's attendance on her on 25 June 2010, the obstruction would have been diagnosed and resolved by surgical or non-surgical means and the perforation which led to her death would have been avoided.

The Claimant's colorectal expert, who is in practice as head of colorectal and general surgery at a large NHS Trust stated that he was of the view that the Deceased's bowel had perforated as a result of diverticulitis, and had the Deceased been admitted to hospital on 25 June 2010, her condition would have been diagnosed within a matter of about six hours, appropriate antibiotic medication would have commenced and the blockage would have cleared; the corollary of which is that the Deceased would have survived.

It was alleged by the Defendant's expert that the Deceased had not suffered a perforated bowel due to diverticulitis, but rather due to 'stercoral ulceration'.

It was agreed by both experts that diverticulitis, causing bowel perforation is rare but such perforation caused by stercoral ulceration is extremely rare. It was also agreed that had the Deceased suffered stercoral ulceration (as alleged, on behalf of the Defendant), that she would have died anyway, and the Claimant had no case on causation.

The Trial

At about 6:15 pm the evening before Trial, the defence team served an amended causation report and a new causation report. The Defendant's expert contended that on reviewing the x-rays he believed that the perforation had taken place before 20.39 hours on 26 June, rather than at between midnight and 1 AM on 27 June (2010), as previously jointly agreed by the experts.

All claims in respect of quantum, other than the FAA award, and the funeral costs, were in dispute.

After two days of evidence the Defendant conceded breach of duty. The Learned Judge then heard two days of evidence from the colorectal experts.

Judgment: Criticisms of expert

In his Judgment His Honour Judge Peter Hughes QC, found that "There was a marked contrast between the two experts." (Para 43)

He described the Claimant's expert as "... softly spoken with an unassuming manner. He gave his evidence in a quietly considered way. He demonstrated that he was prepared to make concessions, and to say so when he was unsure of something." (para 45).

Of the Defendant's expert, he said "...at times, though, he was inflexible and dogmatic, and it appeared to me, fell into the trap of becoming an advocate in his own cause." (para 47)

He went on to say at Para 59 "The histological report is clear in its conclusion. The cause of perforation was diverticulitis. Given the rarity of stercoral perforation, that is a much more likely cause. In my judgment, there is no good reason to question the diagnosis in the histology report and I reject the Defendant's expert's alternative diagnosis."

With regard to the issue raised at the 11th hour by the Defendant's expert as to the timing of the perforation, the Learned Judge said: (Para 70) "the Defendant's colorectal expert is not a radiologist. In my judgment, his evidence on this point was entirely speculative."

Judge Hughes QC concluded by saying (Para 75)"I accept his (The Claimant's colorectal expert's) evidence, and find that had Mrs Lister been admitted to hospital on the afternoon of the 25th June 2010, her condition would not have progressed to perforation.

Judgment: Quantum

As to quantum he awarded £7,500 for PSLA for the 24 hour delay in admission (to hospital). He also, awarded £35 per week for loss of services for 7 years (date of death to Trial), with a 5 year multiplier for future loss, albeit that the Deceased was aged 62 at the date of her death, and suffering significant comorbidities.

The Deceased had a car funded by the Motability scheme, and the Judge awarded the Claimant £5000 in respect of the purchase of a replacement car, and £5000 future loss in that regard.

The other items of damages were agreed and the total basic award was just over £57,000.

Part 36 Offer

Some two years before trial the Claimant had made a part 36 Offer of £15,000, the court awarded considerably in excess of that figure and the Claimant beat their own part 36 offer. Consequently the Claimant was entitled to interest at 10% above base rate on all damages awarded except future loss, commencing 21 days after service of the Part 36 offer pursuant to CPR 36.17(4)(a). Further, the Claimant was also entitled to an additional 10% sum on all damages (including future loss) pursuant to CPR 36.17(4)(d).

Note:-

Even before the part 36 offer had been made and at an early stage in the litigation process the Claimant had made it clear to the Defendant that he would abandon his right to make a claim if he received an apology soon after the event and an agreement to pay a donation of around £ 1,000 to the emergency dependency unit. If the defendants had agreed to this then this case would not have proceeded. This is a further example of the NHS fighting a case tooth and nail at every opportunity; they failed to identify issues on breach and causation at an early stage; appear not to have considered the issues on causation with their expert until very late in the day, serving expert evidence at the eleventh hour and reneging on agreements reached during the without prejudice meeting of experts. It is also clear that they failed to take the opportunity to consider the case in detail and settle the case when the part 36 offer was made.

This case example well illustrates how the defendant's conduct in low value claims serves only to grossly drive up costs in low value and other cases, at least here they were heavily penalised for their actions. However, this type of conduct also serves to exacerbate the anger and frustration that many claimants feel during the litigation process; these are often the same feelings that drive them to seek legal advice in the first place.

ASSESS THE RISK or run the risk

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On 21st March 2018, judgement was given by Mr Justice Hoole in the Sheffield District Registry of the High Court in the case of *Herbert v HH Law* who upheld the earlier decisions of District Judge Bellamy.

The claim was brought about by the Claimant who believed she had been subjected to unfair deductions made from compensation awarded following a successful personal injury claim. The judgment is a warning to a significant number of solicitors of the dangers of not carrying out a thorough risk assessment on any personal injury or clinical negligence matter where the claim is to be funded by way of a Conditional Fee Agreement and demonstrates the importance of ensuring the amount of success fee charged is tailored according to the risks in each individual case.

The case

Ms Herbert's claim arose as a result of a road traffic accident in 2015 and the Defendant was instructed to represent her. The Claimant entered into a CFA which provided that if successful in the claim she would pay the Defendant *'...our basic charges, our disbursements, success fee and ATE Premium. You are entitled to seek recovery from your opponent of part or all of our basic charges and our disbursements...'*

The success fee was set at the statutory maximum of 100% subject to the maximum of 25% of the total amount of general damages for pain suffering loss of amenity (PSLA) and damages for past financial loss, in accordance with Articles 3 and 5 of the Conditional Fee Agreements Order 2013 (the 2013 Order).

The Claimant was also provided with an ATE Insurance Policy in the event of an adverse costs order against her at a cost of £349 which was to be deducted from the Claimant's damages at conclusion of the claim as well as up to 25% of her damages.

The Claimant signed an Insurance Information Fact Sheet to confirm that she understood the terms and that *'I am aware that if I do not have the appropriate cover in place for this accident HH will proceed to take out an insurance policy at a cost of £349 to protect me. I am aware that the cost of the policy and a deduction of damages, up to a maximum of 25%, will be taken upon successful conclusion of my claim'.*

The claim was submitted via the RTA Portal and an internal review note prepared by HH in relation to the prospects of success in the case concluded that it;

'...enjoys reasonable prospects of success given it is a rear end shunt and liability has been admitted on the linked files. I am a little wary that the client may have slammed on rather than slowed to a stop given the earlier altercation with the Defendant driver, however I am of the opinion that she would not have done considering she had young children in the back of the vehicle'.

Proceedings were issued in the County Court and a Part 36 Offer was subsequently made in the sum of £3,400 together with costs as agreed or assessed, in full and final settlement of the claim. In a letter to the Claimant, HH advised that she should accept the offer and that if she did so, the total deductions would be £1,178.21, comprising of:

'Contribution towards our Costs (25% of damages) £829.21 and 'ATE Insurance policy £349.00' and stated 'To clarify, if you were to accept this offer you will receive £2,221.79 and balance of £1,178.21 will be paid towards our legal costs'.

The Claimant duly accepted the offer and received the net sum of £2,221.79. HH subsequently delivered two bills, namely the previous invoice totalling £6,175.84 and an invoice in the sum of £691 plus vat (£829.10) which represented the success fee.

The Claimant therefore instructed new solicitors to contend HH's costs. It was the Claimant's case that HH had failed to conduct a risk assessment justifying the level of success fee and that the 100% uplift was out of steps with the fixed success fee of 12.5% under the previous costs regime for RTA claims which settled before trial. That regime had been replaced by LASPO from 1st April 2013.

Assessment of the success fee

The matter was listed for a paper assessment which was limited to the amount of the success fee, pursuant to s.70(6) Solicitors Act 1974.

The post-LASPO CPR provisions for a solicitor-client are in CPR 46.9 and provide that:

(3) Subject to paragraph (2), costs are to be assessed on the indemnity basis but are to be presumed

(a) to have been reasonably incurred if they were incurred with the express or implied approval of the client;

(b) to be reasonable in amount if their amount was expressly or impliedly approved by the client;

(c) to have been unreasonably incurred if

(i) they are of an unusual nature or amount; and

(ii) the solicitor did not tell the client that as a result the costs might not be recovered from the other party.

