action against medical accidents

LAWYERS SERVICE NEWSLETTER

MARCH 2016

EDITORIAL

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We had fully expected that by this stage we would be discussing the details of the Fixed Recoverable Costs Consultation. In fact, it has been put back yet again, the most recent indication suggests that the consultation will be published around Easter time although there is still no firm date. We understand that the consultation period will be 6 weeks and that the government remains committed to rolling out the changes in October 2016. The consultation on non-recoverability of ATE premiums is expected to be published around the same time.

There can be little doubt that the two consultations have huge potential implications for access to justice and patient safety. One of the difficulties is that we still don't have any concrete information on how the proposed regime will work and in particular the level of remuneration likely to be paid. This is especially true of claims with a value of £25,000 or less and as a result it is very difficult to anticipate the likely effect of the reforms on clinical negligence claims, particularly the low value claims. The detail will not become apparent until such time as we have had the opportunity to consider both proposals and consult on it in a meaningful way.

In the meantime, there have been a number of portents, not least from Jackson LJ. On the 28th January he gave the IPA Annual Lecture, a presentation entitled "Fixed Costs – The Time has Come" in which he said that "***Remuneration on a time basis rewards inefficiency***". He also stated that ***"it would be illogical to fix the costs of clinical negligence claims in the multi-track (as the Government is now proposing) without sorting out the fast track at the same time".*** He went on to justify this stance on the basis that there is enough experience ***"…to devise a coherent scheme of fixed costs for the whole of the fast track and for the lower reaches of the multi-track".***

Jackson LJ also maintained that there was ***"a shift of political and judicial opinion. The view that we should move towards fixed costs is steadily gaining ground... there is overwhelming support for fixed costs both in the fast track and in the lower value multi-track cases. This would save time and costs. I have not heard a voice which dissents from this view."***

However, Master Cook (the senior clinical negligence Master at the High Court)

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whilst not directly opposing the introduction of fixed recoverable costs, does appear to be taking a more cautious approach. On 18th February he addressed an audience of clinical negligence lawyers at the 7 Bedford Row, Skeleton lectures on the issue of **"Costs Budgeting v Fixed Costs"** saying: "***research is essential in order to properly understand the impact on access to justice of the existing system of funding before implementing any further changes"***.

Master Cook made a number of other pertinent observations including:

- The rise in the number of litigants in person appearing in clinical negligence cases; he indicated that this fact alone raises questions about current access to effective legal advice.
- The increase in the number of non-specialist firms moving in to clinical negligence work.
- That the drivers of clinical negligence costs not referred in the NHSLA annual report 2015 include the failure to provide prompt disclosure and respond adequately to pre-action protocol letters.
- That Jackson LJ's costs grid (set out in the IPA Annual Lecture) did not enable the work necessary to prove breach of duty and causation to be done.
- The fact that claims worth between £50 - £100,000 are not low value claims.

He does perhaps express some tacit support for fixing costs up to a threshold of £50,000 saying: "***in my view before extending fixed costs beyond £50,000 the working of the current costs regime should be reviewed and its effects should be subject to proper scrutiny and research which should then inform any further development of the fixed costs regime".***

Some of what Master Cook has said echoes concerns previously expressed by AvMA. In our response to the pre-consultation exercise and our briefing document (October 2015), we identified that consideration needed to be given to the potential to save costs by improving defendant behaviour. That the proposals were premature as no assessment had been made of the effect of the Legal Aid Sentencing and Punishment of Offenders Act or whether the proposals are necessary or justified.

AvMA continues to work with the Law Society, Society of Clinical Injury Lawyers and Association of Personal Injury Lawyers. Together, we met with Ben Gummer in an attempt to try and persuade the Department of Health to engage in an inclusive discussion about making clinical negligence litigation more efficient and less costly. There are some key members of parliament who support our concerns.

As part of this initiative, AvMA arranged to meet with the NHS LA on 16th March to identify whether there was any merit in revisiting the 2013 NHS LA Low Value Scheme**.** SCIL, the Law Society and APIL also attended the meeting, in conclusion we have all agreed to explore whether there is a mutu-

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ally acceptable, alternative way to resolve clinical negligence claims. Parties recognise that any alternative to the current litigation procedures must offer a system that: works well for patients, ensures effective learning from claims, provides access to justice at reasonable cost and quick, effective and high quality advice.

AvMA is keen to ensure access to justice and to use the discussion on FRC as an opportunity to push for improved patient safety. We, along with many other claimant lawyers, strongly believe that more needs to be done to stem the flow of clinical negligence claims and the associated costs. This means addressing the root cause of the problems that give rise to negligence in the first place. AvMA believes that the consultation offers an opportunity to explore how parties can harness the learning that comes from litigation.

AvMA is also pulling together a coalition of patient groups. Many of these groups have acted as signatories to a letter to Jeremy Hunt and Ben Gummer asking for the consultation to be delayed until such time as there has been a thorough review of the factors that give rise to high costs in clinical negligence claims.

Turning to more practical matters, there is some good news for claimants in the common sense decision given by the Supreme Court in the recent case of ***Knauer v Ministry of Justice***. As a result, all Fatal Accident Act claims which include a claim for damages for future income and services are to be assessed from the date of trial rather than at the date of death. I am pleased to recommend Sebastian Naughton (barrister at Serjeants' Inn Chambers) article: "Knauer: Multipliers in Fatal Accidents Act 1976 Claims" which can be found in this copy of the Newsletter.

There have been a couple of recent cases on causation in clinical negligence and I am grateful to John De Bono QC, (Serjeants' Inn Chambers) for his contribution to the Newsletter on the Privy Council case of ***Williams v Bermuda***. This is an interesting case as the Privy Council rejected an argument that the decision in Bailey v MOD was wrong.

The issue of consent remains as lively as ever. James Counsell of Outer Temple has prepared an interesting article which looks closely at the case of ***Jones v Royal Devon & Exeter NHS Foundation Trust***; James represented the claimant at trial. The case is a good illustration of the importance placed on the information provided to the patient at the outset as well as the ongoing duty to keep the patient informed not just about the nature of the operation and its risks but also the identity of the surgeon to carry out the procedure.

Alison Johnson, Senior Associate and Emma Beeson solicitor both at Pennington Manches LLP have provided helpful articles. "Loss of earnings claims: what a child "could have been"" Alison takes a closer look at the difficulties in assessing post injury earning capacity for an infant or child. Emma has written about her experience of how healthcare providers are apparently failing to appreciate the early

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warning signs of latent miliary TB and the effect that delays in treating this condition has on patients.

Dr. Charlotte Connor a caseworker in AvMA's Medico Legal Team worked with Frances McClenaghan barrister at Serjeants' Inn to provide representation to the Calvo family through AvMA's pro bono inquest service. The inquest into the death of their infant daughter, Amelia, concluded in the week commencing 7th March. This was a difficult case, involving the birth of twins both of whom had a congenital, life limiting condition. The coroner issued a Prevention Future Death Report in relation to issues concerning the different grading of airways by neonatologist and anaesthetists as well as writing a letter under Paragraph 37 of 'Guidance sheet no. 5 Reports to Prevent Future Deaths'. Paragraph 37 enabled the coroner to write a letter to the CEO of the trust expressing concern about a number of points, including the insensitive way the trust's High Level Investigation report had been phrased. Full details of the case have been written up by both Charlotte and Frances.

From time to time, we are asked to review books and I have no hesitation in recommending the 2nd Edition of Giles Eyre and Lynden Alexander's book **"Writing Medico-Legal Reports in Civil Claims An Essential Guide".** Given the emphasis on proportionality and the much anticipated and highly likely introduction of fixed recoverable costs it is now more important than ever for lawyers instruct their medico-legal experts properly. It is equally important that experts comply with their instructions and that they understand their role and duty to the court. This book sets out in a clear, concise and user friendly way what lawyers and experts should expect of each other; a full review is included in the Newsletter.

We are always pleased to receive any articles you would like to be considered for the Newsletter. If would like to make a contribution then please email your article to norika@avma.org.uk for consideration. The next Newsletter will be published in June just before the Annual Conference.

