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LAWYERS SERVICE NEWSLETTER

NOVEMBER 2015

EDITORIAL

INSIDE THIS ISSUE

The Department of Health's (DoH) forthcoming consultation on fixed recoverable costs (FRC) remains a continuing source of concern. Following an initial short pre- consultation in August we had been advised that the formal consultation was to be published this month (November). At that time the consultation period was expected to close in December with changes to be implemented in October 2016. However, in the last day or so we have learned that the formal consultation is likely to be delayed until January 2016; it is not yet clear when the consultation will close although the consultation period may be as little as six weeks.

As you are no doubt aware, the main tenets of the proposals are as follows: (i) solicitors costs will be awarded on a fixed fee basis relative to the value of the claim, rather than the complexity (ii) claims with a value of up to £250,000 may be included in this regime (iii) experts fees are to be capped at a maximum recoverable sum which reflects the likely number and cost of experts reports needed. The cap would apply to all reports, those on liability, causation, quantum and prognosis. .

Currently, the DoH has failed to provide any real detail on how these proposals are expected to operate in practice. In turn this means that we are only able to comment in general terms about the likely impact. For example, we do not know what level of remuneration is going to be offered on fixed fee work or what the cap on experts' fees is going to be. Given that the proposals are part of a raft of measures to save the NHS up to £80 million per annum, we consider there is little cause for optimism. It is crucially important that we are given sufficient time to properly assess how the formal proposal on FRC costs will impact on access to justice

AvMA has made it clear to the DoH that we consider these proposals to be premature. There has been insufficient time to properly identify what effect reforms to the legal system introduced in April 2013 under the Legal Aid Sentencing & Punishment of Offenders Act 2012 (LASPO) and the Civil Procedure Rules have had. In particular, too few post April 2013 cases have concluded and gone through the costs assessment process to enable an objective analysis of the strengths or otherwise of the courts approach to proportionality.

AvMA has asked that any consultation on FRC be delayed until there has been a review to identify the factors which give rise to any unnecessary costs being incurred in clinical negligence cases. This would include a full analysis of the

EDITORIAL

effect of the changes introduced post April 2013 and consideration of the alternatives to litigation including a small claims/NHS Redress Scheme.

In order to promote these objectives we have taken a number of steps which are highlighted below. This includes key documents prepared and activities being pursued by us:

- AvMA's Briefing document

- AvMA has written to all MPs making them aware of our briefing document.

- AvMA will meet with Julie Badon from the DoH later this month to discuss our concerns about their proposals in more detail. A number of key politicians have expressed support for our concerns about FRC and we have also arranged to meet with Heidi Alexander MP and Tom Blenkinsop MP later this month.

- We have been working with other charities discussing how FRC proposals will impact on the people they represent. A number of charities, including Meningitis Trust and SANDS have become important signatories to the letters AvMA sent to Jeremy Hunt and Ben Gummer; these letters specifically ask the DoH to delay introducing FRC pending a review on how clinical negligence costs can be appropriately reduced. A further meeting of charities is expected to take place in December to keep the groups updated.

- Tom Brake MP for Liberal Democrats has sent parliamentary questions which includes asking the Secretary State for Health:

  (i) What assessment his department made on the likely effect on access to justice for victims of clinical negligence before developing proposals to introduce a fixed recoverable costs regime for clinical negligence, and which other stakeholders were consulted, if any, about this before and what was their response?

  (ii) What assessment was made of the effect of the Legal Aid Sentencing and Punishment of Offenders Act on reducing costs associated with clinical negligence; or of the NHS and NHS Litigation Authority causing unnecessary costs in clinical negligence cases before deciding to take forward proposals for a fixed costs regime in clinical negligence?

  (iii) What assessment was made of the likely effect of his plans for improving patient safety and "zero harm" on reducing the cost of clinical negligence before taking forward proposals for a fixed costs regime in clinical negligence?

  He will also ask the Secretary of State for Justice:

EDITORIAL

(iv) How does he justify allowing the Department of Health to develop and consult upon changes to Ministry of Justice policy with regard to the proposed 'fixed cost regime' changes to the civil procedure rules? How will he ensure that any proposed changes are fair to any side in civil litigation and do not harm access to justice?

- We continue to engage with the Law Society, APIL and SCIL to share information including responses to our respective FOIA requests.

- We have approached the BMA, MDU and other defendant organisations as well as the Expert Witness Institute (EWI) to see if they are willing to enter into dialogue about medico legal expert's rates. We are meeting with the BMA & EWI later this month to explore whether there is any common ground.

- We have a lever arch file of cases which are being reviewed for the purposes of attracting media attention.

Thank you to everyone who has sent in case studies. Please do continue to send in any case studies you would like us to consider for use in our campaign. It really assists if your client is willing to speak to the media. If you have any queries please do not hesitate to contact either Peter or myself.

With the impending consultation on loss of recovery of ATE premiums firmly in mind, I am pleased to recommend David Pipkin's article "The Long and Winding Road" which concentrates on the likely effect removing recoverability of ATE premiums will have on the after the event insurance market in clinical negligence cases. David is a Director in the underwriting division at Temple Legal Protection and will be known to many of you.

We are also pleased to recommend two cosmetic surgery articles entitled "Cinderella Surgery" and "Fly in, fly out" submitted by Penningtons as well as an article by Dominic Ruck Keene, Barrister at 1 Crown Office Row who was instructed by AvMA in the case of "KW".