(4) Where the court is considering a percentage increase on the application of the client, the court will have regard to all the relevant factors as they reasonably appeared to the solicitor or counsel when the conditional fee agreement was entered into or varied.'

HH submitted that following LASPO, the business had to restructure the charges to client in order to cover overheads and remain profitable. By routinely charging a success fee of 100% (which was capped at 25%) HH was adopting the 'market' rate, on the basis, it was argued, that many of their competitors followed the same model when charging success fees.

Moreover, the Defendant did not accept that the size of the success fee must be calculated according to the risk in the particular case. Furthermore, HH argued that it was a cost incurred with the client's approval in accordance with CPR r.46.9 (3) (a) and (b).

The Judge agreed that CPR 46.9(4) cannot be read as a "stand alone" and that CPR 46.9 must be read as a whole. The Judge held that CPR 46.9 *'places the burden on the client to prove the charges are unreasonable. It also significantly restricts the scope of the court's discretion to interfere with contractually agreed amounts through the mechanism of the presumptions' and that 'It follows that the Claimant needs to establish good reasons why she should not be bound when challenging the success fee by the presumptions in 46.9(3)'.*

The Judge concluded that it was difficult to see in the circumstances of the case known to HH at the time the CFA was entered into that an uplift of much more than 12.5% could ever be justified. He concluded that the case was straightforward, and the nature of the Claimant's injuries were minor. In the circumstances of the particular case and allowing for the fact that the "modest" disbursements were funded by HH for a *"fairly short"* period, the appropriate success fee was 15%, namely £276 plus vat (£331.20).

Appeal

Mr Justice Soole dismissed the Defendant's appeal on the basis that there must be informed approval by the Claimant, not just mere consent to the type or amount of costs incurred. Crucially, the Defendant had not done enough to achieve this. He did not accept that LASPO had removed the requirement for a risk assessment as a relevant factor when considering the success fee on each individual case's merits.

The Judge therefore upheld District Judge Bellamy's decision to reduce the success fee to 15%.

In respect of the second point of the appeal on the ATE premium, Mr Justice Soole agreed with the District Judge that the Defendant's error in omitting the ATE premium from the final cash account meant that they were the authors of their own misfortune and upheld the decision that the premium (which had been deducted from the global settlement figure) should be refunded to the Claimant.

Summary

Since the introduction of LASPO in April 2013, it has become more difficult to make lower value claims profitable. It is important to keep costs down in such cases and arguably it is therefore a needlessly time-consuming exercise to prepare a bespoke risk assessment on each matter.

This case does however serve as a stark reminder of the importance of a properly calculated risk assessment in all cases funded by a Conditional Fee Agreement and ATE policy, whether they be personal injury or clinical negligence.

The decision here is a reminder that blanket success fees in risk assessments are very dangerous. It is essential to ensure that success fees are calculated correctly based on the prospects of success. As a rule of thumb, the ready reckoner prescribes the following uplifts versus prospects of success:-

Prospects of "Success"	% Increase
100%	0%
95%	5%
90%	11%
80%	25%
75%	33%
70%	43%
67%	50%
60%	67%
55%	82%
50%	100%

It is also important to consider whether liability and quantum considerations mean a variable success fee is important.

What can be done to ensure you are not caught out?

1. Conduct audits on risk assessments to ensure they are calculated correctly.
2. Check if any risk assessments have already been miscalculated.
3. Provide training for any staff who will need to calculate a risk assessment.
4. Ensure detailed file notes are prepared when explaining funding to clients.

It is also important to be aware that we have not heard the last of this case yet. The matter is due to be heard in the Court of Appeal in March 2019 and so the saga will yet continue. Definitive guidance does however look to be coming one way or another. It is best practice to protect your position now.

If in any doubt you can contact a specialist who will be able to assist.

Duce v Worcestershire Acute Hospitals - the limits of the duty of informed consent

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Introduction

In ***Montgomery v Lanarkshire Health Board*** [2015] UKSC 11; [2015] AC 1430 it was held that the doctor must take reasonable care to ensure that a patient is aware of any material risks and of any reasonable alternative treatment. This was a landmark case. It made clear beyond doubt the importance of the patient's right to informed consent, albeit this had already been established in ***Chester v Afshar*** [2004] UKHL 41; [2005] 1 AC 134. The more radical aspect of ***Montgomery*** was the ruling that the issue of what constituted a material risk was a matter for the court and was not subject to the test in ***Bolam v Friern Hospital Management Committee*** [1957] 1 WLR 582. Thus, if the court considers that objectively the risk was one which should have been brought to the patient's attention, it is no defence that a responsible body of doctors would have chosen not to do so.

It had been anticipated that ***Montgomery*** would open the door to many successful claims based upon a failure to provide informed consent. After all, the ***Bolam*** test has traditionally been the highest hurdle in establishing clinical negligence. It might reasonably have been expected that there would be a significant number of claims which previously would have fallen at this hurdle but now would succeed in light of its being removed.

However, in practice that has not turned out to be the case. Subsequent authority has demonstrated that claims based purely upon an absence of consent (i.e. those where there has been no negligence in the diagnosis, advice or treatment per se) face formidable obstacles in establishing both breach of duty and – especially – causation. ***Duce v Worcestershire Acute Hospitals NHS Trust*** [2018] EWCA Civ 1307 is the latest and clearest illustration of why this is so.

The facts

Mrs Duce underwent a total abdominal hysterectomy and bilateral salpingo-oophorectomy in order to treat extremely painful and heavy periods. She was 41 years old at the time. On 4 March 2008 she met with a consultant gynaecologist who recorded that the claimant was sure she wanted to have a hysterectomy. The notes concluded with "risks explained". On the morning of surgery on 25 March 2008 the claimant had been consented by a registrar, who warned her about post-operative pain normally associated with surgery. It was accepted that the registrar did not advise her about developing chronic pain or neuropathic pain following surgery. The anaesthetist also agreed that she too would have only warned the claimant of normal post-operative pain.

Following surgery the claimant developed Chronic Post-Surgical Pain (CPSP) as a result of nerve damage. There was no negligence in the performance of the operation itself. The claim was advanced on the basis of a lack of informed consent. Both breach and causation were in issue.

The Royal College of Obstetricians and Gynaecologists guidance did not refer to a risk of chronic, long-term or neuropathic pain. The experts agreed that CPSP was not common knowledge amongst gynaecologists in 2008.

Decision at instance

HHJ Worster found that there was no duty to warn a patient of the risk of chronic or neuropathic pain. Such requirement did not follow the Royal College guidance and the understanding of such pain by gynaecologists in 2008 did not justify the imposition of a duty to warn of it. He went on to find that even if the claimant had been warned of the risk, she would still have opted to undergo the operation on the day she did and suffered the same outcome in any event.

Arguments on appeal

In respect of breach of duty the claimant argued that the judge had erroneously applied the Bolam test rather than the ***Montgomery*** test of materiality.

In respect of causation, the claimant's primary argument was that the judge erroneously applied the "but for" test. She argued that following ***Chester*** there was no need to establish that she would not have undergone the

operation in question had she been properly informed of the relevant risk. There was an alternative route to causation which could be established by proving that (1) the injury was intimately involved with the duty to warn; (2) the duty was owed by the doctor who performed the surgery to which the patient had consented; and (3) the injury was the product of the very risk that the patient should have been warned about when she gave her consent. Her alternative argument was that even applying the conventional but for test, causation was made out on the facts.

Breach of duty

The Court of Appeal (Hamblen, Newey and Leggatt LJJ) upheld the judge's decision. The claimant's argument conflated the distinct limbs of what was a two stage test:

1. What risks were or should have been known to the medical professional. This is a question for the experts.
2. Whether the patient should have been told about such risks by reference to whether they were material. This is a question for the court, although expert evidence is likely to assist.

The judge did not have to consider materiality because the evidence was that the risks of chronic/neuropathic pain were reasonably not known to the relevant treating doctors. The claim thus failed at the first hurdle and did not proceed to the second.

The Court nevertheless went on to consider causation in detail.

Causation

The Court rejected the claimant's primary argument as amounting to a wholesale disapplication of conventional causation principles. It held that ***Chester*** was (a) limited in scope, the court therein modifying the causation test because of the very unusual circumstances of the case; and (b) not on proper analysis support for the proposition that there was no need to satisfy the but for test where there had been a failure to give informed consent.

Chester concerned a small (1-2%) surgical risk of a very serious complication (cauda equina syndrome). This risk eventuated. Whilst the claimant failed to establish that had she been informed of the risk she would not ultimately have undergone the operation, crucially she was able to establish that in those circumstances she would not have consented to undergo the operation on that day. The chances of that risk eventuating during a subsequent operation were much less than 50%; they were 1-2%. Had the claimant been warned of the risk as she should have been the injury would thus probably have been avoided, albeit by serendipity. The injury was a result of the breach of duty because (i) the operation would not have taken place when it did and (ii) the risk of injury was very small and so was unlikely to have occurred if the operation had been carried out on a subsequent occasion. Therefore, as a matter of strict factual causation, the but for test was satisfied.