Kind regards

Lisa O'Dwyer
Director Medico-Legal Services

PETER WALSH, CHIEF EXECUTIVE, AVMA

Patient safety initiatives announced by Jeremy Hunt

On 9th March Secretary of State Jeremy Hunt announced three new initiatives regarding patient safety: The Healthcare Safety Investigation Branch (to be part of NHS Improvement later this year), to carry out around thirty 'no-blame' theme based investigations a year The introduction of Medical Examiners to investigate causes of unexpected hospital deaths and patient safety lessons from them A "Learning from Mistakes" league table of NHS trusts drawing on data from the staff survey and rates of reporting incidents AvMA welcomes the commitment to introduce a system of Medical Examiners from 2018. This is something that was recommended from the Shipman Inquiry and again by the Mid Staffordshire Inquiry and the Morecambe Bay investigation. Pilots of medical examiners have shown promising results in identifying causes of avoidable deaths and identifying patient safety issues. The 'Learning from Mistakes League Table' is more controversial. It may provide an extra incentive for poorly performing trusts to improve, but the effectiveness of league tables to drive improvement is questionable and some would say counter-productive. The new Healthcare Safety Investigation Branch (HSIB) is to be welcomed, but many will be disappointed with its limited remit and capacity. It is only expected to conduct around thirty theme based investigations a year, so will do very little to address the widely acknowledged problem with the quality of local NHS investigations of serious incidents, of which there are about 10,000 a year. Controversially, Mr Hunt announced that as well as being focussed on learning for patient safety rather than apportioning blame, his intention is that there would be legal protection of some information gleaned from investigations – even going as far as patients/families having to get a court order if they wanted to use such information in a legal case. Mr Hunt went on to say he was considering adopting a similar approach for all safety investigations – not just those carried out by HSIB. AvMA fully supports staff taking part in investigations being supported and treated fairly and these investigations should not seek to apportion blame. There is also a sound case for some information being kept confidential. However AvMA and others believe it is inappropriate to place any restriction on the ability of patients/their family's ability to access and use information about their own treatment in the way they see fit. Mr Hunt's remarks came before he had had the opportunity to hear the advice from the expert group he established to advise him on how HSIB should work and which is expected to advise that not only should there be full disclosure of information about the patient's treatment to the patient or their family, but that there should be no restriction on how they access or use that information.

Maternity Review proposed 'rapid resolution and redress scheme' must not short change brain-damaged

AvMA broadly welcomes the Maternity Review published in February 2016 but is warning that the proposed 'rapid resolution and redress' scheme (a form of 'no fault' compensation) should not short-change brain-damaged children and their families and calls for robust safeguards. AvMA believes

PETER WALSH, CHIEF EXECUTIVE, AVMA

that a well-run scheme would be in everyone's interests – a scheme that is proactive in identifying when treatment has caused avoidable harm and offering full and prompt compensation and care packages without forcing families to take legal action. However, the report proposes limiting compensation to a predetermined 'capped amount', regardless of the child's actual needs. This would deprive children who have been brain damaged by sub-standard treatment of the compensation and support they need and deserve. Families need fair compensation to pay for expensive services and equipment that their children need to cope with the injuries caused. The situation would be made even worse if families were compelled to access only services which were on offer from the NHS or local authorities. This would leave brain-damaged children with no choice or security over the services they will continue to need for the rest of their lives. Access to such services is subject to policy and priority changes in the NHS and in each local authority. Unlike Sweden, on whose scheme the Maternity Review proposal is mainly based, England does not have the social security system or services that can cope with the complex needs of these children or guarantee continuity. AvMA is calling for any such scheme to meet the following standards: It must be sufficiently independent and expert enough to be able to investigate and determine whether cases meet the criteria for compensation. It should ward compensation based on actual needs rather than a 'capped' amount It must guarantee ongoing access to the services that the child needs, be that from the state or private providers The family has to have access to specialist advice to empower them in the investigation and determination of their case It is also imperative that families retain their civil right to resort to legal action if they need to (and we are pleased that the Review agrees on this point) AvMA Chief Executive Peter Walsh said: "The proposed rapid resolution and redress scheme does have a lot of positive potential but must be considered with extreme caution. Whilst no doubt well intended, it could end up depriving children damaged as a result of NHS negligence of the compensation and services they need and deserve. To be fit for purpose, such a scheme must be able to guarantee that children will get compensation and services based on needs – not just what suits the state. This was agreed with regard to the 'no fault compensation' proposals in Scotland. Why should children in England deserve any less? "If the scheme is designed properly and operates fairly it would be in everyone's best interests. We hope the Department of Health and NHS England will work closely with AvMA and other stakeholders to ensure any scheme that does emerge is fair and fit for purpose.

SERJEANTS' INN CHAMBERS

Knauer: Multipliers and Fatal Accidents Act 1976 claims

Summary:

All future loss multipliers are now to be calculated from the date of trial, NOT from the date of death. The (dormant) actuarially recommended approach contained in the 7th Edition of the Ogden Tables (see paragraph 64 onwards of the explanatory notes) are ready for use and should be applied.

All FAA claims should therefore be re-pleaded.

1. On **28 January 2016**, over the course of just 2 hours, the Supreme Court (constituted of no less than seven Justices of the Supreme Court) heard the appeal in the case of **Knauer v Ministry of Justice**[1], the judge of first instance, Bean J, having granted to the Claimant permission to appeal directly to the Supreme Court upon the simple issue of **whether damages for future income and services dependency under the Fatal Accidents Act 1976 ("the FAA") should be assessed at the date of trial, rather than at the date of death**. They have on 24 February 2016 handed down their Judgment, and have unanimously allowed the appeal. In anticipation of this appeal, the editors of Kemp & Kemp have breathlessly pointed out that **Knauer** represents "the first time in a generation that the issue of fatal accident multipliers is being reviewed at this judicial level … this may well shape the approach on this issue for the next generation". The stars were finally aligned in **Knauer** with (i) a Tribunal willing to leapfrog an appeal to the Supreme Court (Bean J), and (ii) a Claimant and a legal team with an appetite for an appeal.

Background: the "conventional approach"

2. In **Cookson v Knowles [1979] A.C. 556**, the House of Lords determined that unlike in personal injury claims, the fatal accident multiplier should be calculated at the date of death. This is because the deceased's life expectancy can only reasonably be set at the date the Claimant died. As Lord Fraser put it:

> "… in a fatal accident case … everything that might have happened to the deceased after that date remains uncertain."

[1] [2014] EWHC 2553 (QB)

3. The loss of dependency leading up to trial has always been treated as special damages. However for the future loss multiplier, the conventional approach requires the multiplier to be taken from the date of death. The period which has elapsed between the date of death and the date of trial is then subtracted from that multiplier to provide the future loss multiplier. This has the practical effect of applying the multiplier which has been discounted to take account of future contingencies, to the past loss.

4. Interest is payable on the past loss only, and not upon the future loss. The theory for this has never been easy to understand if the basis for damages are supposed to have crystallised at the point of death. The conventional approach was further endorsed by the House of Lords in **Graham v Dodds [1983] 1 WLR 808**.

What's wrong with the conventional approach?

5. The conventional approach has been widely criticised. Were the FAA award to be made at the point of death there would be no disadvantage to a Claimant, but since that is not possible every Claimant has their damages reduced as a consequence of the discount being applied to the past loss. The longer the delay, the greater the prejudice. In **Knauer** at first instance, Bean J described the conventional approach as "illogical" (§16) for this reason.

6. The Law Commission in its report on Claims for Wrongful Death (Law Comm. Number 263) recommended that in order to deal with the problem, a multiplier which has been discounted for the early receipt of damages should only be used in the calculation of post-trial losses. The Government Actuary's Department under the chairmanship of Sir Michael Ogden QC agreed.

7. The disadvantage is particularly obvious in cases concerning dependent children who have a limited period of dependency.

Illustration

8. The prejudice is neatly illustrated by case of **Corbett v Barking HA [1991] 2 QB 408**; a dependant boy was aged two weeks, when his mother, the deceased, died at the age of 29.

9. The action took place 11 years and six months after the date of death. The trial judge held

that the boy would have been dependent on his mother until the age of 18, and that the multiplier to be adopted was 12 years from the date of death.

10. Under the conventional approach (which the Judge applied), the boy would receive just six months future dependency, even though he would have been dependent for a further 6.5 years.

11. The Court of Appeal increased the multiplier to 15, on the grounds that there was discretion to vary the multiplier, and since it had become a "known fact" that the son had survived to trial and remained dependent at that point, and that "some account must be taken" of these facts to adjust the multiplier upwards, but this still meant that the future multiplier for the 11 ½ year old boy would be 3.5 years, rather than 6.5 which was the actual period of dependency. The Court of Appeal's approach of gentle uplift to the multiplier was something of a fudge and in any event, not a satisfactory way to cure the prejudice caused by the conventional approach; a term certain multiplier from the date of trial for a 6.5 year period would be about 6, which is much closer to the actual period of dependency, and therefore much fairer.