Many of you will be aware of the judgment recently handed down in the case of ***Reaney v (1) University Hospitals of North Staffordshire NHS Trust and others***. This case highlights the importance of carefully considering the "but for" test and how it relates to post negligence care. We are grateful to Shahram Sharghy and Tom Mountford both of 9 Gough Square for setting out the key aspects of this case in their joint article entitled "Quality v Quantity – The Balancing Act". However, you will also find of interest the summary of the case of ***Simon v Imperial College Healthcare NHS Trust*** (2015) prepared by leading counsel for the claimant in that case, William Audland QC of 12 Kings Bench Walk. In that case, the claimant was able to successfully resist the defendant's application, made earlier this year, to stay the proceedings pending the outcome of the Court Appeal's decision in Reaney. As William points out, decisions on case management are rarely reported, so it is appropriate to include the case at this time, however it is also a reminder that the interests of individual litigants cannot be subordinate to the legal issues alone.

EDITORIAL

I have particular pleasure in referring you to an article submitted by one of our experts, Stephen Playfor, a Consultant Paediatric Intensivist at Royal Manchester Children's Hospital. The article is written by Stephen and his colleague, Joe Brierley and is entitled "Re: A (A child) - Practical problems arising with brain stem death". Stephen was directly involved in the case of Re A which illustrates problems doctors can be faced with when a parent cannot accept a diagnosis of brain stem death. In Re:A the parents refused to agree to have their child's mechanical life support turned off. The article was originally written as a letter which was sent to the Paediatric Intensive Care Society as a way of providing guidance to other paediatricians faced with similar difficulties. For full details of the facts the case citation is: ***Re: A (A child) [2015] EWHC 443 (Fam) (1)***. If any of you have any comments or observations on Stephen's article we are happy for you to send them to us (Norika@avma.org.uk) and we will forward these on.

Understandably, most of us have been focusing on the forthcoming consultations on fixed recoverable costs and loss of recoverability of ATE premiums, however there are a number of other issues which are being driven on. Peter Walsh's update is included in this edition of the Newsletter and looks at the a number of relevant developments including the Duty of Candour and the Access to Medical Treatments (Innovation) Bill.

We are always looking for articles to include in the Newsletter and Clinical Risk. For those of you who are unaware, Clinical Risk is an academic journal which is aimed primarily at senior clinicians, managers in NHS Trusts and independent health sector providers as well as claimant and defendant lawyers specialising in clinical negligence. It is an international forum for the exchange of new knowledge and ideas in the fields of patient safety, risk management and medico-legal issues. By contrast articles suited to the Newsletter tend to be those of current, general interest and might offer practical tips or advice on legal practice and or procedure.

I would like to take this opportunity to draw your attention to the new AvMA website which was launched at the end of October. We do hope you find the website easier to navigate and user friendly but let us know what you think, good or bad, by emailing Norika.

Best wishes

Lisa

Lisa O'Dwyer
Director Medico-Legal Services

EDITORIAL

David Pipkin

The Long and Winding Road

Paul McCartney was probably not thinking of Clinical Negligence Lawyers when he penned the lyrics to this Beatles classic all those years ago but the title of that song, aptly describes the road being trodden by Lawyers at present. They must wonder whether the end of that road is in sight for the seemingly endless reforms this area of litigation has had to bear.

Over the past decade or so, there has been the erosion of Legal Aid, followed by the Redress proposals and then the Jackson Reforms. We now face a double whammy from the Government with the proposals to introduce a fixed costs regime and end the partial recoverability of After the Event (ATE) insurance premiums.

We await two separate consultation papers expected to be published this month. The fixed costs consultation is to be managed by the Department of Health (DoH) rather than the Ministry of Justice (MoJ). This it is said to be due to a lack of resource at the MoJ. The sole purpose of the exercise is to reduce legal costs so we expect swingeing cuts to current cost levels.

The MoJ will manage a review of the partial recoverability of ATE premiums and they called some "Stakeholders" including Temple Legal Protection to a series of "pre- consultation" meetings in August and September this year.

This article concentrates on the review of premium recoverability but I cannot divorce the effect of the introduction of fixed fees which alone, may affect the ATE insurance model. For example, if expert fees were to be capped, this might affect ATE premium pricing. With reduced exposure it might be possible to reduce the ATE premium but what if fixed fees lead to much reduced litigation so reducing the number of ATE insurance policies taken out. We might then see ATE premiums increasing.

A piecemeal reform may lead to many other unintended consequences.

ATE Insurers did their best to introduce competitive premium levels in April 2013. This was despite the late publication of the Regulations. From the outset, the National Health Service Legal Authority (NHSLA) has and continues through their appointed Costs Draftsmen, regularly challenged the level of recoverable premiums.

ATE Insurers have had to wait over two years for a "test case" to be decided and in May 2015 the decision in *Nokes v Heart of England Foundation Trusts [2015] EWHC B6 (COSTS)* found that an ATE premium of £5860.00 plus IPT was reasonable.

Shortly after that decision, the MoJ announced they were to review the recoverability of ATE insur-

ance premiums for Clinical Negligence cases. "Stakeholders" including Temple Legal Protection Limited, attended a series of "pre consultation" meetings and were advised of the following agenda:

2015 MoJ Review

1. *Assessment of impact of Jackson/LASPO costs reforms on clinical negligence cases, including ATE premiums for expert reports.*

2. *What data do you have on claims that you deal with: (i) up to April 2013; (ii) post April 2013. What does the data show: number of claims; value of claims; merit of claims; legal costs claimed and recovered; costs of ATE premiums?*

3. *Current state of ATE market: numbers and details of providers (if appropriate with areas of specialisation within clinical negligence).*

4. *MoJ is drawing up various proposals for reforming the arrangements for ATE premiums for clinical negligence expert reports:*

   - Abolishing recovery for clinical negligence expert reports.
   - Restrict recoverability of expert reports to cases above the Department of Health fixed costs limit.
   - ATE insurance premiums not recoverable if no expert evidence has been obtained.
   - Introduce a notice period.