Leggatt LJ went further and questioned the correctness of ***Chester*** even on its own facts. He considered it to be highly problematic in respect of ordinary causation principles, the scope of the duty of care and in respect of the burden of proof. He trenchantly observed at [85]

> *In law as in everyday life A's wrongful act is not normally regarded as having caused B's injury if the act made no difference to the probability of the injury occurring. In such a case the fact that the injury would not have occurred but for the wrongful act is merely a coincidence. To take an example given by Lord Walker, if a taxi driver drives too fast and the cab is hit by a falling tree, injuring the passenger, it would not be said that the negligent driving caused the injury: the driver might equally well have avoided the tree by driving too fast, and passenger might equally well have been injured if the driver had been observing the speed limit. Similarly, in Chester if the operation had taken place on a later date the risk of a serious injury occurring would have been exactly the same. As Lord Hope accepted at [81], "to expose someone to a risk to which that person is exposed anyhow is not to cause anything".*

He further noted that the right to make an informed choice is not a right that is traditionally protected by the tort of negligence; the purpose of the tort is to protect a person from being exposed to injury through another's carelessness. In consent cases the duty is not to protect the claimant from a risk of injury; the duty is to enable the claimant to decide whether or not that risk is acceptable to her. He concluded by saying that these matters may be ripe for further consideration by the Supreme Court.

The alternative causation ground was a pure challenge to findings of fact. The Court had little difficulty rejecting this.

The appeal was therefore dismissed on all grounds.

Comment

This decision confirms that the ***Bolam*** test still needs to be satisfied in claims based upon absence of informed consent, albeit the test has a more limited ambit in these cases than in those based upon conventional allegations of negligence. Unless it can be shown that it was ***Bolam***-

negligent for the clinician not to have identified the risk in question, the claim will not make it off the ground.

This is unsurprising. Whilst judges are perfectly well-equipped to answer the question "Would I as a layperson consider this to be a material risk of which I should have been told?", they are self-evidently not equipped to answer the logically anterior question "Would a reasonable clinician have identified this as a risk in the first place?" More basically, it is impossible to see how anyone (be they a doctor, other professional or lay person) could be negligent for failing to warn of a risk of which they were reasonably not aware.

The analysis of the causation requirements, whilst strictly obiter, is perhaps therefore of greater importance. It is clear that (a) the but for test will still have to be satisfied; and (b) the modifications to conventional causation principles that ***Chester*** did make were to be restrictively applied.

On the latter point, even though ***Chester*** did not modify the but for test for factual causation, there can be no doubt that it departed from the established test for legal causation. As Hamblen LJ observed at [66] the "modification was to treat a 'but for' cause that was not an effective cause as a sufficient cause in law". An injury which would have been avoided by serendipity but for the breach of duty would appear squarely within Lord Hoffman's famous example in ***SAAMCO (Banque Bruxelles Lambert SA v Eagle Star Insurance Co Ltd*** [1997] AC 191) of a mountaineer who is negligently advised by a doctor that his knee is fit for a difficult climb and then suffers an injury which is a foreseeable risk of mountaineering but has nothing to do with the state of his knee. Although he would not have gone mountaineering but for the negligent advice, the doctor is not liable as there is an insufficient causal connection between the injury and the subject of the duty which was breached. It therefore could not be said to be an effective legal cause of the injury. ***Chester*** precludes reliance on this principle in informed consent cases; ***Meadows v Khan*** [2017] EWHC 2990 (QB) (although note that the defendant's appeal in this case was be heard by the Court of Appeal in October 2018; this might ultimately be a vehicle for challenging ***Chester*** in the Supreme Court).

The confirmation of the need to satisfy the but for test is consistent with a long line of recent authorities . In ***Shaw v Kovac***[1] [2017] EWCA Civ 1028; [2017] 1 W.L.R. 4773 the Court of Appeal comprehensively rejected an attempt to circumvent the causation requirement by framing the claim as one for invasion of the claimant's personal autonomy (thereby giving rise to vindicatory as opposed to compensatory damages). The restrictive approach to the application of ***Chester*** is a consistent theme here.

The but for test will as a matter of practice generally be difficult to satisfy in pure informed consent cases. Where there has been no other negligence, by definition even if the clinician had warned of the material risk he would still have advised the patient to proceed with the treatment in question. That the clinician did not consider the risk sufficient to merit a warning, whilst not an answer to materiality in the context of breach, is likely to be a strong indicator that the risk was not one which would have told heavily against the treatment being undertaken. All things being equal, patients tend to follow doctors' advice unless there is a good reason not to; see ***Pearce v United Bristol Healthcare NHS Trust*** [1999] P.I.Q.R. P53.

The injured patient will of course invariably state that they would not have undergone the treatment in question had they been informed of the risk. However, such counterfactual evidence will nearly always be too influenced by hindsight in light of the bad outcome to attract much weight by itself. It is highly susceptible to the Mandy Rice-Davies response: "Well he would say that, wouldn't he?". See in this regard ***Smith v Barking, Havering and Brentwood HA*** [1994] 5 Med. L.R. 285, ***Sem v The Mid Yorkshire Hospitals NHS Trust*** [2005] EWHC 3469 (QB) at [51-54] and ***Jones v North West SHA*** supra at [70].

There is an argument for claimants that, as it was the defendant's negligence which has created the uncertainty as to whether or not the treatment would have proceeded, the benefit of any doubt on that issue should be resolved in the claimant's favour; see ***Yam Seng Pte Ltd v International Trade Corp Ltd*** [2013] 1 CLC 662 at 709A and ***Keefe v Isle of Man Steam Packet Co*** Ltd [2010] EWCA Civ 683 (applied, albeit unsuccessfully, in the clinical negligence context in ***Shawe-Lincoln v Neelakandan*** [2012] EWHC 1150 (QB). However, this point is likely only to act as tie-breaker in very rare cases

1 *Jones v North West SHA [2010] EWHC 178 (QB); [2010] Med. L.R. 90; Packham v Hazari [2014] EWHC 3951 (QB); Meiklejohn v St George's Healthcare NHS Trust [2014] EWCA Civ 120; [2014] Med. L.R. 122; A v East Kent Hospitals University NHS Foundation Trust [2015] EWHC 1038 (QB); [2015] Med. L.R. 262; Border v Lewisham and Greenwich NHS Trust (formerly South London Healthcare NHS Trust [2015] EWCA Civ 8; [2015] Med. L.R. 48; (2015) 143 B.M.L.R. 18; Connolly v Croydon Health Services NHS Trust [2015] EWHC 1339 (QB); Barrett v Sandwell and West Birmingham Hospitals NHS Trust [2015] EWHC 2627 (QB); (2016) 147 B.M.L.R. 151; Correia v University Hospital of North Staffordshire NHS Trust [2017] EWCA Civ 356; [2017] Med. L.R. 292, Diamond v Royal Devon and Exeter NHS Foundation Trust [2017] EWHC 1495 (QB)*

where it is not possible on the available evidence to make a finding either way.

It follows that cases purely based on a failure of informed consent are likely to be inherently difficult to establish. (It was worth emphasising that the position may be different when the informed consent allegation does not stand alone. See for example ***Thefaut v Johnston*** [2017] EWHC 497 (QB); [2017] Med LR 319 where a surgeon not only failed to warn of the risks of surgery but also conveyed to the patient that the prospects of a positive outcome were much higher than was in fact the case). It should also not be overlooked here that (a) factual questions of what advice was given will often be disputed; and (b) the patient must at the relevant time have been in a fit state to give informed consent (see ***ML v Guy's and St. Thomas' National Healthcare Foundation Trust*** [2018] EWHC 2010 (QB), although this point might possibly cut both ways and tends to underline the need to canvass all material possibility well before the procedure in question; see also ***Thefaut***, supra, at [78] and ***Hassell v Hillingdon Hospitals NHS Foundation Trust*** [2018] EWHC 164 (QB); (2018) 162 BMLR 120 at [53, 74]).