12. One way to mitigate that unfairness might be to award interest upon the whole of the sum awarded. That approach is not permitted under the conventional approach, however; see **Cookson**, and **Spittle v Bunney [1988] 1 WLR 847** where the argument was attempted.

13. There have been two significant challenges to the conventional approach; before Nelson J in **White v ESAB Group (UK) Ltd** (unreported), and the Court of Appeal in **Fletcher v A Train & Sons Ltd [2008] EWCA Civ 413**. In both cases, the Courts considered themselves bound by **Cookson**.

Knauer

14. There is nothing remarkable about the case; Mrs Knauer was a prison officer who died of mesothelioma in 2009 after exposure to asbestos at Guy's Marsh Prison in Dorset. Using the conventional approach reduced the overall value of the Claimant's claim by around £50,000 (about 10%).

15. In summary, the Supreme Court have concluded that:

    a. the conventional approach came from a different era, and was now outdated and

unscientific (§12);

b. when Lord Fraser said that "all that remained after death was uncertain", he was thinking about the vicissitudes of life, rather than accelerated receipt (§14);

c. now that we have the Ogden Tables, which did not exist when **Cookson** or **Graham** were decided, and because these should always be used as a starting point from which a judge should be slow to depart (as confirmed in **Wells v Wells [1999] 1 AC 345)** the landscape had changed and there was an overwhelming case for changing the law (§16, 23);

d. there were no good reasons for not altering the law. **Cookson** and **Graham** are no longer to be followed; the correct date at which to assess the multiplier when fixing damages for future loss in claims under the FAA should be the date of trial, and not the date of death.

What now?

16. The Ogden Party guidance is set out at §64 onwards of the Guidance Notes to the Ogden Tables. It is ready for use.

17. In summary this:

a. recommends using multipliers from the date of trial and provides guidance and worked examples to illustrate how this can be done;

b. suggests that pre-trial damages may be discounted to reflect the likelihood that the deceased would not have survived to provide the dependency to the date of trial (see Table E; note that the reduction to pre-trial damages is modest) (see §67-70);

c. suggests that damages from the date of trial to retirement may be treated as a term certain and then adjusted for contingencies other than mortality (Table F) and potentially the risk of mortality of the deceased (§70-75).

How might this affect your cases?

18. All FAA claims will be worth more now. The longer the delay between the date of death and the date of trial, the higher the value of the claim. This is likely to affect in particular cases in which there are young dependent children. Our analysis suggests that the increase in overall value of FAA cases is likely to be between 5-25%; see appendix for some worked example illustrations.

19. All existing FAA claims should therefore be re-pleaded where they do not adopt the actuarial approach from the Ogden Tables, which have now been given the green light by the Supreme Court.

20. Part 36 Offers in FAA claims should be reviewed; these may (under the current Part 36 Provisions) be varied and increased (CPR 36.9(1)), although an increased offer is treated for the purposes of Part 36 as a new offer (CPR 36.9(5)(a)).

SEBASTIAN NAUGHTON

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25TH FEBRUARY 2016

APPENDIX

Some basic illustrations

Facts	Conventional Approach	New Approach
Dependent child, aged 10 at date of death, aged 15 at date of trial. Financially dependent until the age of 25 on deceased father, aged 50. Multiplicand of £20,000.	Past loss (5 x £20,000) = £100,000 Multiplier from date of death period 15 years, thus 12.5 (table 28) Future loss multiplier 7.5 (12.5 – 5) 7.5 x £20,000 = £150,000 Total: £250,000	Past loss (5 x £20,000), but adjust multiplier by Table E risk of mortality before trial (0.99) 4.95 x £20,000 = £99,000 Multiplier from date of trial period 10 years, thus 8.86 (table 28), adjusted by Table F (post trial damages adjustment due to mortality before trial) 0.97, thus 8.6 Future loss 8.6 x £20,000 = £172,000 Total: £271,000 (8 % increase)
Dependent child, aged 2 at date of death, aged 15 at date of trial. Financially dependent until the age of 25 on deceased mother, aged 40. Multiplicand of £20,000	Past loss (13 x £20,000) = £260,000 Multiplier from date of death period 23 years thus 17.5 (table 28) Future loss multiplier 4.5 (17.5 – 13) 4.5 x £20,000 = £90,000	Past loss (13 adjusted to 12.74 (Table E) x £20,000) = £254,800 Multiplier from date of trial period 8.86 adjusted to 8.77 (Table F) 8.77 x £20,000 = £175,400 Total: £430,200 (23% increase)
(§83 – this example is from Ogden Tables guidance notes – you can go through the workings there) Dependent female, 38 at date of trial which is 3 years after date of death of husband, aged 37, on whom financially dependent. Deceased had A levels, in employment, good health, stable relationship. Multiplicand of £30k up to age 65, no fi-	Total financial dependency = £538,500	Total financial dependency = £573,300 (6.5% increase)

SERJEANTS' INN CHAMBERS

Williams v. Bermuda [2016] UKPC 4

1. On 25th January 2016 the Privy Council upheld the decision of the Appeal Court of Bermuda to award significant damages to a claimant on the basis that a short delay in operating on his appendix had materially contributed to his injury. The headline is that the doctrine of material contribution survives and that the Privy Council did not accept an argument that the decision in Bailey v. MoD was wrong.

The facts

2. Mr Williams attended hospital at 1117 on 30th May 2011 with acute appendicitis. After an examination the doctor, at about 1215, ordered an 'immediate' CT scan. The scan was not performed until 1727 and not reported until about 1930, Mr Williams underwent surgery at around 2130. His appendix was found to be ruptured with widespread pus around the pelvic region. The ruptured appendix had led to sepsis which in turn had caused damage to his heart and lungs.

The litigation in Bermuda

3. At first instance the judge found that there had been a negligent delay in performing the CT scan which had led to an overall delay in surgery of between 2 and 4 hours. He found for the defendant on causation, concluding:

> "*I find that the plaintiff has failed to prove that the complications that Mr Williams developed during and after surgery were probably caused by the [hospital board's] failure to diagnose and treat him expeditiously. Had the CT scan been obtained and interpreted promptly these complications might have been avoided, but I am not satisfied that they probably would have been avoided.*"

4. Unsurprisingly the plaintiff appealed. The Court of Appeal of Bermuda relied on Bailey v. MoD and held that the test on causation was whether the breaches of duty had contributed materially to the injury. In the Court's view they plainly had.

The appeal to the Privy Council

5. The Hospital Board of Bermuda appealed to the Privy Council. It sought to rely on Bonnington v. Wardlaw to argue that material contribution was only available in limited circumstances i.e. where: i) there had been a single causative agent; ii) the defendant had contributed to the pathological process in a way that was material; iii) the defendant's contribution was concurrent with any non-negligent cause; iv) and as a matter of probability the defendant's contribution had increased the magnitude (and not merely the risk) of harm.

6. The Privy Council roundly rejected this attempt to narrow the doctrine of material contribution, holding:

a. there is no basis for limiting material contribution to cases where the timing of origin of

the contributory causes is simultaneous;

b. Lord Simon was correct in McGhee v. NCB to say that where on the balance of probabilities an injury is caused by two (or more) factors operating cumulatively, one (or more) of which is a breach of duty, it is immaterial whether the cumulative factors operated concurrently or successively.

c. The Appeal Court of Bermuda had been right to infer on the balance of probabilities that the plaintiff's heart and lungs had been injured by a single agent, sepsis from a ruptured appendix. The development of the sepsis and its effect on the heart and lungs was a single continuous process, during which the sufficiency of the supply of oxygen to the heart steadily reduced. The hospital board's negligence in delaying the CT scan and hence the time of surgery, materially contributed to the process. That was sufficient to establish causation.

7. The Privy Council restated the principle in Wilsher that where the most that can be said is that a claimant's injury is likely to have been caused by one or more of a number of disparate factors, one of which is attributable to a breach of duty then that will not be sufficient to establish causation. Proving that a breach might have made a material contribution is not enough.

8. The Privy Council did not specifically raise the issue of whether the same damage would probably have occurred in any event. It is clear from the judgment however that they did not believe that it would have done. If the same damage would probably have occurred in any event then they would not have found a material contribution from the delay.