From the above it seems apparent the MoJ have little idea about the current state of the ATE Insurance market and the ATE industry must consider providing as much information as possible to enlighten them. On the other hand do the MOJ just want the information to more accurately calculate the potential savings an end to partial recoverability would bring about?

As to the options for changes set out in item 4 above my view is that:

Abolishing recovery for clinical negligence expert reports.

The premium for expert reports would not reduce just because it was no longer recoverable, as the same costs exposures would remain. The increase in the Claimants responsibility to pay all the ATE premium could mean many lower value cases are simply unviable, like small Commercial disputes have become, limiting access to Justice.

It is also quite probable that behaviors will change with more extreme risks being selected for insurance and good risks not being insured. The current premiums would have to rise to pay for the claims of a smaller risk pool, again making ATE insurance too expensive for many.

Restrict recoverability of expert reports to cases above the Department of Health fixed costs limit.

The introduction of fixed recoverable legal fees and the level of damages where this new regime would apply has been mentioned as being up to anywhere between £25k and £250k. If fixed costs apply to damages as low as £25k that could remove 80% of cases from the risk pool, leaving just 20% of the current market to insure. It may be considered that such a small basket of risks is not sufficient to form a proper risk pool for insurance purpose. This could result in either the Insurers not participating in this class, or premiums would be excessive.

Also, unless the proposed fixed cost regime also deals with the current high costs of expert reports (which we understand it will) the above proposal will not help as Claimants will still be liable for expensive expert reports.

ATE insurance premiums not recoverable if no expert evidence has been obtained.

Most Clinical Negligence cases do have an expert report, so any savings here would be limited. This could also affect the basket of risks which Insurers need to provide a viable product, in that for every good case that is removed from the risk pool, the cases that are left are more costly on average and so the premiums have to increase to compensate. The NHSLA would therefore still be paying the same overall amount, but on fewer cases.

Introduce a notice period.

Similar to Defamation cases where premiums could not be recovered for a set period to allow the opponent to reach a decision as to liability and causation.

The same basket of risks theory applies as was discussed above, this might take too many risks out of the "basket" leaving the market unviable.

Timetable for change

We can anticipate that the two separate Consultation papers will be published before the end of the year. The consultation period is likely to be as short as six to eight weeks.

The decisions are likely to be made before Easter 2016 with introduction in October 2016.

Lawyers and other interested organisations together with Stakeholders must all contribute to the consultation. We must all lobby Parliament; after all it is less than three years ago that MP's considered the exemption to loss of recoverability afforded to Clinical Negligence claims was appropriate. What has changed except a diktat from Government to find more monetary savings?

The amount of misinformation being issued by the Department of Health must be exposed and I would suggest you read the most informative papers written by Andrew Ritchie QC of 9 Gough Square Chambers. The papers were published in July and August 2015 and provide a wealth of relevant facts and figures which clearly suggests there have already been many savings as a result of the recent reforms.

The foreseeable future

Will there be a future for the funding of Clinical Negligence cases? If recoverability of ATE premiums for Clinical Negligence is ended, many thousands of Claimants will not be able to afford the insurance premiums.

Costs are being squeezed and so Solicitors, Counsel and ATE Insurers are all looking to negotiate a viable deal for them to continue offering their services.

It seems to me, many Law Firms have been slow to react to the 2013 changes and a further significant drop in their fee income as a result of fixed cost regimes, coupled with having to advise Clients they have to pay all of the ATE insurance premium may be the last straw.

Temple Legal Protection has had to cancel several insurance facilities with Law Firms already, as they are not commercially viable. Some Firms have failed over the last 2 years and there will be more mergers and acquisitions to come.

In times of adversity there are always those who rise to the challenge. Many Personal Injury Law Firms have recently entered this market and as an Underwriter, with experience of considering and monitoring Clinical Negligence it worries me that the complexities of this type of work will not be appreciated by those Lawyers, leading to poor service and disastrous results. On the other hand can Clinical Negligence Lawyers learn from the efficiencies already being employees by their Personal Injury colleagues to ensure they remain in the frame?

As McCartney trod his long and winding road he sang:

Why leave me standing here.

Let me know the way!

By early 2016 I am sure the way will be clearer.

David Pipkin CFILEx

Director Underwriting Division

Temple Legal Protection Limited

Andrew Ritchie's article can be found here.

Reference - The Long and Winding Road by Paul McCartney

Sarah Gubbins, Associate, Penningtons Manches, London

NO FAIRY TALE ENDING FOR CINDERELLA SURGERY PATIENTS

As people become more comfortable with the concept of altering their body through cosmetic surgery, the industry is developing new and innovative procedures to resolve every conceivable body issue. The latest offering is 'Cinderella' surgery, named after one of the favourite fairy tale princesses. As the name suggests, this procedure is for women seeking to change the size and/or shape of their feet so that they can fit into, or look better in, designer shoes.

To achieve this, some women ask for the removal of bunions while others want their toes to be shortened and straightened so they look better in 'peep-toe' shoes. Increasing the arch in someone's foot in an attempt to make high heels more comfortable is also a popular request. Some women have even opted to have fat inserted into the soles of their feet so they can walk more comfortably in high heels.