With the inevitable but important caveat that each case turns on its own facts, it follows that causation will be inherently unlikely to be proved save in the following types of cases:

(1) Those cases where there is good evidence, beyond assertions made in hindsight, that the patient would have been sufficiently concerned by the risk that should have been disclosed that they would have gone against medical advice and refused the treatment. Prior evidence (e.g. in the medical records) that the patient was particularly risk adverse would be an example of this. In ***Webster v Burton Hospitals NHS Foundation Trust*** [2017] EWCA Civ 62; [2017] Med. L.R. 113 the mother's own clear evidence that she would have elected for a caesarean which would have prevented a hypoxic brain injury was supported by the facts that she had a degree in nursing and had earlier in the pregnancy discharged herself from hospital against medical advice. In ***SXX v Liverpool Women's NHS Foundation Trust*** [2015] EWHC 4072, the fact that the father's brother and sister-in-law suffered the loss of one of their two twins during a vaginal birth gave obvious credibility to the parents' evidence that they would have elected for a caesarean. Similarly, in ***FM v Ipswich Hospital NHS Trust*** [2015] EWHC 775 (QB) the mother could point to the difficult vaginal birth of her first child. In **Birch v University College London Hospital NHS Foundation Trust** [2008] EWHC 2237 (QB); (2008) 104 B.M.L.R. 168 the claimant had suffered previous problems in the past which had resolved spontaneously without the need for risk-carrying tests. In ***Hassell***, surpra, the claimant had elected for conservative treatment before, and benefitted from it. (Such evidence can of course go the other way. In ***Sem***, supra, the psychiatric evidence demonstrated that patients in the claimant's position would almost certainly have elected for the procedure which was in fact performed. In Duce itself the pre-operative records demonstrated that the claimant had been urged by her doctors on several occasions to consider less invasive options given the serious risks of surgery but was determined to press ahead as she wanted her symptoms dealt with decisively).

(2) Those where there is more than one reasonable option and where the question of which option to choose will be heavily influenced by the patient's personal views. This is opposed to those cases where it is simply a question of weighing up the medical pros and cons; in such the choice is likely to predominantly informed by clinical advice. Obstetric cases such as ***Montgomery*** (a shoulder dystocia case) are probably the most obvious example; see also ***Webster***, ***SXX***, and ***FM*** supra. In such cases there often will be multiple factors informing the choice to be made (not least because, rather than it just being the risks and benefits to one person to consider, the risks and benefits to both mother and baby would need to be taken into account), and it is plausible that personal and subjective considerations (e.g. the preference or otherwise for a caesarean) could be crucial. Likewise, cases such as those concerning elective surgery where the pros and cons of invasive and conservative treatment are quite evenly balanced such that the clinician would not (or at least should not) give a particularly firm steer either way; see for example ***Holloway v DCM Optical Ltd*** unreported, Central London County Court, 26 September 2014 and ***Hassell***, supra. Cosmetic surgery cases where the procedure is purely elective in it is for purely aesthetic rather than medical treatment purposes might also fall into this category.

(3) Those like ***Chester*** (see also J***ones v Royal Devon and Exeter NHS Foundation Trust*** unreported, Exeter County Court, 22 September 2015; ***Crossman v St George's Healthcare NHS Trust*** [2016] EWHC 2878 (QB); (2017) 154 B.M.L.R. 204) where informed consent would have caused the patient to delay the treatment and thereby avoid the risk eventuating. (This obviously excludes cases where the patient has

a latent vulnerability which probably would have been triggered whenever the treatment was performed).

Cases within the second category will nevertheless remain difficult. In ***Montgomery*** there was no need to rely solely upon the claimant's evidence of what choice she would have made. The evidence from the treating obstetrician herself, and that of the defendant's medico-legal expert, was that if a patient such as Mrs Montgomery was warned of the risk of shoulder dystocia she would almost inevitably have elected for a caesarean. Indeed, this was precisely why the obstetrician consciously (and unacceptably) decided not to warn of that risk. Likewise in ***Webster, SXX***, and ***FM*** there was evidence beyond the patient's retrospective assertions. In ***Jones v North West SHA*** supra (another shoulder dystocia case) the argument that patients normally follow medical advice prevailed, albeit in light of evidence that in 1992 patients almost invariably followed medical advice (patients have become less deferential since), as it did in ***Pearce***, supra (where a stillbirth would have been avoided by caesarean). ***Tasmin v Barts Health NHS Trust*** [2015] EWHC 3135 (QB) and ***MC v Birmingham Women's NHS Foundation Trust*** [2016] EWHC 1334 (QB) provide further examples of the difficulties such claims can face.

Cases falling within the third of these categories are likely in practice to be rare. There is also the risk, that even if the factual basis were established the defendant could accept Leggatt LJ's invitation to revisit the legal principles in the Supreme Court.

It would be remiss to conclude on too pessimistic a note. ***Montgomery*** remains a landmark case. Informed consent claims can be won. It is just that considerable skill and care is required to identify those that can be won and then assemble and present the evidence necessary to win them.

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A variation of the Montgomery principle: C v County Durham & Darlington NHS Foundation Trust

JUSTIN VALENTINE
ST JOHN'S CHAMBERS

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The Claimant sought damages from the Defendant Trust arising out of (i) their failure to diagnose Crohn's disease, a serious condition causing inflammation of the digestive tract, prior to receipt of the results of a highly-raised faecal calprotectin sample or in the alternative (ii) their failure to inform the Claimant or his GP of that diagnosis subsequent to receipt of those results at which point the diagnosis was all but certain.

The failure to diagnose and/or inform the Claimant of the diagnosis led to the development of a fistula requiring emergency surgery.

The Claimant had a history of colicky pain. In September 2011 he suffered a severe episode of diarrhoea with abdominal pain whilst on holiday in Turkey. On his return he attended his GP who referred him to the Defendant Trust's Rapid Access Medical Assessment Centre ("RAMAC"). RAMAC proceeded on the basis of suspected Crohn's Disease, rather than bacterial infection, and prescribed steroids. He was referred to gastroenterology.

The Claimant was seen on 29th November 2011 by a consultant gastroenterologist, Dr M, who arranged a colonoscopy and took a biopsy. A diagnosis of early Crohn's or possibly a healing enteric infection was made. The Claimant was seen again by Dr M on 28th December 2011. Again a differential diagnosis of either acute self-limiting infective ileitis or possibly Crohn's disease was made. The steroids were reduced. The Claimant's expert gastroenterologist believed that Crohn's disease should have been diagnosed on this occasion. The Defendant's expert gastroenterologist argued that although the raised inflammatory markers were consistent with Crohn's *"It is not possible to totally rule out infective ileitis"*.

The Claimant re-attended Dr M's clinic on 29th February 2012. On this occasion the Claimant was well. He was told that he probably did not have Crohn's disease as there was no evidence of granulomas on the biopsy. The gastroenterology experts were agreed that the absence of granulomas was irrelevant in the diagnosis of Crohn's disease. In any event, he was given a sample pot for faecal calprotectin and told to contact his GP if there were any further problems. The Trust claimed that a further follow-up appointment was made for 30th May 2012. The Claimant denied receipt of the appointment letter.

On 3rd March 2012 the Claimant was very unwell. He was suffering diarrhoea and rectal bleeding and attended the Trust's Urgent Care Centre. On a date during March, the Claimant could not recall when, he rang, he said, Dr M's clinic on three occasions where, he alleged, he was fobbed off by the secretary and told that Dr M was *"not concerned"*. The Trust did not keep records of such calls and denied that those words would have been used.

On 5th March 2012 the Claimant took the sample pot given to him by Dr M to outpatients. The results were reported at the end of March 2012 and sent to Dr M. They showed a highly-raised, 10 fold increase in faecal calprotectin. This was all but determinative of Crohn's disease in the context of the Claimant's clinical history, a fact that the expert gastroenterologists were agreed upon.

On receipt of the results, Dr M moved forward the appointment for 30th May 2012 to 24th April 2012. The computer records of the Defendant's central booking department demonstrated that letters were sent out both in relation to the original appointment on 30th May 2012 and the expedited appointment on 24th April 2012. The computer records further demonstrated that the Claimant rang the central booking department on 10th April 2012 cancelling the appointment on 24th April 2012 and that no further appointment was required. The Claimant denied cancelling any appointments.

The Claimant's evidence was that he was experiencing so much pain at that time that he would have made every effort to attend the hospital appointment and would not have cancelled it. The Claimant did not thereafter attend his GP for intestinal symptoms for several months. His evidence was that he had formed the view that the pain he was suffering was in his head so much so that his GP referred him for cognitive behavioural therapy. In the event, by February 2014 he developed an intestinal fistula (an abnormal connection) between the terminal

ileum and the umbilicus which required surgery. Crohn's disease was definitively diagnosed. The gastroenterology experts were agreed that he had been suffering Crohn's disease from the autumn of 2011.

The matter proceeded to trial at the County Court in Newcastle-upon-Tyne on 1st October 2018 before HHJ Freedman. The Claimant's claim was advanced on the following bases:

1. A failure by Dr M to diagnose Crohn's at the latest by the appointment in February 2012, ie before receipt of the highly-raised faecal calprotectin sample. This was an issue primarily for the medical experts applying the *Bolam* test.