The attack on Bailey

9. The Hospital Board attacked the reasoning of the Court of Appeal in Bailey v. MoD. Here it is frustrating not to know from the judgment of Lord Toulson what the attack was. The Privy Council's view was that Bailey had been correctly decided albeit not for the right reasons. In Bailey the claimant suffered brain damage having aspirated her vomit and suffered a cardiac arrest. The concurrent causes were weakness from her pancreatitis (non-negligent) and dehydration (negligent). Lord Toulson said:

"In the view of the Board, on those findings of primary fact Foskett J was right to hold the hospital responsible in law for the consequences of the aspiration. As to the parallel weakness of the claimant due to her pancreatitis, the case may be seen as an example of the well-known principle that a tortfeasor takes his victim has he finds her. The Board does not share the view of the Court of Appeal that the case involved a departure from the 'but for'

test. The judge concluded that that the totality of the claimant's weakened condition caused the harm. If so 'but for' causation was established. The fact that her vulnerability was heightened by her pancreatitis no more assisted the hospital's case than if she had an egg shell skull."

Analysis

10. When Bailey v. MoD was decided in July 2008 there was considerable surprise amongst clinical negligence practitioners. The decision made it much easier for claimants to establish causation. The decision in Williams, whilst not strictly binding, plainly leaves material contribution as a powerful weapon in the claimant's armoury for the foreseeable future.

11. Some will question Lord Toulson's reference to eggshell skulls but in practice nothing has really changed. Under Bailey a claim would still fail if the outcome would probably have been the same in any event. That remains the case. Williams and Bailey explain causation in slightly different ways but the decisions are consistent with each other and lead to the same result. A claimant will win where she can prove:

a. *either* that but for the substandard treatment she would probably have avoided injury;

b. *or,* that her injury has been materially contributed to by the sub-standard treatment (but note, there is no material contribution if the outcome would probably have been the same in any event).

A defendant will win if the claimant cannot prove a material contribution. This includes:

a. cases where the outcome would probably have been the same in any event;

b. cases where the most that the claimant can prove is that the breach of duty is a possible cause of the injury.

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26TH JANUARY 2016

Outer Temple Chambers

Late switch of surgeon: Can this invalidate consent?

James Counsell reports on a successful claim based on lack of consent, in which a patient was told, only on the day of the operation, that her spinal surgery was not to be performed by the expected clinician.

How often does a patient turn up to hospital to be told that the operation is to be performed by a different clinician from the one expected? How much worse when the operation then goes wrong and the patient is left, not only with serious and permanent spinal injuries, but also wondering whether things would have been different if the clinician of choice had been there to perform it?

This was the position facing the 69-year-old Claimant in *Jones v Royal Devon and Exeter NHS Foundation Trust* (Lawtel 22 September 2015) when she went into hospital in July 2010 for spinal decompression surgery. After a trial in August 2015, Mr Recorder Blunt, QC dismissed her claim that the operation had been performed negligently and that the replacement, more junior, surgeon ought to have been (more closely) supervised but, giving judgement for the Claimant, found that there had been a breach of the Trust's duty to provide sufficient information to ensure that full and informed consent had not been given.

The case is a useful application of the principles in *Chester v Afshar* [2004] UKHL 41 [2005]; 1 AC 134 and is a reminder of the ongoing duty to provide sufficient information so that the patient can *"make an informed choice as to whether, and if so when, and by whom to be operated on."*

The Facts.

Mrs Jones was referred, with a history of low back pain, to the Trust's orthopaedic department under the care of consultant orthopaedic surgeon, Mr Daniel Chan in November 2009. Although she had an epidural injection in January 2010, her back pain continued and, at a clinic in March, she was reviewed by Mr Chan and "put on his waiting list" for bilateral decompression surgery. That operation was carried out on 29 July 2010, not by Mr Chan, as the Claimant had expected, but by a more junior clinician, a spinal fellow, called Mr Sunduram.

Unfortunately, the operation did not go well. A dural tear, caused by the surgical instrumentation, has left the Claimant, a previously active lady, with permanent numbness, bladder and bowel problems and a significant loss of mobility.

The claim

Mrs Jones brought a claim on three grounds. The judge, having heard expert evidence, rejected her case that the procedure had been performed negligently and an allegation that Mr Sunduram ought to have been supervised was abandoned during the trial. However, he found that the Trust had breached its duty by not informing her that the operation was not to be performed by Mr Chan and that causation was made out.

Consent

Mrs Jones's case was that she had been led to believe that Mr Chan would perform the operation and had never been told otherwise. She was particularly anxious that he should do so because, it seems, Mr Chan has a particularly impressive reputation as a spinal surgeon in the South-West and even nationally. After she had been placed on his waiting list, she went away with her husband to France for a holiday but had to return early because of her pain. She then contacted the hospital to see if she could arrange an earlier operation, only to be told that the hospital could only give her an earlier date with a different surgeon. Having discussed this with her GP, she decided to wait until Mr Chan was available. Her evidence was that the first that she heard that it was not to be performed by him was on the very day of the procedure when she asked the theatre sister where Mr Chan was, only to be told that it was not he who was to perform the operation. By then, her husband had left to go to work and she was in her theatre gown, and she felt that she had no option but to go ahead.

The Trust evidence was different. Mr Sundaram had performed the consent procedure a few days before the operation. His evidence was that he had provided Mrs Jones with all the information which she needed to give consent and that he had specifically told that it was to be he who was to perform the operation. She had signed the consent form, a document which set out explicitly that the Trust could not provide "*a guarantee that a particular person will perform the operation*". Not only that, but Mr Sundaram said that he saw her again on the morning of the operation and repeated that he was to carry out the operation.

The Recorder resolved those factual differences in the Claimant's favour. He did not accept Mr Sundaram's evidence that he told her that he was to do the operation at the time of the consent procedure or even on the day of the surgery. Had he done so, in advance of the day, the Recorder concluded that Mrs Jones would have "questioned why" that was to happen, given that she had already turned down the opportunity to have the operation done earlier by a surgeon other than Mr Chan.

Breach of duty.

In deciding that a breach was made out, the Recorder said this:

> "The scope and rationale of a doctor's so-called *"duty to warn ",* was articulated by Lord Hope (with whom Lord Walker and Lord Steyn agreed) in a passage in his opinion in *Chester v Afshar*:-
>
> > *"I start with the proposition that the law which imposed the duty to warn on the doctor has at its heart the right of the patient to make an informed choice as to whether, and if so which and by whom, to be operated on. Patients may have, and are entitled to have, different views about these matters. All sorts of factors may be at work here - the patient's hopes and fears and personal circumstances, the nature of the condition that has to be treated and, above all, the patient's own views about whether the risk is worth running for the benefits that may come if the operation is carried out. For some the choice may be easy - simply to agree to or to decline the operation. But for many the choice will be a difficult one, requiring time to think, to take advice and to weigh up the alternatives. The duty is owed as much to the patient who, if warned, would find the decision difficult as to the patient who would find it simple and could give a clear answer to the doctor one way or the other immediately."*

Accordingly, the Recorder found the breach proved.

Causation.

The real significance of the judgment is, perhaps, the way in which the Recorder tackled causation. Three issues arose for his decision:

First, the Trust had sought to rely upon the fact that the Claimant had been told, on the morning of the operation, that Mr Chan was not to be there and had chosen to proceed. The contention that causation was not, therefore, made out was not pursued at trial. As the Recorder made clear, any decision taken "*so far down the line*" was unlikely to be taken freely.

Secondly, it was contended that, if she had been informed in advance of Mr Chan's unavailability, then she would have decided, as she did on the morning of the operation, to proceed. The Recorder, again rejected this argument, observing that:

> "…the fact that Mrs. Jones originally wanted her operation to be carried out by Mr. Chan is corroborated by the reference to Mr. Chan in the GP's Note of the attendance on 9 June 2010: Mr. Chan had and has a high reputation locally and nationally: Mrs. Jones's evidence, which I accept, was that several people whom she knew had been operated on by him, and

> that when, in June, she raised with her GP the fact that there would be a delay if she wanted him to carry out the operation, the GP advised that it would be preferable to wait: in spite of the severity of her symptoms, and she did decide to wait until Mr. Chan was available. I therefore reject this contention."

The third causation issue was more difficult. It was the Defence contention that the Claimant could not prove, on the balance of probabilities, that the operation would have been performed with any better result had it been done by Mr Chan.

The judge approached this issue in two ways by reference to *Chester v Afshar*.

First, he referred to the facts of *Chester* and reminded himself that that was a case where the surgeon failed, in breach of duty, to warn a patient as to the 1-2% chance of serious neurological damage arsing from spinal surgery. That chance occurred during the operation. Had the patient been told, she would not have agreed to the operation but would have sought further advice on alternatives and the operation would not have gone ahead when it did. Had she later gone ahead, however, the risk would have been the same and it would been equally improbable that she would have sustained the damage. Accordingly, the majority of the judicial committee was unable to find causation proved on conventional principles.