Recent headlines claimed that, in advance of her wedding, Kim Kardashian may have undergone a liposuction procedure on her toes to remove 'toebesity'. The procedure is nick-named a 'Loub job' in acknowledgement that it allows people to wear very high Christian Louboutin shoes without their feet hurting.

As well as allowing women to wear designer heels, Cinderella surgery can help to repair the damage caused by wearing high heeled shoes. When you wear high heels, your foot slides forward in your shoe, redistributing your weight and creating unnatural pressure points and misalignment. Over time, problems can develop, particularly if you wear shoes with narrow, pointed toes.

High heel problems

Some of the problems that can arise from wearing high heels include:

- Hammer toe – a deformity where a toe curls at the middle joint. This is caused by high heels because they force the toe against the front of the shoe, causing unnatural bending.

- Corns and calluses – think hard layers of skin which develop as a result of friction.

- High heels can cause painful rubbing and uncomfortable pressure points.

- Bunions and bunionettes - bony bumps that form on the joint at the base of your big toe (bunions) or on the joint of your little toe (bunionettes). Tight-fitting high heeled shoes do not necessarily cause bunions but can exacerbate an existing problem.

- Stress fractures - tiny cracks in the bone caused from the pressure that high heels place on your forefoot.

- Toenail problems – constant pressure can cause in-growing toenails and nail fungus.

- Joint pain in ball of the foot (metatarsalgia) - high heels put more weight on the ball of your foot which causes increased pressure, and therefore pain, in your forefoot.

Toe shortening and other toe curling surgical procedures

Shortening the toe may include shaving off the bone and because toes help to support people's weight and balance the body, cosmetic surgery can affect people's balance and redistribute their weight. This can lead to complications later in life, such as the development of serious arthritic pain. Surgeons have also warned of months of swelling after foot surgery.

Any shaping of the bones will be subject to swelling and bruising but the feet are even more susceptible. After foot surgery, patients must stay off their feet for several days but many do not have the patience to do this, putting weight on their feet before they have properly healed and injuring themselves. Many people end up with long term issues with their feet even after surgery – with no fault on the part of the surgeon.

This trend for foot surgery goes even further. As people start having all kinds of procedures for purely cosmetic reasons, their judgement of what is reasonable can become distorted and the pursuit of beauty can go too far. It was recently reported that one patient asked her surgeon to amputate her little toes. Thankfully he refused but this highlights concerns that some people will stop at nothing to achieve their cosmetic goals. It is unclear whether this particular patient had ever considered that removing her little toes was likely to significantly affect her ability to balance.

Shoes to fit your feet not feet to fit your shoes

Sarah Gubbins, associate in the clinical negligence team at Penningtons Manches LLP, comments: 'While this treatment is biggest in America, it is also available in the UK where it is often referred to as a 'foot face lift'. But before rushing out for Cinderella surgery in the hope that your perfect feet will help you catch your very own Prince Charming, it is important to consider the realities of this type of surgery.

“One of the problems is that people seek such surgery from cosmetic surgeons, podiatrists and orthopaedic surgeons – all of whom may have different approaches, expertise and medical qualifications. We have dealt with a number of claims involving surgery performed by podiatrists which was not advisable and/or was done to a poor standard.

“We appreciate that some people will be keen to correct bunions or hammer toes but they must realise that there are associated long-term risks and that after-care is vitally important to prevent further damage. Our advice is, that if you are considering Cinderella surgery purely for cosmetic reasons, choose shoes that fit your feet rather than trying to make your feet fit the shoes. And if you do opt for surgery, research the procedure you are having and the expertise of the person doing it very carefully.”

Penningtons Manches LLP has a leading clinical negligence practice that deals with clients nationwide. Within that practice, we have a specialist team dealing with cosmetic surgery claims relating to treatment performed in the UK and abroad. Members of the team can advise on issues arising from such treatment and the options in relation to any claim.

For more details see http://www.penningtons.co.uk/expertise/clinical-negligence/cosmetic-surgery-claims/ or call **0800 328 9545**

Alison Johnson

Senior Associate, Penningtons Manches, Basingstoke

"FLY IN, FLY OUT" COSMETIC SURGEONS – DO THEY LEAVE PATIENTS STRANDED?

The British Association of Aesthetic Plastic Surgeons (BAAPS) has called for changes to the law to help combat problems that can arise when cosmetic clinics in the UK use so-called "fly in, fly out, surgeons". We support their concerns, having seen the problems first hand that can arise for patients when they suffer complications from surgery done in these circumstances.

"Fly in, fly out" surgeons are foreign surgeons who fly in to the UK, carry out a list of operations in a condensed period of time on a private basis and then fly out again leaving the patient under the care of the clinic with no follow up from the surgeon who performed the operation. The clinics encourage the surgeons to complete as many operations as possible in one day – rather like a factory production line. Surgeons are often paid according to the number of procedures they perform and, as the clinic's income is clearly determined by the number of patients, there is pressure to obtain patients' consent and process them through surgery as quickly as possible.

Potential risks from 'production line' surgery

There are a number of potential problem areas with 'production line' surgery. The first is that of pre-operative preparation and consent. One of the issues with cosmetic surgery procedures is that patients may have unrealistic expectations about the outcome and, if sufficient time is not taken to understand the patient's history and expectations, there is a risk that the outcome may not be as the patient hoped.

The second potential area of risk is if complications arise during surgery. For a surgeon with a production line of patients and an expectation of flying home at the end of the day, the care of a patient who suffers complications may be left to nursing staff and not monitored or managed in the same way as in a 'normal' hospital environment. The lack of facilities to deal with critical patients can also cause problems and, in situations involving bleeding or other progressive complications where the patient deteriorates significantly, the only recourse will be to transfer them as an emergency to a hospital elsewhere.