2. Failing to make a further appointment for the Claimant after attendance at clinic in February 2012 and/or cancelling that appointment (in the context where the Claimant denied receiving appointment letters and denied cancelling the appointment in April 2012). This was an issue of fact to which the *Bolam* test would clearly not apply.

3. Even if the Claimant had cancelled his appointment and requested no further appointments, a failure by the Trust to inform the Claimant or his GP of the results of the highly-raised faecal calprotectin sample and that, accordingly, a diagnosis of Crohn's disease was all but certain. This was an administrative issue which, it was argued, was more akin to a *Montgomery* test rather than a *Bolam* test.

During evidence Dr M agreed that on receipt of the results of the faecal calprotectin sample it is highly likely that the Claimant had Crohn's disease. This was, after all, why he had moved the appointment forward. He stated, however, that he was unable to communicate this important information due to the Claimant cancelling the appointment without letting his department know.

The system operated by the Trust at the time was that if a patient cancelled an appointment via central booking then the consultant would not be informed. The patient, in such a situation, would simply disappear from the consultant's list of appointments for that day.

Dr M gave evidence that if the Claimant had failed to attend his appointment on 24th April 2012, rather than cancelling it through central booking, then he would at the least have written to his GP informing him of the now almost certain diagnosis. In addition, Dr M stated that if the Claimant had rang the gastroenterology department rather than central booking then again, he would have contacted the Claimant's GP and/or offered a further appointment.

In his witness statement, Dr M had stated that it would be inappropriate to chase a patient who had cancelled via central booking by offering another appointment. However, at trial he gave evidence that had he known that the booking had been cancelled then he would have written to the Claimant's GP. He stated that he would not have wanted to lose the Claimant from the system and, by necessary implication, made common cause with the Claimant in criticising the Trust's policy of not informing consultants of a centrally-cancelled appointment which policy had subsequently changed.

The Court heard from the manager of the central booking department, Mrs H. Mrs H stated that at the time consultants were not informed of cancellations made centrally but that this had now changed for all patients but primarily for child safeguarding reasons (so guardians were not able, without consultants' knowledge, to cancel an appointment for a child). She was unable to state what the rationale of the previous system was and agreed, on questioning by the judge, that the system was somewhat arbitrary. She confirmed that there was no significant cost attached to informing consultants of cancelled appointments since the computer would automatically generate such letters if set up in that way.

Before the expert gastroenterology experts were due to give their evidence the judge heard submissions on the issue of whether, even assuming that the Court found that the Claimant had cancelled his appointment, the Trust were in breach of duty by failing to inform the Claimant of the diagnosis of Crohn's disease which Dr M agreed was appropriate on receipt of the highly-raised faecal calprotectin sample.

HHJ Freedman gave judgment for the Claimant on that issue. He held that in all likelihood the Claimant had cancelled his appointment but that he had then fallen out of the system and that no letter had been sent either to him or his GP informing him of his serious condition. The judge noted that Dr M said that it was his intention to inform the Claimant of the nature of the problem but the system had deprived him of this opportunity.

The judge held, with reference both to *Montgomery v Lanarkshire Health Board* [2015] UKSC 11 and to *Spencer v Hillingdon Hospital NHS Trust* [2015] EWHC 1058 (QB) that the question to be asked is **what would a reasonable patient expect to be told.** There came a time when Dr M knew what the diagnosis was and the hospital had a duty to take reasonable steps to inform the Claimant. It was no answer to say that the Claimant had cancelled his appointment as the Claimant did not know of the diagnosis at the time he cancelled his appointment. Breach was

therefore made out. Causation was conceded and damages were awarded to the Claimant at the previously agreed sum of £15,000.

Comment

In the event, the judge did not need to hear from the gastroenterology experts. The decision was made purely on the basis of the illogicality of an administrative system which, although not defective, failed to inform consultants of cancelled appointments. As the judge observed, in many cases this would make no difference but in the Claimant's case after many months of symptoms but no diagnosis he had formed the impression that he was worrying needlessly, that his symptoms were partly psychological and that he should attempt to get on with his life. In the event, the diagnosis remained within the hospital.

The case demonstrates a variation on the *Montgomery* principle. It is self-evidently not a clinical decision as to whether the Claimant should have been informed of the diagnosis but rather, as expressed in *Spencer v Hillingdon Hospital NHS Trust* at paragraph 68 *"I ask myself the question, would the ordinary sensible patient expect to have been given the information contended for; put another way I ask myself, would such a patient feel justifiably aggrieved not to have been given on discharge the information contended if appraised of the significance of such information".*

The advantage of presenting a case on such a basis is clear. The *Bolam* test places professional decision-making centre stage. It can prove difficult to demonstrate that the actions of a medical expert would not be accepted as proper by a responsible body of medical men skilled in that particular art and judges demonstrate reluctance to criticise medical professionals.

The more patient-centred Montgomery principle allows a broader enquiry into the relationship between patient and health provider than allowed by Bolam with no necessity for the Court to criticise individual medical practitioners in the exercise of their profession. The instant case succeeded because Dr M agreed with the Claimant that the information that had not been provided should have been. Although fact-specific there are many cases where there can be justified complaint about the provision or non-provision of information whether complications, possible treatments, procedures or diagnoses. It is clear that allegations concerning such issues should now be dealt with on the basis of what the ordinary sensible patient would expect to be told.

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Doing the right thing

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There are times when health professionals endanger their lives and limbs to care for their patients. Nearly 900 medical staff contracted Ebola virus disease in Sierra Leone, Liberia, and Guinea, with 513 deaths, in the Ebola outbreak of 2014-2015.

Army medical personnel have also risked all to treat injured soldiers on the battlefield, under the threat of snipers, ambushes, and roadside bombs. So too have the thousands of humanitarian health workers who have been victims of violence, or threats of violence, in conflict zones.

While physical courage is lauded by all, lesser known is the moral variant of courage. Moral courage is when you act on the conviction that something is morally right even though you believe that something of personal value may be lost. It need not be heroic in the grand, traditional sense. A doctor breaking bad news may show moral courage by avoiding the temptation to dodge the difficult issues. She will tackle head on the question about, say, whether the patient will ever walk again.

Since 2010, Washington Hospital Center in Washington, DC, has given moral courage awards to clinicians who have "exemplified the virtue of courage and acted against difficult and ethically challenging circumstances." A past winner of the award was a nurse, Crystal, who called a dying patient's family. The relatives were several hours away and the patient only minutes from death. Anticipating the inevitable, the medical team left the patient, but Crystal stayed behind. For several minutes she held the patient's hand and uttered comforting words. "No one should ever die alone," she told the colleague who eventually nominated her for the award. The colleague wrote, "We convince ourselves that we tried our best, so we move on to the next room while a patient dies in solitude. It is difficult to stand in a room and face what feels like defeat. So patients die alone because of our own cowardice and false sense that there must be somewhere more important for us to be at that moment."

In another act of moral courage a doctor may speak out against an ethical violation when all others are silent. At a morbidity and mortality meeting, the consultant orthopaedic surgeon describes how the operation was conducted on the wrong level of the spine. Another procedure, at the correct level, is needed. No one asks whether the patient has been informed, until a trainee surgeon raises his hand: "Has the patient been told about this?" In a hierarchical department where consultants are emperors, asking that simple question could require tremendous courage.

Under England's duty of candour a health service body such as an NHS trust has a statutory obligation to notify patients of a safety incident that has resulted, or has the potential to result, in moderate or severe harm. As the organisation's representatives, doctors are responsible for discharging the duty. If their trust has not provided them with training or information on the duty of candour, they should ask for it.

And yet, even with the duty of candour and the GMC's guidance that doctors must be open and honest with patients, a culture of secrecy still lingers in many departments. In those places, a doctor who strives to act morally and legally will need moral courage.

At times, matters should be raised with those higher up the chain of command. Few doctors seem aware of paragraph 25 of the GMC's guidance on consent, which states, "If you think that limits on your ability to give patients the time or information they need is seriously compromising their ability to make an informed decision, you should raise your concerns with your employing or contracting authority." If there is no time to obtain proper consent, whether through lack of staff or some other systemic reason, doctors should tell the managers and include paragraph 25 in their letter.

Neither should long term gaps in the rota be tolerated, which can push staff to the brink, violate the law on safe working times, and put patients at risk. The GMC states, "All doctors have a duty to raise concerns where they believe that patient safety or care is being compromised by the systems, policies and procedures in the organisations in which they work." Many doctors know that these practices are unsafe and probably illegal, but they do nothing. As Theodore Roosevelt said, knowing what's right doesn't mean much unless you do what's right.