The Recorder distinguished *Chester* from Mrs Jones's claim because he found that, on the balance of probabilities, the damage would not have occurred if the operation had been performed by Mr Chan. He listed a number of reasons for coming to that conclusion, including the smallness of the risk of damage in any event, the expert evidence that "*experience counts*" in this operation, the absence of any pre-existing condition likely to increase that risk, whoever performed the operation, the seniority and experience of Mr Chan and the statistical evidence that such complications are rare and rarer still in the hands of a surgeon of the experience of Mr Chan.

In *Chester*, of course, the committee went on to decide the issue of causation on non-conventional principles of causation. The Recorder addressed that issue as follows:

> "If I am wrong in concluding that causation is established on conventional principles, I would nevertheless consider that it is established on the basis of the principle upon which it was found, by the majority of the committee in **Chester** v Afshar, which, I think, is encapsulated in paragraphs 86 and 88 of the opinion of Lord Hope, with which Lord Steyn and Lord Walker concurred, in which he stated: -
>
> > *"I start with the proposition that the law which imposed the duty to warn on the doctor has at its heart the right of the patient to make an informed choice as to whether, and if*

so when and by whom to be operated on. Patients may have, and are entitled to have, different views about these matters. All sorts of factors may be at work here - the patient's own views about whether the risk is worth running for the benefits that may come if the operation is carried out....

... The function of the law is to enable rights to be vindicated and to provide remedies when duties have been breached. Unless this is done the duty is a hollow one, stripped of all practical force and devoid of all content. It will have lost its ability to protect the patient and thus to fulfill the only purpose which brought it into existence. On policy grounds therefore I would hold that the test of causation is satisfied in this case. The injury was intimately involved with the duty to warn. The duty was owed by the doctor who performed the surgery that Miss Chester consented to. It was the product of the very risk that she should have been warned about when she gave her consent. So I would hold that it can be regarded as having been caused, in the legal sense, by the breach of that duty."

Although in the present case there was no breach of the duty to warn Mrs. Jones of the risks of the operation there was an infringement of her right *"to make an informed choice as to whether, and if so when, and by whom to be operated on".* Unless a remedy is provided in the present case that right would he a hollow one."

Conclusion

This case is unusual because Mrs. Jones was able to get over the causation difficulties, which often make it impossible for a claimant to establish that, if the breach had not occurred, the outcome would have been likely to have been different. She did so because she was able to rely upon the fact that she had already turned down the offer of an earlier operation with another clinician, because Mr. Chan was exceptionally experienced in this procedure, whereas his replacement was junior and inexperienced and because Mrs. Jones was an exceptionally impressive witness.

Be that as it may, the case is a good illustration of the importance of the information provided to the patient. To give consent, more is needed than simply a recitation of the risks and benefits and the filling in of a form. For good financial reasons, it is, of course, often necessary for the NHS to switch clinicians, even at the last moment, but Trusts will need to bear in mind that patients are entitled to be kept informed not only of the nature of the operation and its risks but also of the identity of the surgeon to perform it.

JAMES COUNSELL

OUTER TEMPLE CHAMBERS

Counsel for the Claimant at trial

(instructed by Crosse and Crosse LLP, Exeter).

LOSS OF EARNINGS CLAIM: WHAT A CHILD "COULD HAVE BEEN'

Alison Johnson, Senior Associate, at Penningtons Manches LLP

Whilst no-one can predict with any certainty what an infant or child 'could have been' but for their disability, assessing a loss of earnings claim for a young person with a partial or total disability remains an important issue and one we frequently grapple with. A child with a long life-expectancy can have a significant loss of earnings claim often running into the *hundreds* of thousands of pounds in compensation.

Determining pre and post-injury earnings capacity for an infant or child is of course extremely difficult, given the lack of earnings history to base it upon. There is inevitably huge speculation involved. Looking at this for a child with a birth injury makes this even trickier when there is no evidence whatsoever of how the child would have developed and the cognitive ability he or she would have expressed but for the injury at birth. There is however a strong correlation between earnings and the level of potential educational attainment and therefore looking at the child's general level of learning ability is the usual starting point. Statistics can then be used to look at average net lifetime earnings for graduates or non-graduates, depending on whether it is asserted that the child would have gone to university or not.

However, this in itself can also be very contentious. We often look at the achievements of the child's family for an indication of what the child is likely to have achieved in a non-injured scenario. If there are siblings already doing well at school, even attending university themselves, this can be compelling evidence that the injured child is likely, on the balance of probabilities, to have done likewise. We take detailed witness statements from family members of their earnings and achievements. Again this is far from an exact science as arguably earlier generations were less likely to go to university than is the case now. It is not uncommon for children of non-graduate parents to attend university and to be the first in their respective families to have done so.

Graduation itself is no guarantee of future earnings, as defendants will usually argue. One eminent leading counsel we work with once commented that her brother, an Oxbridge graduate, was arguably far more academic than her and whilst she struggled at university in comparison to him, she has become a high-earning Queen's Counsel, whilst her brother has chosen a much lower-profile and lower-earning career as a vicar. They both had the same parents, same upbringing and same opportunities but of course made their own personal choices.

If it is believed that the child still has the ability to undertake remunerative employment of some kind, even if this is very low paid and possibly part-time only, then looking at school records to assess learning ability and likely future earnings is possible, if only on a broad brush basis. The claimant can then give credit for the earnings capacity he or she has retained.

Alison comments: “Statistical data on life expectancy, work-life expectancy and average earnings is now far more sophisticated than it used to be. When this is considered together with evidence of the achievements of close family, with an eye on the nature of the upbringing the child is likely to have had and the support and opportunities the parents would have tried to give, it should be possible to form a view on loss of earnings capacity and bring this issue of the claim to a favourable outcome. It can be a substantial head of loss so is well worth taking the time to investigate evidence fully.

Latent Miliary TB – Practical Observations and Comments

Emma Beeson, Associate at Penningtons Manches LLP

Following a successful settlement for the family of Mrs S, after Surrey and Sussex Healthcare NHS Trust admitted its negligent failure to treat her for miliary tuberculosis in 2012, Penningtons Manches LLP has been instructed by another family whose mother also died from the same disease. Although the team is in the early stages of its investigation, it is clear that the circumstances of this case are extremely similar to that of Mrs S, albeit in a different hospital.

This new case coincides with the publication of the new National Institute for Health and Care Excellence (NICE) guidelines on how to better tackle tuberculosis.

Public Health England reported last year that, despite a reduction in the number of tuberculosis (TB) cases in the past three years, England still has the highest number of cases in Western Europe. Public Health England produced a report entitled 'Public Health England (2015) Tuberculosis in England: 2015 report (presenting data to end of 2014)'.

TB is an infectious disease which can be cured. It is caused by a bacterium called Mycobacterium tuberculosis. In some people, a defensive barrier is built around the infection and the TB bacteria can lie dormant. This is latent tuberculosis and is where the person has been infected with the bacteria but does not have any symptoms of active disease and is not infectious. If the immune system fails to build this defensive barrier or the barrier later fails, then latent tuberculosis can spread within the lungs or develop in other parts of the body.

Miliary tuberculosis is the wide spread of the TB bacteria which is carried around the body in the blood. It can occur in an individual organ, in several organs or throughout the entire body. It is characterized by a large amount of TB bacteria. It can be missed and, if left untreated, it is fatal. It is therefore important to obtain an early diagnosis to ensure that treatment is given to increase the likelihood of survival.

Actress Emma Thompson’s son contracted the disease while working in Liberia and she recently campaigned on the streets of London to raise awareness of tuberculosis. World Tuberculosis Day is 24 March 2016 this year.

Professor Mark Baker, Director for the Centre of Clinical Practice at NICE, also commented recently saying: “TB is a disease that is treatable and curable, but it preys on the vulnerable.”

Emma Beeson, the clinical negligence solicitor who dealt with Mrs S’s case and is dealing with the new instruction, comments: “The fact that tuberculosis is a treatable and curable disease is what makes these cases so upsetting and frustrating. The key is to ensure that the possibility of tuberculosis is considered at the earliest opportunity and treatment commenced immediately. Cases involving a failure to diagnose tuberculosis, particularly miliary tuberculosis, are specialized cases and it is important for any family to ensure that they choose the right legal representation to investigate the case for them.”