We are currently dealing with just such a claim for a client who suffered bleeding following a gastric banding operation. Her condition deteriorated to the point where she was in danger of losing her life before she was transferred elsewhere as an emergency for life-saving surgery.

Even if the surgery itself goes to plan, patients can then struggle to obtain good consultant aftercare as their surgeon may not be back in the UK for some time.

Difficulties in pursuing a claim – some case examples

If things do go wrong, it can prove difficult to pursue a clinical negligence claim for damages against

a foreign surgeon whose professional indemnity insurer may or may not cover his or her practice abroad. Tracking down the surgeon and any medical defence organisation or insurer can be tremendously difficult particularly if there are complex issues involving jurisdiction and multiple defendants. All in all, patients can be left in a very difficult position if things do not go to plan.

We have recently settled two cases that are good examples of the problems that can arise. In the first case, we represented a client who had received very poor care from a French plastic surgeon operating in the UK. Our client's facial fat injections migrated from their intended position leaving her with a cosmetic deformity and causing her considerable distress. She had met the surgeon only a few days before the fat injections were given because he was only in the UK for a short period of time and did not have time to offer the minimum two week "cooling off' decision period before her procedure.

If our client had been given longer to think things over and to weigh up the risks associated with the treatment, she would not have rushed into having her procedure - and may not have proceeded at all. There were, in fact, less invasive options open to her and, had she known about them, she was likely to have tried them first.

The French plastic surgeon was very reluctant to disclose her medical records and, when he did, we strongly suspected that they had been falsified to some extent. The records suggested that there had been a much earlier initial consultation, which our client denied and provided evidence that it had never happened. The claim settled with our client receiving damages of £28,000.

In the second case, we successfully settled a claim for a client who had a very poor result from surgery undertaken by an Austrian plastic surgeon arranged through one of the leading national cosmetic surgery clinics in the UK. Tracking down and liaising with the surgeon was very difficult as he repeatedly ignored our correspondence and tried to stall our investigations.

Our perseverance paid off and we eventually discovered the details of his professional indemnity insurers. They were a foreign company but, once we established contact with them, they co-operated and we were able to open negotiations and settle a claim for £20,000 plus costs. Considerable time and legal costs would have been avoided had the defendant surgeon been UK based or had insurance cover with a UK insurer who understood the legal process.

The BAAPS three point plan

BAAPS has come up with a three point plan to help avoid these difficulties:

- Informed consent – the consultation must be with the surgeon and not a nurse or any sales person for the clinic involved. The surgeon must consider the patient's suitability for the intended procedure and discuss the treatment thoroughly in order to take informed consent.

- Indemnity insurance – all surgeons operating in the UK should have adequate insurance cover, either from companies based in the UK or policies that provide equivalent cover, so that their work here is covered and they can meet claims for damages and legal costs if necessary.

- Equivalent standards – all foreign surgeons should undergo the equivalent of the revalidation with the General Medical Council (GMC) as UK surgeons are required to do.

BAAPS has said that its recommendations would be a “costs-neutral way of establishing proper informed consent, a proper insurance cover and proper standards for the benefit of all patients” and we agree.

Penningtons Manches LLP has a leading clinical negligence practice that deals with clients nation-wide. Within that practice, we have a specialist team dealing with cosmetic surgery claims relating to treatment performed in the UK and abroad. Members of the team can advise on issues arising from such treatment and the options in relation to any claim.

For more details see http://www.penningtons.co.uk/expertise/clinical-negligence/cosmetic-surgery-claims/ or call 0800 328 9545

Dominic Ruck Keene

1 Crown Office Row (Instructed by AvMA to represent the family)

Re: KW

In June 2013, KW was admitted to Hospital. He had a previous history of chronic obstructive pulmonary disease for which he had been treated with oxygen at home. In particular, chest x -rays taken over the previous two years had revealed the presence of a large emphysematous bulla or air pocket in the right side of his chest.

However, on admission, the treating Accident and Emergency locum consultant did not review Mr KW's previous chest x-rays and diagnosed the symptoms of his bulla as a right sided tension pneumothorax. He proceeded to insert a chest drain as though Mr KW was in *extremis* due to a tension pneumothorax. Sadly, the insertion of the chest drain caused the existing bulla to collapse, and more seriously ruptured a blood vessel within Mr KW's chest cavity. Bleeding from that ruptured blood vessel led to a haemothorax, which ultimately caused Mr KW's death two days later.

An inquest into his death was heard in November 2014. Given the issues in the case, AvMA agreed to assist the family and Mr. Dominic Ruck Keene of 1 Crown Office Row kindly represented the family on a pro bono basis. The Inquest took place over three days and included expert evidence from a professor of respiratory medicine. The Coroner accepted the expert evidence that once the chest drain had been inserted and had ruptured the blood vessel; Mr KW's death was, on a balance of probabilities, inevitable. The Coroner found the death to have been caused by complications following the insertion of a chest drain.

The inquest focussed on two key issues regarding the treatment given to Mr KW. Firstly, whether the Accident and Emergency consultant was right to have treated Mr KW as if he was in *extremis* suffering from a tension pneumothorax and/or whether the consultant should have identified from a review of Mr KW's previous x-rays (had they been reviewed in the first place) that he was in fact suffering from the same bulla that had been identified two years previously. Secondly, whether there had been any missed opportunities to save Mr KW's life following the insertion of his chest drain.