Few doctors work in splendid isolation. Most form part of an organisation. The solution is to create an organisational culture where doing the right thing no longer requires moral courage. It should be expected, even encouraged. And if no award currently exists for "moral courage shown by a clinician" in the United Kingdom, someone should create it.

Experts' Agendas – a Warning from the Bench

DR SIMON FOX QC
NO 5 AND EXCHANGE CHAMBERS

"It certainly should not become routine to provide two versions which, as here, travel over much of the same ground. That approach tests the patience of the experts (and frankly of the court); produces a lengthier joint statement; potentially increases costs and is simply not the best way to focus on the issues. I do not think that anything further needs to be said or done in this case. However, if this worrying trend continues, parties may find that courts begin considering costs consequences." - Mrs Justice Yip commenting on the experts' agendas in the recent case of **Welsh v Walsall Healthcare NHS Trust 2018 EWHC 1917 QB.**

Expert meetings and their agendas have been provided for under the Court rules for over 20 years, but despite this have until recently attracted little comment, guidance or case law.

CPR 35 tells us simply –

- A joint meeting is not mandatory and is at the discretion of the Court;
- The purpose is to identify the issues between the experts;
- The content of the discussion cannot be referred to at Court and the parties are not bound by any agreement which the experts reach.

The accompanying **Practice Direction and 2014 Guidance for Instruction of Experts** add –

- The purpose of the agenda is to help the experts focus on the issues;
- The agenda must not be in the form of leading questions or hostile in tone;
- The parties should cooperate in preparing the agenda;
- The experts should set out the reasons for their disagreement;
- The experts should not seek to settle the case.

Standard directions in clinical negligence cases give us some further guidance–

- The Claimant prepares the agenda and sends it to the Defendant to agree or amend;
- Parties should use their best endeavours to agree a final version of the agenda;
- In doing so the parties should not argue over semantics or points that the experts can resolve themselves;
- If they cannot agree one agenda, the default position is that both the Claimant and the Defendant's version of the agenda should both be considered by the experts.

Until recently that was pretty much it in terms of guidance to practitioners in preparing agendas. My experience of the last 20 years is that it has become common practice –

- For each side to be partisan in the preparation of their respective versions of the agenda, trying to make sure that their version covers what they regard as their best points in the expert evidence;
- Agendas have become longer and longer – I have seen some with 50 questions (and I suspect barristers are more guilty here than solicitors);
- What should be the default position, of two agendas going to the experts, has become the standard position.

Mrs Justice Yip has issued a wake-up call for practitioners adopting such an approach. A judge who previously specialised in personal injury and and clinical negligence, Yip J has given those of us working in those areas a series of useful judgments on different topics since her appointment last year, but she has spoken in particular on the topic of experts' agendas.

Her most recent judgment - **Welsh v Walsall Healthcare NHS Trust 2018 EWHC 1917 QB** - was a bariatric surgery case in which the Claimant claimed negligence in the surgery and post-operative management in a gastric bypass operation, resulting in the 40 year old claimant

having to undergo a reversal of the bypass and ileostomy with long term ongoing disability.

At the liability trial (the Claimant won), of the joint statements, Yip J stated –

"35. As I observed during the trial, the joint statements in this case were not as useful as they might have been. The difficulty was caused by the inability of the parties to agree a single agenda for the experts' consideration. This is not the first time that I have expressed concern about this and counsel confirmed that it is a problem that appears to be arising more frequently. When I enquired as to why that might be, Mr Counsell, having sought instructions, referred to the model direction for clinical negligence actions which provide for the claimant's solicitors and experts to prepare a draft agenda to be sent to the defendant's solicitors and experts for comment and for the defendant to then agree the agenda or propose amendments within 21 days. Paragraph 13 of the model order says:

"7 days thereafter all solicitors shall use their best endeavours to agree the Agenda. Points of disagreement should be on matters of real substance and not semantics or on matters the experts could resolve of their own accord at the discussion. In default of agreement, both versions shall be considered at the discussions."

36. It was suggested that the form of the model order encourages more than one agenda to be sent to the experts. I cannot agree with this. The standard direction makes it clear that the solicitors are required to do their best to agree a single agenda. In the vast majority of cases, any disagreement ought to be capable of resolution through a bit of give and take. It may be appropriate to insert some additional questions into the draft at the defendant's request. It certainly should not become routine to provide two versions which, as here, travel over much of the same ground. That approach tests the patience of the experts (and frankly of the court); produces a lengthier joint statement; potentially increases costs and is simply not the best way to focus on the issues. I do not think that anything further needs to be said or done in this case. However, if this worrying trend continues, parties may find that courts begin considering costs consequences."

Yip J's reference to this not being the first time she has criticised the lack of a single agenda refers to her judgment earlier this year in another surgical case - **Saunders v Central Manchester University Hospitals NHS Foundation Trust 2018 EWHC 343 QB**. This was a claim for alleged negligence in the performance of an operation to reverse an ileostomy in which she stated of the experts –

"their joint statement was disappointing. It was 60 pages long and did not fulfil the purpose identified in CPR 35PD 9.2 "to agree and narrow issues". It seemed to me that the difficulty may have arisen not through the fault of the experts but in the way the agendas were drafted. I say "agendas" because, for reasons not explained to me, there had apparently been two separate agendas that the experts were required to consider. Both involved repetitive questions for the experts and far from producing a focus on the real issues, the result was a document that served only to confuse rather than assist.

I can see no good reason why the parties were unable to agree a single agenda in this case. Perhaps greater input from Counsel may have assisted. The joint statement is an important document. It ought to be possible to read it and understand the key issues and each expert's position on those issues. Sometimes less is more as far as the agenda is concerned. Parties should adopt a common sense and collaborative approach rather than allowing this stage of the litigation to become a battleground. Frankly, the approach to the joint statement in this case achieved nothing of value".

So we need to be careful in adopting the default position of a Claimant's and a Defendant's agenda both being put to the experts. However, the default position will sometimes still have its place.

By stating *"The joint statement is an important document. It ought to be possible to read it and understand the key issues and each expert's position on those issues"* in my view Yip J is also making the point that the agenda should be drafted in a way that means that the joint statement derived from it encapsulates the key issues in the case. Any person should be able to read it in 15 minutes and understand the case, or at least the case relevant to that discipline of expert. This takes some time, thought and careful drafting. If the Defendant turns your carefully crafted, clear and succinct agenda which will help the judge, into a lengthy dog's dinner which will only confuse them, then the default position of two agendas remains the appropriate one.

In respect of Yip J's final comment of the risk of costs consequences if a party does not act appropriately in preparing an agenda, this was considered previously in the case of **Cara v Ignotus**, a case management decision by Master Yoxall on 7th October 2015 (reported on Lawtel) in which the Master did impose a costs sanction over an agenda.

In that case the Defendant asserted that the Claimant's proposed agenda contravened para 9.3 of the practice direction to CPR 35 which states *"The agenda must not be in a form of leading questions or hostile in tone."* Master Yoxall agreed with the Defendant that the questions were in contravention of the practice direction and awarded costs of the application against the Claimant. This illustrates the principle that an agenda should be drafted in a neutral manner and a partisan one will be sanctioned.

So, what should we take away from these recent judgments?

I suggest –

1. Keep the agenda simple. Ensure it covers the key issues in the case, not peripheral ones. This means 10 questions, not 50.
2. Try to keep the wording balanced, neutral and objective – covering the points both parties need to be addressed and anticipating objections from the Defendant. This means it will not simply be a list asking the experts to agree all of your best points – that is the job of your closing submission at trial.
3. Ask the Defendant, if they cannot agree it, to make as few amendments as possible - the fewer the amendments, the more likely one agenda can be agreed.
4. Also invite them, if they cannot agree it, to propose extra questions rather than changes to existing questions – these can be added to the end of yours, effectively maintaining one agenda but avoiding the effectiveness of yours being reduced.
5. Cooperate … Be reasonable and cooperate with the Defendant as much as you can. Demonstrate this in correspondence by offering concessions. Justify any objection you have to any proposed questions. You may need to refer to this on costs later.
6. … But don't capitulate. Don't feel you have to agree at all costs, especially if it means replacing your carefully crafted ten questions which will explain the case perfectly to the trial judge (and anyone else who cares to read it) with a dog's dinner which leaves the reader more confused about the case than enlightened. If you need to, don't be afraid to revert to the default position anticipated by the standard direction – the meeting proceeds with the experts addressing both agendas, but be ready to explain it to the trial judge and the costs judge.
7. Don't delay – the directions don't give you much time to draft and seek to agree the agenda. In addition, if you want your expert to do a decent job, the least you can do is send it to them in good time for the meeting.
8. Have a telecon with your expert the day before the joint meeting – this ensures that an otherwise poorly prepared expert has got the papers, has read them and is up to speed on the issues to be covered in the meeting, which is possibly the most crucial part of any case.
9. Don't interfere – once the experts start their discussion (by telephone or email exchange) leave them to it. Politely decline any invitations to "approve" a draft statement.