AvMA PRO BONO INQUEST PROJECT

INQUEST TOUCHING THE DEATH OF AMELIA CALVO

Represented by: Frances McClenaghan of Serjeants’ Inn Chambers and

Dr Charlotte Connor, Medico-Legal Advisor at AvMA

An inquest was heard from March 7th-11th 2016 at Manchester Coroner’s Court touching the death of Amelia Calvo. Amelia was born on the 27th of March 2014 and sadly died on the 28th of March 2014 following an operation to correct Oesophageal Atresia (OA) and Tracheo-oesophageal fistula (TOF) at Royal Manchester Children’s Hospital which is part of Central Manchester Foundation Trust (CMFT)

Amelia was born via Caesarean section at 20:23 hrs at 31+4 weeks gestation following a twin pregnancy which was complicated by intra-uterine growth restriction and polyhydramnios. At birth Amelia’s APGAR scores were 5 and 7 and due to poor respiratory effort the treating Paediatricians decided to intubate. The Consultant Neonatologist was able to successfully intubate Amelia on the fourth attempt.

Amelia was then transferred to the NICU where a nasogastric tube was placed. When an x-ray was performed to confirm correct placement it was noted that the tube was curled in the oesophagus and that there was free gas in the stomach. These findings were suggestive of OA and TOF respectively.

In the morning Amelia was reviewed by the Paediatric Surgical Registrar with a plan for surgery later that day to ligate the TOF and possibly repair the OA. The Consultant Paediatric Anaesthetist, Dr Doherty, ordered investigations which subsequently found that Amelia had a number of cardiac congenital abnormalities. Dr Doherty also noted that Amelia had dysmorphic features, was a very small baby (1.15kg) and that there was no leak surrounding the endotracheal tube (suggestive of possible airway oedema/swelling). All of these features led Dr Doherty to suspect that Amelia may have a difficult airway.

Prior to transfer to theatre Dr Doherty briefly spoke with the Consultant Paediatric Surgeon, Mr Bow-

en in the theatre corridor and mentioned Amelia's surgery that afternoon. Mr Bowen informed Dr Doherty of his intention to perform a rigid bronchoscopy prior to undertaking thoracotomy to ligate the fistula. This procedure is often undertaken prior to ligation of the fistula in order to identify the exact location of the fistula. This procedure however requires removal of the endotracheal tube (breathing tube). Dr Doherty therefore asked the Mr Bowen to consider other options such as flexible bronchoscopy or no bronchoscopy (which would not require removal of the endotracheal tube). The decision to perform a rigid bronchoscopy, flexible bronchoscopy or no bronchoscopy is usually based on the Surgeon's preference and whether or not it is safe to do so in the circumstances.

A team debrief was conducted in theatre prior to surgery being undertaken. The Anaesthetic team were present and although the Surgical Registrar was present, Mr Bowen who was due to perform the surgery was not as he was attending another meeting.

Amelia was then transferred to theatre and on arrival of Mr Bowen there was discussion again about the advisability of performing a rigid bronchoscopy. Dr Doherty again asked if a flexible bronchoscopy could be considered as an alternative. Dr Doherty then performed a visual assessment of the larynx which showed that Amelia had a grade 4 airway. This means that the larynx could not be visualised at all and would suggest that if the airway was lost that re-intubation would be extremely difficult and almost impossible. A breakdown of communication ensued and Mr Bowen performed an examination of Amelia's airway without anyone there to hold the endotracheal tube in place to prevent dislodgment.

Unfortunately the endotracheal tube became dislodged and ventilation was inadequate. The team in theatre attempted to re-intubate with great difficulty. Eventually Amelia's airway was secured again via a tracheostomy tube inserted by the ENT surgeon but by this point attempts at re-intubation had resulted in bilateral pneumothoraces and likely intraabdominal bleeding.

By the time the airway was secured again the bleeding had become life-threatening with major coagulopathy, poor cardiac output and difficulty ventilating. The decision was made to discontinue resuscitation and Amelia sadly passed away.

A post-mortem examination was conducted and listed the cause of death as follows:

1a) Multi-organ failure, DIC (Disseminated Intravascular Coagulation)

1b) Hypovolaemic shock

1c) Haemorrhage during procedure

2) Trisomy 18

Amelia underwent Cytogenetic examination with clinical genetics which revealed that both her and her sister Sophia had Trisomy 18/Edward's Syndrome which is associated with heart defects, kidney problems, oesophageal atresia and polyhydramnios. Sadly Sophia also passed away a few months later.

An Inquest was listed for 5 days in March 2016 before HM Area Coroner for Manchester, Ms Fiona Borrill. Ms Frances McClenaghan of Serjeants' Inn Chambers was instructed in late 2014 when the family first approached AvMA's pro bono Inquest Service. Mr and Mrs Calvo first approached AvMA following disclosure of the High Level Investigation (HLI) report highlighting the events that occurred in theatre. Initially after Amelia's death they were simply told that Amelia's airway had been lost and everything possible had been done to save her. It was not until they read the HLI report that they learned of what transpired in theatre. The fact that the family only learned of the circumstances surrounding Amelia's death some seven months after it occurred highlights the far-reaching impact of the Duty of Candour which came into effect after Amelia's death.

The Inquest had initially been listed with 2 days of evidence being heard in September 2015. This hearing was adjourned as it became clear that there was a factual dispute between Dr Doherty and Mr Bowen and therefore there existed a conflict of interest. The Coroner identified that both needed to be recognised as Interested Persons in their own right separate to the Trust. This issue had been raised previously with the Trust by the Coroner and by AvMA at the PIR heard in April 2015. Despite this issue being flagged the Trust was content to represent both parties in September 2015.

AvMA subsequently wrote a letter to the representatives of the Trust in November 2015 asking them to cover out of pocket expenses incurred by AvMA and Counsel (but paid for by the client)at the adjourned hearing. While AvMA's Inquest service is free we ask clients to cover any out of pocket expenses incurred through travel. The Trust refused to cover the expenses.

The major issues highlighted and dealt with by the Coroner at the Inquest included the appropriateness of the handover between the Neonatology team to the Anaesthetist regarding the difficulty of Amelia's airway, the communication between the clinicians regarding the surgical plan (ie rigid scope vs flexible scope vs no scope) and the difficulty that would be faced if Amelia's airway was lost, the absence of certain equipment in theatre and the events which led to the endotracheal tube becoming dislodged.

The Coroner when delivering her conclusion found that there was a 'gross failure' by the treating Surgeon, Mr Bowen, to not have a member of the Anaesthetic team holding the endotracheal tube in place when he performed his examination of Amelia's larynx. This failure would have therefore minimised the risk of dislodgement of the ETT. The conclusion was listed as 'natural causes' with a short narrative acknowledging there was a lack of 'minimisation of the risk of loss of intubation by not

guarding the endotracheal tube in a ventilated baby and a breakdown in communication by staff in theatre on the 28th of March 2014.'

The Coroner also issued a Regulation 28/Prevention of Future Death Report in the case. It is the Coroner's intention to write to both the Department of Health and the Central Manchester Foundation Trust regarding the issue of grading of airways by neonatologists and anaesthetists. Currently both specialities use different systems to classify airways, Neonatologists simply describe the airway subjectively whereas Anaesthetists use the Mallampati airway grading system. Grade 1 refers to a clear view of the laryngeal structures and therefore signifies a relatively straight forward airway to intubate whereas grade 4 signifies that the laryngeal structures have not been visualised suggesting an extremely difficult and almost impossible airway to intubate. Although this issue was not causative in Amelia's death the Coroner is not restricted to matters causative of the death when considering whether or not to make a Preventing Future Death Report.

The Chief Coroner and all interested parties will be copied in to this letter and any correspondence and the Trust and Department of Health will have 56 days following receipt to respond.

The Coroner also referred to paragraph 37 of 'Guidance sheet no. 5 Reports to Prevent Future Deaths'. This states that 'where the duty to make a report does not arise, but the coroner wishes to exceptionally draw attention to a matter of concern arising during the investigation (including the inquest), the coroner may choose to write a letter expressing that concern to the relevant person or organisation'. The Coroner in Amelia's case plans to write a letter addressed to the Chief Executive Officer of CMFT regarding three areas of concern:

1. Concern that the morbidity and mortality meetings by the Paediatric Anaesthetic department were not minuted.

2. Dissatisfaction with the explanation of the use of the word 'outcome' in the HLI. The report gave the impression that in some point in the future Amelia would have died due to her Edwards' Syndrome and therefore any issues with her care did not impact on the clinical 'outcome'. The family were also concerned about the insensitive nature of this wording.