The Accident and Emergency consultant claimed for the first time during the course of his oral evidence that he had in fact been aware that Mr KW suffered from emphysematous bullous disease, and continued to assert that Mr KW had been in *extremis* such that if he had not intervened immediately to insert a chest drain, Mr KW would have gone into cardiac arrest within at most 20 minutes. However, evidence was given by independent respiratory and accident and emergency experts instructed by the Coroner disagreed. It was their view that Mr KW was not in fact in *extremis* and did not require an immediate chest drain. Accordingly, there was time during which his previous chest x-rays should have been reviewed and/or a urgent CT scan of the thorax performed, which would have clearly indicated that his presentation was due to his pre-existing bulla, and that a chest drain was not the appropriate treatment. The Coroner decided to make a Prevention of Future Death report asking that steps should be taken to ensure that previous patient radiology, history and medication had to be taken into consideration prior to the insertion of a chest drain, and that input from a respiratory consultant should be sought prior to the insertion of a chest drain.

With regards to any missed opportunities, the Coroner ultimately accepted that although there had been missed opportunities to perform a timely review of Mr KW by a respiratory consultant these would not have affected the outcome. However, the Coroner went on to add to his PFD report that the respiratory team had to undertake an assessment of all patients who had a chest drain inserted, and that there should be a *de novo* review when patients were transferred from A&E that did not just rely on previous medical information or diagnoses.

Comment – This case raised interesting questions regarding the immediate care given when a patient is (mistakenly) diagnosed with a relatively rare condition (tension pneumothorax without any external wound) and where a simple check of previous medical records is likely to have prevented an unnecessary and ultimately fatal insertion of a chest drain. It also raised wider questions regarding the systemic problems with providing 24/7 respiratory consultant advisory input, as well as the danger of a mistaken diagnosis made in A&E becoming the default interpretation for a significant and potentially crucial period of later care.

Dominic Ruck Keene

1 Crown Office Row

QUALITY v. QUANTITY – THE BALANCING ACT

INTRODUCTION

In early November, the Court of Appeal handed down its judgment in *Christine Reaney v (1) University Hospital of North Staffordshire NHS Trust (2) Mid Staffordshire NHS Foundation Trust* [2015] EWCA Civ 1119, which clinical negligence practitioners need to be aware of and prepare for evidentially.

The Court of Appeal (Lord Dyson MR, Tomlinson LJ Lewison LJ) unanimously agreed that where a negligent defendant caused a loss which was quantitatively, but not qualitatively different from the claimant's pre-existing needs, the defendant would only be liable for a claimant's *additional loss*.

On the other hand, where the loss arising out of the negligence can be said to be qualitatively different then a claimant could recover for all of those losses as they can be said to have arisen/ caused entirely by the negligence of the defendant. Although at first glance this may appear to be a simple and straight-forward distinction, it is not as this case demonstrates.

THE FACTS

Ms Reaney had been diagnosed as suffering from transverse myelitis, a neurological disorder caused by inflammation across both sides of one level, or segment, of the spinal cord at the age of 61. She failed to recover from this condition and became paralysed below the mid-thoracic level.

As a T7 paraplegic she required a few hours of care each week rising to 31½ hours after the age of 75. Such care would have enabled her to lead a largely independent life.

Unfortunately, during an extended period of hospitalization, Ms Reaney developed several deep pressure sores with consequent osteomyelitis (inflammation of the bone marrow due to infection), hip dislocation, lower limb contractures and increased spasticity. This was caused by the defendant's admitted negligence. As a result, Ms Reaney required 24 hour care provided by two carers. This was a substantial quantitative increase but was not qualitatively different because it concerned care for the same matters as previously required, albeit for longer.

THE ISSUE

Foskett J. at first instance (*Reaney v University Hospital of North Staffordshire* [2014] EWHC 3016 (QB), [2015] PIQR P4), found that Ms Reaney "…*would not have required the significant care package (and the accommodation consequent upon it) that she now requires but for the negligence*". He went on to find that the requirement for 24 hour care provided by two carers for the rest of Ms Reaney's life was "*materially different from what she would have required but for the development of the pressure sores and their sequalae*". His Lordship therefore concluded that Ms Reaney was entitled to full compensation of <u>all</u> her care, physiotherapy and accommodation costs.

The defendant appealed contending that it should only be liable for Ms Reaney's care needs over and above those that would have existed 'but for' the negligence.

THE DECISION

In allowing the appeal, the Court of Appeal concluded that the findings of Foskett J. did not support his conclusion that the significant care package required as a result of the negligence was *qualitatively* different from that which would have been required 'but for' the negligence. Ms Reaney's post-negligence care needs were substantially of the same kind as her pre-existing needs and therefore the defendant was only liable to meet the cost of her additional needs arising as a result of the admitted negligence (*Performance Cars v Abraham* [1962] 1 QB 33*, Baker v Willoughby* [1970] AC 467 *and Halsey v Milton Keynes General NHS Trust* [2004] EWCA Civ 576, [2004] 1 WLR 3002 followed). The decision in *Sklair v Haycock* [2009] EWHC 3328 QB upon which Foskett J. had relied upon in reaching his decision on causation was distinguished by the Court of Appeal on the basis that in that case the post-accident care needs were *qualitatively* different.

The Court of Appeal also noted that there was no cause for recourse to the modified "but for" test of material contribution as set out in *Bailey v Ministry of Defence* [2008] EWCA Civ 883, [2209] 1 WLR 1052, as Ms Reaney's pre-accident condition and the injuries suffered as result of the defendant's negligence were not in doubt.

THE IMPLICATIONS FOR CLAIMANT'S AND THEIR REPRESENTATIVES

Determining the *qualitative* difference in the case of a loss/need will not be a straightforward exercise, especially where a claimant's pre-negligence needs are expected to change over time.