Dr Simon Fox QC

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Special Educational Needs Law – Considerations for other professionals

VICTORIA FEDERICO
SOLICITOR & HEAD OF EDUCATION LAW
ACCESS LEGAL SOLICITORS

As specialists working for people affected by medical accidents, you may be acting for children and young people who have suffered birth and brain injuries, resulting in varying degrees of disabilities. These children and young people will, in all likelihood, require assistance with their educational needs, from primary schooling all the way through to college and further education.

The EHCP regime

This assistance can include specialist therapies, equipment and sometimes a change in their school or college placement. Many of the children and young people affected will need the additional help they receive to be detailed within an Education, Health and Care Plan (EHCP).

EHCP: a powerful tool only when the content is right

This assessment and the plan itself will be specific for each child or young person. EHCPs cover the age range from birth up to 25 years and there is a real focus on the views and wishes of the children or young person and their family to be taken into account by Local Authority Special Educational Needs Departments when drawing up EHCPs. An EHCP is a powerful tool, but it is only effective if it specifies and quantifies exactly what support a child needs.

As EHCPs are legal documents it is crucially important that the content is right, and all the required support is detailed within them. EHCPs are outcomes focused and the outcomes are listed in Section E. An outcome is described as being the 'benefit or difference made to an individual as a result of an intervention'. Section E must contain outcomes that are focused on preparing the child or young person for their adulthood, and whatever that will look like for them. The provision and additional support is then tailored to help them achieve the outcomes. Outcomes must be SMART and person centered for the particular individual, so not taken from a generic list a Local Authority holds for children with certain diagnoses or disabilities.

The majority of EHCPs that we review for clients who have had no specialist advice are woefully inadequate and unlawful. The impact of this is that the children and young people are not receiving the vital therapies and provision they require, and are often placed in the incorrect school or college.

The provision and support that a child or young person requires within school or college must be very clearly detailed, 'specified and quantified' in order to be legally enforceable and for the correct level of funding to be provided by the Local Authorities. Families often rely on the professional reports and recommendations made by experts instructed through their accident or negligence claim, but it is important to recognise the difference in detail required for the Special Educational Needs Tribunal. There are, of course, also issues of disclosure and so often for the education work supplementary or shortened versions of the reports are used specifically relating to EHCPs and educational provision. Whilst some of the experts instructed may be the same within both fields, what is required of them and the format of their reports is likely to differ.

If special educational provision within an EHCP is withdrawn by a Local Authority, or not provided for any reason then it is possible to judicially review the Local Authority. This is only possible if there is no ambiguity within Section F of the EHCP about the provision that must be arranged and funded. An example of this is for a child who has written into Section F of their EHCP that they *"must be provided with occupational therapy, direct from a qualified occupational therapist for a minimum of 30 minutes per day"*.

There are problems with EHCPs not being specific enough, and with the provision being included within the wrong sections of the EHCP. Section F is for special educational provision, and this must include all provision that 'educates or trains' the child or young person. There is guidance and established case law that this includes speech and language therapy for example. However, we still see Local Authorities detailing this therapy in Section

G, health care provision. They may do this because the therapy is provided by an NHS employed speech and language therapist. This is incorrect, as it is the benefit and difference it makes to the child or young person, and not the funder or employer, that determines which section within an EHCP provision is included. Legally, provision in Section G is not as easy to enforce as provision included in Section F and this can cause difficulties if provision is removed or reduced, without notice or an amendment being made to the EHCP.

EHCPs must be reviewed at least every 12 months. The school, parents/carers, child or young person, Local Authority representative and any relevant other professionals should be invited to attend and contribute to this review. This is a good opportunity to request any amendments to the EHCP, if the content is no longer sufficiently clear or if the child/young person's needs have changed. The Local Authority makes a decision following the review about whether or not any amendments to the EHCP will be made. If no amendments are made,but were requested then an appeal to the Special Educational Needs and Disability Tribunal may be pursued. If amendments are to be made then an amended draft EHCP will be issued and comments invited. If parents are not happy with the final amended EHCP then they will also have a right of appeal to the Special Educational Needs and Disability Tribunal.

Expert advice is essential to obtain or challenge provision

Parents, and young people themselves can challenge the content of an EHCP, and this is done by appealing to the Special Educational Needs and Disability Tribunal. There is a requirement for mediation to, at least, be considered before any appeal is lodged.

Appeals are a relatively complex and paperwork heavy process, with many parents and young people opting to receive legally based advice and assistance rather than tackle it on their own. Local Authorities will often instruct solicitors and barristers to represent them in these appeals.

The strength of any appeal and the prospects of success are determined by the evidence available and how it is presented to the Tribunal and Local Authority, as respondent to the appeal. Seeking expert advice, ideally before lodging an appeal is going to give the case the best prospects of success.

A complex and niche area of law

We recently dealt with a tribunal appeal for **Oscar Gerring,** whose parents spent months trying to obtain an EHCP specifying a specialist school that would better meet their son's needs. The Local Authority insisted that Oscar's identified special educational needs could be met at his local primary school. It was clear however that the school was inappropriate.

School staff did not have any knowledge of Autism Spectrum Disorders (ASD) such as Oscar had and the youngster was subject to sustained and persistent bullying, to the point where he threatened and attempted to self-harm so he could be admitted to hospital rather than go to school.

His anxious parents faced a fight with an unsympathetic and needlessly obstructive local authority. When that draft plan did arrive it was woefully inadequate and there was no alternative but to go to the Special Educational Needs and Disability (SEND) Tribunal.

The Appeal to the SEND Tribunal was ultimately successful, but only because expert advice, evidence and opinion was obtained to support the case. Some of that was in the form of legal advice, but marshalling advice and opinion from relevant experts was also crucial.

Adding value and improving lives in medical negligence cases

Having that specialist advice to hand makes this process much easier for the family involved, and other professionals working with and supporting them. The advice and input of a special educational needs solicitor can distinctly add to the value of a medical negligence or personal injury claim.

If education law advice is sought as part of a clinical negligence claim then the legal fees can be included in the schedule and claimed. This benefits our clients as they do not have to privately fund the specialist education law advice and their child or young person benefits from the vital and much needed provision. This advice is likely to be needed at several stages during a child's education, particularly when moving from one school to another, if the nature of their needs changes or develops and if a Local Authority considers education and/or the support is no longer required and looks to take away the EHCP. It is important for these possibilities to be considered and for education law fees for this to be included in the schedules, which will require collaboration between the clinical negligence and education solicitors.

Our education law team extended and amplified the support we were able to give to **James Robshaw**. This bright young boy suffered severe birth injuries after a failure by medical staff to properly monitor his mother

during labour led to James being born with severe cerebral palsy.

James was awarded £14.5m in damages, one of the largest court-ordered awards for compensation for birth injury at that time, which reflected his complex and high level of need which will continue for the rest of his life. A key and ongoing element of our support for James and his family is ensuring that he has all his special educational needs met for as long as is required.

Similarly **Holly Greenhow**, who suffers from severe choreoathetoid cerebral palsy following an avoidable period of profound hypoxia during her birth had a settlement with a capitalised value of almost £15.6m recently approved at the Royal Courts of Justice.

Our team were called upon to secure Holly's entire educational needs, from appealing her original Statement and ensuring she had an adequately proscribed and funded EHCP to managing her transition to secondary school and beyond to college if required. It was also crucial that her needs could be met at schools near to her family home, without Holly having to go away to board or the family move to another part of the country to secure suitable education.

For more information on this area and the work that we do and how that might enhance your service to clients, please visit our website **here**.

Book Review: A practical guide to wrongful conception, wrongful birth and wrongful life claims

AUTHOR: REBECCA GREENSTREET, HARDWICKE

"A practical guide to wrongful conception, wrongful birth and wrongful life claims" is more than a practical guide, it is a must have, go-to book for any practitioner undertaking this type of claim.

This book focuses on the medico-legal issues arising in wrongful conception, wrongful birth and wrongful life claims and gives an informative overview and analysis of the law in relation to these claims. It provides an in-depth detailed knowledge of the key judgements, McKay v Essex Area Health Authority (1982), McFarlane v Tayside Health Board (2000), Parkinson v St James and Seacroft University Hospital NHS Trust (2001) and Rees v Darlington Memorial Hospital NHS Trust (2004). Each of these cases is examined in detail in separate chapters including the judgement decisions from the House of Lords and Court of Appeal and there is a very useful analytical summary by the author at the end of each chapter.

There is an interesting chapter on the way such claims have been treated in foreign jurisdictions and chapters on quantum and whether the principles laid down by the key cases ought to be revisited by the Supreme Court.