3. A mandatory requirement for all Paediatric Surgeons to attend the team debriefing prior to surgery. The Coroner requested further clarification as to how competing commitments of Surgeons are being dealt with.

It is unclear as to whether the Chief Coroner is included in this correspondence

While it is very difficult to ever categorise the outcome of an Inquest in positive terms especially when

it involves the death of a baby, the Calvo family were nonetheless pleased that a Regulation 28 report (in particular addressed to the Department of Health) and a separate paragraph 37 letter had been issued. They have found some comfort in knowing that Amelia's legacy may well avoid deaths of other babies in similar circumstances.

McMillan Williams Solicitors are now kindly assisting the Calvo family. The Calvo family and AvMA would also like to extend their thanks again to counsel, Ms Frances McClenaghan of Serjeants' Inn Chambers.

Writing Medico-Legal Reports in Civil Claims - An Essential Guide

This excellent book is written by Giles Eyre, an experienced barrister and Lynden Alexander, a communication skills consultant. The book is well laid out; the topics are covered in a logical and easy to follow sequence. As you might expect, the earlier chapters look at the essential qualities of a medical expert and then move on to deal with opinion evidence both in general terms and more specifically in complex claims. There are specific chapters on reporting in clinical negligence claims as well as addressing practical concerns in the expert witnesses practice with sections on cost budgeting and maintaining the integrity of an expert witness practice.

This is book is in its second edition. It includes updates on recent case law including the Jackson Reforms and more recently the Montgomery ruling on consent and is recommended to lawyers and medical experts alike.

New medico-legal experts will find the book particularly valuable, whilst the more experienced expert will find it at the very least, a helpful point of reference and update for their legal knowledge. The book also serves as a useful reminder to lawyers that good communication and engagement lies at the heart of the lawyer/expert relationship.

The book is thorough and readable with useful templates for personal injury and clinical negligence practice. We particularly liked the "key-point summary" that appears at the end of each chapter. AvMA are pleased to recommend this well written, user friendly reference book.

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AVMA FUND RASING EVENTS

Calling All solicitors & barristers – Walk with AvMA

Team AvMA will be walking in the London Legal Walk 2016
If your firm or set doesn't have a team entered - join us

Our AvMA pro-bono inquest service recently supported the family of Stuart Hurrell during an inquest. Stuart was a 39 year old man who had a condition called generalised idiopathic dystonia. During a stay in a local hospital Stuart was not given his correct medication and developed complications. He was moved to a second hospital and after several weeks died of kidney failure and brain trauma. For a year AvMA provided help for his family during the long investigation process and secured pro-bono barrister support at his inquest in 2015.

"The support and assistance from AvMA was invaluable to us... we are able to move on knowing that we did all that was possible".
Mr Hurrell, Stuart's father, 2015

This year AvMA wants to raise **£3,000** for our patient safety work
This money will support bereaved families needing our support

- Families not knowing why their loved ones suffered
- Families who suffer the trauma of an unexplained death
- Families who need our help to attend the inquest and seek answers

Help AvMA this year and walk with us on the 2016 London Legal Walk
Contact Phil Walker at AvMA or phone 020 8688 9555

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Legal Harmony, established in August 2013, is a choir competition for choirs in or connected to the legal industry. It is a not-for-profit organisation that, through its competitions, raises funds for and awareness of participating choirs' nominated charities. Over the past 2 years, over 25 choirs from multinational, national and small firms of solicitors, commercial and criminal chambers have competed, all raising funds for their chosen charities. The Legal Harmony Choir was established to perform at the American Bar Association's Opening Ceremony as part of the 800th Magna Carta cerebrations in June 2015.

The Event

The aim of **Musical Gala 2016** with Lesley Garrett is to raise funds and awareness of the London Legal Support Trust, Sparks Children's Medical Charity and Action Against Medical Accidents. The choir at the event will comprise of singers and performers from over 20 of the most prestigious law firms and barrister's chambers, together with members of the Bar Choral Society.

The Charities

The London Legal Support Trust raises funds so that Law Centres and Citizens Advice Bureaux can help the most vulnerable people in London. From homeless people, elderly housebound, children to trafficked women, the advice and casework funded by the Trust changes lives and makes invaluable and tangible differences to peoples' lives .

Sparks Children's Medical Charity raises money to fund pioneering children's medical research. It supports clinicians and scientists in order to find cures and treatments to help the 1 in 30 children born in the UK with a condition that may affect them for life.

Action against Medical Accidents (AvMA) is the UK charity for patient safety and justice. It provides free independent advice and support to people affected by medical accidents (lapses in patient safety) through its specialist helpline, written casework and inquest support services. They work in partnership with health professionals, the NHS, government departments, lawyers and, most of all, patients, to improve patient safety and justice.

CONFERENCE NEWS

FORTHCOMING EVENTS FROM AvMA

For programme and registration details on all of our forthcoming events, plus sponsorship and exhibition opportunities, go to **www.avma.org.uk/events**, call the AvMA Events team on 0203 096 1140 or e-mail conferences@avma.org.uk.

Duty of Candour – Beyond Compliance

22 March 2016, 7 Bedford Row, London

After a year of the statutory Duty of Candour being in force, and with updated regulations expected in April 2016, this one day conference provides an ideal opportunity for anyone sharing responsibility for the successful implementation of the Duty of Candour. The conference will help you understand not only how to comply with the CQC regulations, but how to do so compassionately and proportionately.

Essential Medicine for Lawyers

27 April 2016, De Vere Holborn Bars, London

This conference has been structured to ensure delegates gain a good grounding in the key areas of the major body systems. The increased understanding gained will underpin all future medical learning in relation to clinical negligence and enable you to apply medical knowledge to your cases. Each speaker will address the essential areas that clinical negligence solicitors need to know, including an introduction to the anatomy and physiology of each system, useful terminology and an examination of the common conditions that affect these systems, their symptoms and standard procedures for diagnosis and treatment.

AvMA Annual Charity Golf Day

30 JUNE 2016, MANNINGS HEATH GOLF CLUB, WEST SUSSEX

The 2016 AvMA Charity Golf Day will take place on Thursday 30 June at Mannings Heath Golf Club, near Horsham. The Welcome Event for the Annual Clinical Negligence Conference will take place later that evening in Brighton (30 minutes' drive away) so the Golf Day offers the perfect start to the essential event for clinical negligence specialists.

We will be playing Stableford Rules in teams of four and you are invited to either enter your own team or we will be happy to form a team for you with other individuals. The cost is only £98 + VAT

per golfer, which includes breakfast rolls on arrival, 18 holes of golf and a buffet and prize-giving at the end of the day. All profits go directly to AvMA's charitable work.

Annual Clinical Negligence Conference 2016

1-2 JULY 2016, HILTON BRIGHTON METROPOLE

AvMA's Annual Clinical Negligence Conference (ACNC) is ***the*** event that brings the clinical negligence community together to learn and discuss the latest developments, policies and strategies in clinical negligence and medical law.

ACNC 2016 will offer the usual high standard of plenary presentations and focused breakout sessions that you would expect from this event, ensuring that you stay up to date with all the key issues. The programme this year has an oncology theme, whilst also still covering many other key medico-legal topics.

Networking is also a big part of the ACNC experience. On the day before the start of the conference, we will be holding the AvMA Annual Charity Golf Day, and our Welcome Event will take place later that evening. The Mid-Conference Dinner will be held on the Friday evening.

As well as providing you with a top quality, thought provoking, learning and networking experience, the success of the conference helps AvMA to maintain its position as an essential force in promoting justice. We look forward to welcoming you to Brighton for the 28th Annual Clinical Negligence Conference.

Sponsorship and Exhibition Opportunities at ACNC 2016

The unique environment of the ACNC offers companies the ideal opportunity to focus their marketing activity by gaining exposure and access to a highly targeted group of delegates and experts. Contact us for further details on the exciting opportunities available to promote your organisation at ACNC 2016.

Tel **0203 096 1140** e-mail **conferences@avma.org.uk** web **www.avma.org.uk/**

WEBINARS

Medico-legal learning when you need it!
AvMA Medico-legal Webinars - New titles available now

AvMA's 'Medico-Legal Issues in Orthopaedic Surgery' conference, which took place in London on 21 January 2016, was filmed so the presentations are also available as webinars.

Topics include upper limb surgery focusing on the shoulder, hand and wrist surgery, spinal, foot and ankle surgery, knee surgery as well as joint replacement of the hip and knee. Types of injury and fracture were also looked at within each area as well as highlighting where negligence may occur within each condition.