In the Court of Appeal, counsel for Ms Reaney sought to argue that the expertise now required of the carers was different (more specialist) to that of the occasional carer that would have sufficed had Ms Reaney not suffered the bedsores and their consequences. He also argued that the physiotherapy regime required as a result of the negligence was different in kind to that required previously.

These arguments were roundly rejected by their Lordships because it was said that there was an absence of reasoned findings by Foskett J that the care package required following the negligence was different in kind from that which would have required but for the negligence.

This reasoning illustrates the importance of claimant representatives obtaining direct quantitative as well as qualitative evidence from their experts detailing the pre and post-negligence position. Furthermore, at trial, it is imperative that claimant counsel stresses to the trial Judge the need to clearly deal with these two substantive matters in the overall balancing exercise when giving judgment on losses claimed. Failure to do so is likely to result in full losses which are in reality qualitatively different not been awarded.

It will be interesting to see what the Judges consider to be the threshold beyond which losses are considered qualitatively different.

Shahram Sharghy and Tom Mountford

9 Gough Square

Simon v Imperial College Healthcare NHS Trust (2015) QBD 04/06/2015

William Audland QC, acting for the Claimant, successfully resisted an application by the Defendant/NHSLA to stay the proceedings in a clinical negligence claim (and adjourn the assessment of damages) pending the outcome of the Court of Appeal's decision in *Reaney v University Hospital of North Staffordshire NHS Trust* (and whether the decision in *Sklair* is wrong in law). Supperstone J held that the balance of justice under the overriding objective required the claim to proceed to trial.

The full case report can be found on Lawtel

The Claimant in *Simon* claims damages in respect of sacral pressure sores which he developed as a result of clinical negligence occurring in the course of his treatment by the Defendant Trust for spinal injuries. The Claimant's case is that he spent an additional year in hospital as a result of the pressure sores, and was under-rehabilitated on his discharge due to the fact he could not undergo the spinal rehabilitation programme that would otherwise have been offered to patients with his condition. He claims substantial damages for his increased lifelong care needs attributable to his permanently vulnerable sacral skin. Although the Trust has admitted breach of duty, causation is denied on the basis that the majority of his care needs would have arisen from his paraplegia in any event. Judgment had been entered for the Claimant, with damages to be assessed at a quantum-only trial listed in 5 months' time. The case had progressed and was almost ready for trial: the only outstanding steps being the joint statements. The Defendant valued the case at £83,000; whilst the Claimant's claim was for £1.6m. The Claimant had relied on *Sklair v Haycock* [2009] EWHC 3328 and *Reaney v University Hospital of North Staffordshire NHS Trust* [2014] EWHC 3016 (QB) in support of his valuation, contending that he does not have to give credit for care that would have been provided by the local authority but for the Defendant's negligence .

The Defendant's primary case was that there is nothing inconsistent between the decision in *Reaney* and its contention that the Claimant does have to give credit but its alternative case was that *Reaney* (and *Sklair*) was wrongly decided, and that as this is an important issue for the NHSLA in clinical negligence claims generally, a stay was appropriate pending clarification from the Court of Appeal as to the correct approach in law to the assessment of damages in such circumstances.

The Claimant argued that a stay was contrary to the overriding objective. First, a stay was inappropriate because these were first instance decisions so the Defendant is not prevented from advancing either its primary or its alternative case at trial. Secondly, the primary issue as to causation turned on the expert medical evidence, not the law, and that would benefit from an early resolution. Thirdly, if the Defendant lost the relevant legal argument at trial, it could seek permission to appeal and a stay of any appeal, or an extension of time in which to appeal, pending the outcome of the appeal in *Reaney*, which was to be heard some two weeks after the trial of this case, so no injustice would flow from the refusal of a stay. Further, it was far from clear that the appeal in *Reaney* will succeed, the decision being in line with *Sklair* (which was never appealed). If, by contrast, the Court of Appeal overturned the first instance decision in *Reaney*, any appeal in the instant case could be compromised in terms of credit given in damages. By contrast, significant injustice would result to the Claimant from any stay: a lengthy delay in the early trial of the expert evidence relating to the key issue; and that delay was prejudicial to the Claimant personally.

The Defendant contended that the Claimant would not be prejudiced by any stay as he would re-

cover damages eventually, was in receipt of local authority care presently and had received an interim payment. It was submitted that a failure to grant a stay would lead to wasted expenses, the likelihood of an appeal, and a delay in the final determination of the matter. It was further argued that the refusal of a stay would result in the parties not being on an even footing because the Trust would be unable to engage meaningfully in ADR.

Supperstone J held that the Court's discretionary power in CPR 3.1(2)(f) to stay proceedings must be exercised in accordance with the overriding objective, and he was not persuaded that there was any substantial or real injustice to the Defendant for the reasons given by the Claimant's counsel. A stay would mean that there would be substantial injustice to the Claimant arising out of a probable delay of a year or more and the consequent financial hardship. Further, for reasons personal to Mr Simon, a stay would be particularly objectionable in this case. It was desirable that the directions set down to trial should proceed. The balance of competing considerations under the overriding objective favoured continuing to the trial originally listed. The application for a stay was therefore refused.

COMMENT

In addition to being a valuable addition to procedural precedent, the case is a reminder that the interests of the individual litigants cannot be subordinated to the legal issues alone.