The book is well written, gives an insightful analysis and is an interesting read. It should be suitable for both junior and senior solicitors wishing to become familiar with the case law, and recent developments where the established case law may be challenged.

Reviewed by:

Moira Gwilliam, AvMA Senior Medico-Legal Advisor

FORTHCOMING CONFERENCES

Experts and Lawyers – Working Better Together

23 January 2019 (evening), Irwin Mitchell, Leeds;

13 February (evening), St John's Chambers, Bristol

Lawyers and experts are on the same team – lawyers need to learn to instruct properly; experts need to report in a focused and timely manner. This forum will provide lawyers and experts with shared essential learning and an important opportunity to network together and discuss issues and concerns to result in working together more effectively. Leading medical experts will give a fascinating insight into experiences that they have come across in their medico-legal practices and work with lawyers, before a panel of experts discuss and take questions on the key issues and best practice surrounding medical experts and lawyers working together. It is intended to be an informal, interactive evening, where the views of lawyers and experts are encouraged and welcomed. There will also be an opportunity to continue conversations over drinks immediately after the seminar.

AvMA Specialist Clinical Negligence Panel Meeting & Christmas Drinks Reception

30 November 2018, America Square Conference Centre, London

The annual meeting for AvMA Specialist Clinical Negligence Panel members provides the opportunity to meet, network and discuss the latest key developments and issues facing clinical negligence law. This year's meeting will take place on the afternoon of Friday 30th November - registration and a networking lunch will commence at 12.30, with the meeting starting at 13.30 and closing at 17.10. AvMA's Christmas Drinks Reception, which is also open to non-panel members, will take place immediately after the meeting, also at America Square. The event provides an excellent opportunity to catch up with friends, contacts and colleagues for some festive cheer!

Medico-Legal Issues in Diabetes

11 December 2018, Irwin Mitchell, London

Many people with diabetes have multiple and complex health problems and, with this significant risk in mind, the potential delay or missed diagnosis of the patient can have serious consequences. This conference looks at the condition in detail, with top medical experts covering endocrinology and diabetes, diabetes in general practice, cardiac complications, peripheral vascular disease, diabetic eye disease and diabetes in pregnancy, and there will also be the view from a solicitor and counsel on how to run a case arising from negligent management of diabetes.

Clinical Negligence: Law Practice & Procedure

31 January - 1 February 2019, 3 Paper Buildings, Birmingham

This is the course for those who are new to the specialist field of clinical negligence. The event is especially suitable for trainee and newly qualified solicitors, paralegals, legal executives and medico-legal advisors, and will provide the fundamental knowledge necessary to develop a career in clinical negligence. Expert speakers with a wealth of experience will cover all stages of the investigative and litigation process relating to clinical negligence claims from the claimants' perspective.

Alternative Dispute Resolution – Effective Use & The Way Forward

27 February 2019, Exchange Chambers, Manchester

In AvMA's experience, most people do not want to take legal action if they can avoid it. Many feel forced to take legal action because of a lack of openness and honesty; to hold people to account; or because they believe that it is the only way available to get the compensation they need and deserve. Increasingly, people are looking for alternatives to litigation and AvMA are interested in any suitable alternatives to litigation that are fair to the injured party and less stressful and expensive for everyone involved. The excellent line up of speakers will help you assess the alternatives to litigation which could reduce cost, stress and time, and, in some cases, save reputations.

Medico-Legal Issues in Accident & Emergency Care

6 March 2019, Fieldfisher, London

Emergency Care Services are facing intense pressures to sustain its urgent and emergency care system. With the changing NHS climate there is a vital need to continually monitor these services and ensure high quality care remains consistent throughout the NHS. This conference will examine the current standards, issues, roles and responsibilities, investigations and management of key areas in accident and emergency care.

31st Annual Clinical Negligence Conference

28-29 June 2019, Royal Armouries Museum, Leeds

Join us in Leeds for the 31st ACNC! This is the annual event that brings the clinical negligence community together to learn and discuss the latest developments, policies and strategies in clinical negligence and medical law. Early bird booking will open in early 2019 and the conference programme will be available in March. Sponsorship and exhibition packages are now available.

For further details of our events:

www.avma.org.uk/events Tel 020 3096 1140 e-mail conferences@avma.org.uk

WEBINARS

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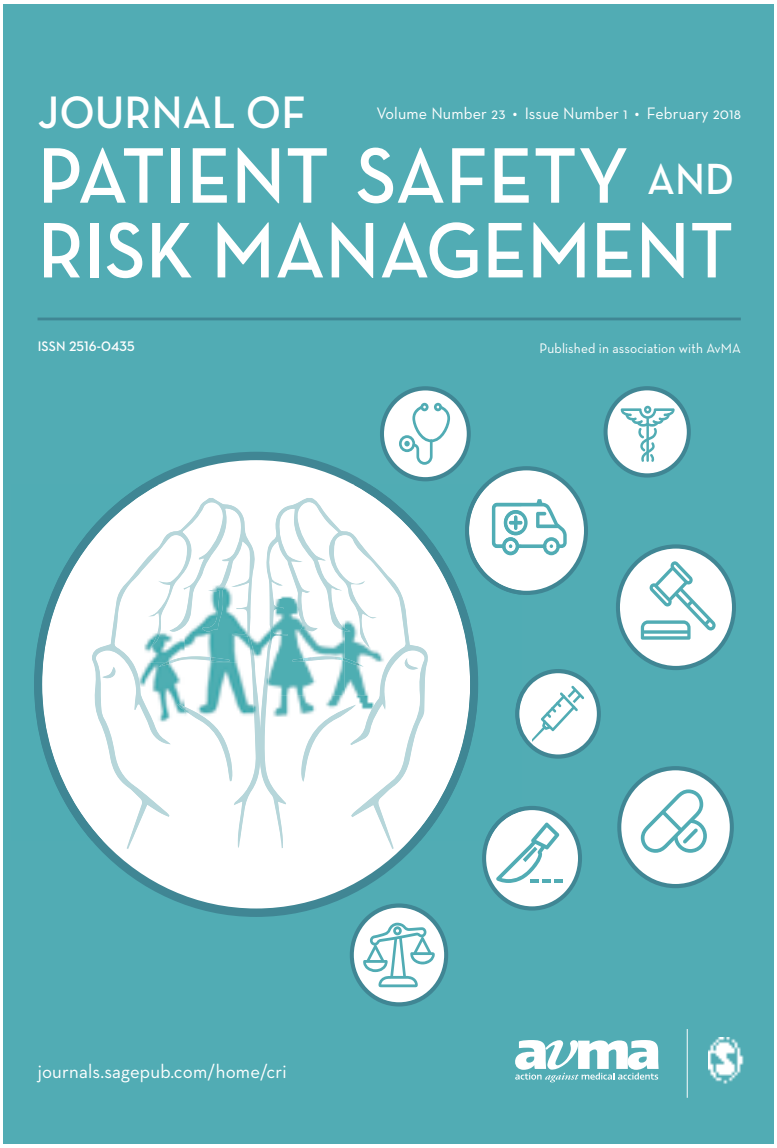
Journal of Patient Safety and Risk Management has relaunched for the 2018 volume with a refocused aims & scope and journal vision, and a redesigned cover. Professor Albert Wu, of Johns Hopkins University in Baltimore, USA, joins as the new journal Editor-in-Chief, with an Editorial Board made up of industry experts in the fields of patient safety, risk management and medico-legal issues.

The journal, published in association with AvMA, will publish research papers, case reports and reviews on topics including innovative ideas and interventions, strategies, and policies for improving safety in health care, as well as new measures, methods, and tools. It will also publish commentaries on patient safety issues from patients, practitioners, health care leaders, educators, researchers, and policy makers both in the UK and worldwide.

AvMA members can benefit from discount of over 50% when subscribing to the Journal, with an institutional print and online subscription at £227.10 (+ VAT), and a combined individual print and online subscription at £177.22 (+ VAT).

If you would like more information about the journal, or are interested in subscribing, please contact Sophie North, Publishing Editor on Sophie.North@sagepub.co.uk



THE EASIEST AND MOST RELIABLE WAY TO FIND SERVICE PROVIDERS SUPPORTING CLINICAL NEGLIGENCE SOLICITORS

The AvMA Lawyers' Service Directory provides listings of key service providers geared to the clinical negligence solicitor, including:

- Costs consultants
- Disability property specialists
- Rehabilitation consultants
- Nursing experts
- Counselling
- Mediators
- Court of Protection deputyship and personal injury trusts
- Medical records pagination, collation and review
- Investment managers

AvMA Lawyers' Service members can access the listings for free at

www.avma.org.uk/directory

avma
action *against* medical accidents