You can purchase three different webinar licences to fit your needs:

Single viewer	Multiple viewer	Subscription
Lawyers' Service rate £49.00 + VAT	Lawyers' Service rate £150.00 + VAT	Lawyers' Service rate £1,200.00 + VAT
Standard rate £65.00 + VAT	Standard rate £195.00 + VAT	Standard rate £1,900.00 + VAT

Single viewer licence:
A personal licence allows one viewer access to a webinar title for 60 days.

Multiple viewer licence:
A group licence allows multiple viewers from the same firm to have access to a webinar for a 60 day period.

Firm subscription:
A firm licence allows multiple viewers from the same firm to have access to the entire webinar library for 12 months.

New titles available now:

1 hour CPD - accredited with APIL and Bar

Hand and Wrist Surgery

- Missed scaphoid fractures
- Problems with distal radius fractures
- Joint replacements
- Problems with Dupuytren's treatment

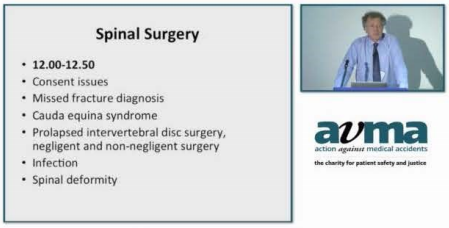
Presented by: **Professor David Warwick**, Consultant Orthopaedic and Hand Surgeon, Southampton University Hospital

Upper Limb Surgery Focusing on Shoulder Surgery

- Types of injury, ie fractures including elbow, dislocation, tendon, vascular and nerve damage and the failure to diagnose and treat appropriately
- Shoulder replacement surgery
- Negligent and non-negligent surgery

Presented by: **Mr Michael Kurer,**
Consultant Orthopaedic Surgeon, North Middlesex Hospital, London

1 CPD hour accredited by APIL and Bar



1 CPD hour accredited by APIL and Bar

Spinal Surgery

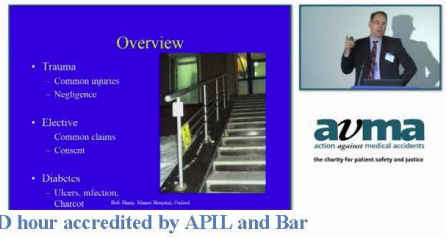
- Consent issues
- Missed fracture diagnosis
- Cauda equina syndrome
- Prolapsed intervertebral disc, negligent and non-negligent surgery Infection

Presented by: **Professor Jeremy Fairbank**, Consultant Orthopaedic Surgeon, St Lukes Hospital, Oxford

Foot and Ankle Surgery

- Types of fracture dislocation of the ankle and foot
- Achilles tendon disorders and the failure to diagnose and treat appropriately
- Forefoot surgery focusing on hallux surgery

Podiatric surgery
Presented by: **Mr Bob Sharp,**
Consultant Orthopaedic Surgeon, Oxford University Hospital



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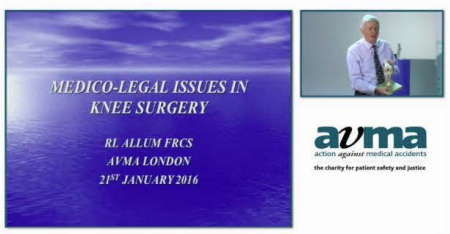


1 CPD hour accredited by APIL and Bar

Knee Surgery

- Arthroscopy
- Types of fracture
- Ligament damage
- Negligent and non-negligent surgery

Compartment syndrome

Presented by: **Mr Robin Allum, Consultant** Orthopaedic Surgeon, Heatherwood Hospital, Ascot

Joint Replacement of the Hip and Knee

- Indications for hip and knee replacement
- Expected outcomes
- Recognised complications
- What constitutes negligence

Presented by: **Mr Jonathan Miles,**
Consultant Orthopaedic Surgeon, Royal National Hospital

1 CPD hour accredited by APIL and Bar

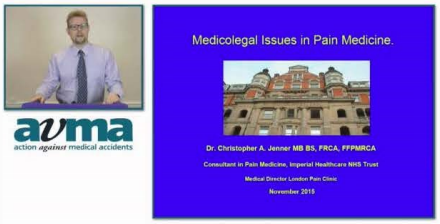
1 CPD hour accredited by APIL and Bar

Cauda Equina Syndrome

- What is Cauda Equina Syndrome (CES)
- Cause CESTypes of CES

Negligent and non-negligent management of CES

Presented by: **Professor Jeremy Fairbank**, Consultant Orthopaedic Surgeon, St Lukes Hospital, Oxford



1.5 CPD hour accredited by APIL and
1 CPD hour accredited by the Bar

Medico-Legal Issues in Pain Management

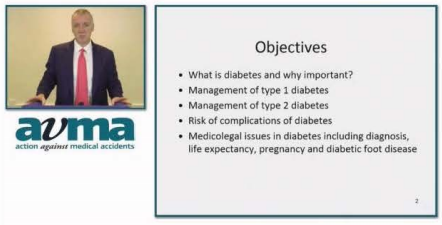
Join this webinar to understand what pain is, how it is managed, what techniques are available and the medico-legal issues involved

Presented by: **Dr Christopher Jenner**, Consultant in Pain Medicine, Imperial Healthcare NHS Trust

Medico-Legal Issues in Diabetes

This webinar will discuss the medico-legal issues in diabetes including diagnosis, life expectancy, pregnancy and diabetic foot disease.

Presented by: **Dr Mark Vanderpump**, Consultant Physician and Honorary Senior Lecturer in Diabetes and Endocrinology, the Royal Free London NHS Foundation Trust in London



1.5 CPD hour accredited by APIL and
1 CPD hour accredited by the Bar

1.5 CPD hour accredited by APIL and
1CPD hour accredited by the Bar

Medico-Legal Issues in Meningitis and Septicaemia

This webinar will help you to understand the biology and the recurring legal issue in the management of this devastating disease

Presented by: **Dr Nelly Ninis**, Consultant General Paediatrician, St. Mary's Hospital, Imperial College Healthcare NHS Trust

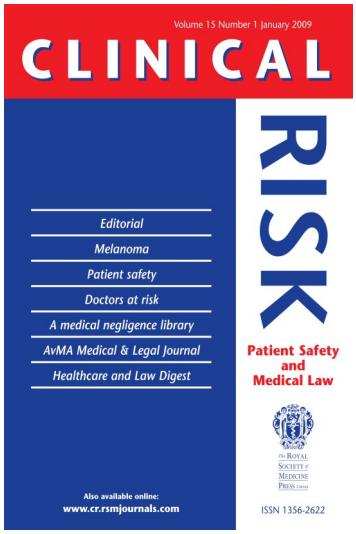
Marketing for Lawyers

This online seminar will give the legal professional an overview of what marketing is, why it is important and highlight the range of tools and tactics available to plan and implement a successful marketing strategy

Presented by: **Adrian Jewitt**, Associate Director of Marketing, Leigh Day

1 hour non-accredited CPD

NOTICEBOARD



Clinical Risk is a leading journal published by the Royal Society of Medicine, which aims to give both medical and legal professionals an enhanced understanding of key medico-legal issues relating to risk management and patient safety. Containing authoritative articles, reviews and news on the management of clinical risk, our quarterly journal aims to keep you up-to-date on current medical legal issues and covers a wide range of recent settled clinical negligence cases. The journal includes both the *AvMA Medical and Legal Journal* and the *Healthcare and Law Digest*.

AvMA members firms and barristers are entitled to a discount to subscribe to Clinical Risk.

Please email norika@avma.org.uk for details.

Clinical Risk is an essential read for anyone working within the medical negligence fields or providing healthcare to the general public, both within the UK and abroad.

For more information see https://uk.sagepub.com/en-gb/eur/journal/clinical-risk or click here

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SEARCH	– search the web and generate funds for free
SHOP	– buy favourite brands from hundreds of retailers
DONATE	– give online, direct to your charity of choice
SPONSORSHIP	– collect sponsorship for fundraising events
eVOUCHERS	– send an online donation as a gift

HELP SUPPORT AvMA TODAY WITH EVERYCLICK

JUST GO TO: http://www.everyclick.com/actionagainstmedicalaccidents

LOOK AFTER THE PENNIES...

Raise money for us by searching the web with everyclick.

Every click is a search engine similar to Google; the difference is that part of it's advertising revenue is donated to your chosen charity.

So, with no effort you can raise money for us. Select AvMA as your chosen charity, make everyclick your home page and Voilà! Every search you make will generate a penny for AvMA. It is amazing how those pennies will turn into to pounds!