Decisions on case management are rarely reported, turning largely on the discretion of the judge hearing the case. However, there is little guidance for practitioners in relation to the circumstances in which the Court should stay/adjourn a trial at first instance pending the outcome of an appeal in another case on a material point of law. It is generally thought that a stay of proceedings may be granted pending the outcome of a test case (see e.g. *Blackstones Civil Practice 2015* and *Zuckerman on Civil Procedure: Principles of Practice*) and the authority commonly cited is *Woods v Duncan* [1946] AC 401. However, although that case is a House of Lords authority, the text of the decision in fact provides little support for the principle. Rather, it is more the circumstances surrounding the case and less the dicta in the case itself which support the principle. The opening paragraphs of the judgment notes that "claims by many other plaintiffs depend on the decision in this appeal."

Supperstone J's decision in this case, however, demonstrates that a close consideration of the factors in the individual case (including the progress of the timetable, the circumstances of the parties, the arguments being advanced by either side, and the procedural alternatives available to each party if a stay is not granted) is determinative of the balance of justice/prejudice pursuant to an application of the overriding objective.

William Audland QC

12 Kings Bench Walk

"Re: A (A child) - Practical problems arising with brain stem death"

Dear All

We would like to alert you to an important Court ruling that affects our speciality:

Re: A (A Child) [2015] EWHC 443 (Fam) (1) involved a 19-month old boy who tragically choked on a piece of fruit leading to cardiac arrest and resultant catastrophic hypoxic-ischaemic brain damage.

Because the UK has no legal definition of death Common Law accepts death verification by practitioners using accepted guidance, which currently is the 2008 Academy of Medical Colleges Code of Practice for the Diagnosis and Confirmation of Death provides the contemporary legal and medical standard. (2)

In line with the standards in that document, brain stem testing was performed and sadly confirmed that the child was dead. The child's devout Muslim parents were students from Saudi Arabia, although the child had been born in the UK, and could not accept the diagnosis. They requested transfer of 'their child' to Saudi Arabia. Because death had occurred the body, still attached to a ventilator, fell under the jurisdiction of the Coroner who recommended removal of the ventilator and transfer of the body to the mortuary. The clinical team spent a significant time with the family, yet no agreement about stopping mechanical support could be reached.

Given recent controversy in the USA regarding the neurological determination of death in a child whose parents consistently refused to accept the diagnosis, the UK court ruling is important to UK-PICU practitioners.

In the US case a 13-year old girl, Jahi McMath, sustained catastrophic hypoxic brain injury following a massive haemorrhage complicating ENT surgery for obstructive sleep apnoea. Brain death tests confirmed the diagnosis, but her family refused to accept this and filed a lawsuit petitioning the local court to require Children's Hospital Oakland to continue 'life support.' Despite ruling McMath dead, based on medical evidence from physicians from the hospital and an independent expert, the Judge ordered mechanical ventilation continue until appeal. (3) At appeal the family argued that application of the US Uniform Determination of Death Act was a violation of constitutional religious and privacy rights, and that because Jahi's heart was beating, she was still alive. McMath, or her body depending on acceptance of certification, has now been moved to another US state in which a patient's religious viewpoint must be considered by physicians when determining death. (4)

Acceptance of such religious influence over how one's death is verified, usually a veto over neurological determination of death, is permitted in several US States and the State of Israel. This objection ranges from an undefined accommodation of religious viewpoints by professionals in New York, to full legal veto in Israel, and New Jersey if an individual's personal religious beliefs would be violated. (5, 6)

Giving judgment in the Re: A case the Honourable Mr Justice Hayden clarified three important points of law:

(i) Shared jurisdiction over this child's brain dead body still attached to mechanical ventilation. The Coroner having traditional jurisdiction to determine who died, where they died and how they died; but the Court also having jurisdiction under both 'the parens patriae' and 'pursuant to an application for declaratory relief made under the inherent jurisdictional power.'

(ii) That 'should a difference of view arise between treating clinicians and family members in circumstances where assisted ventilation is continuing, any dispute, if it cannot be resolved otherwise, should be determined in the High Court, not under coronial powers.'

And finally, whilst expressing profound respect for the child's father in his ruling that child A died on the 10th February when brain stem tests were satisfied and that ventilation should be removed to allow the child 'dignity in death,' he confirmed:

(iii) UK legal acceptance of brain stem death as equating to the death of the person, a ruling consistent with that of Johnson J in the original UK case, another child, in which legal acceptance of the neurological determination of death occurred. (7)

So, with a brain dead child in the UK if parents cannot accept the diagnosis the correct action is to liaise with the Coroner and then approach the High Court. However, the Courts accept that the child is dead so, unlike elsewhere, the UK does not provide for religious control over how one's death is verified.

Dr Stephen Playfor, Consultant Paediatric Intensivist, Royal Manchester Children's Hospital & Dr Joe Brierley, Consultant in Paediatric and Neonatal Intensive Care

References

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2. Academy of Medical Royal Colleges. A code of practice for the diagnosis and confirmation of death. London: Academy of Medical Royal Colleges 2008.
3. Alameda County Case No. RP-13-707598 "Opposition To Plaintiff's Motion To Compel Further Life Support And The Installation Of A Tracheostomy Tube And Gastric Feeding Tube To Allow Transportation Of Jahi Mcmath". United States District Court for the Northern District of California. 7 January 2014. Retrieved 7 October 2014.
4. Paris J, Cummings B, Moore P. "Brain Death," "Dead," and Parental Denial The Case of Jahi McMath. Cambridge Quarterly of Healthcare Ethics (2014), 23 , 371 – 382.
5. Olick R, Braun E, Potash J. Accommodating Religious and Moral Objections to Neurological Death. The Journal of Clinical Ethics 20, no. 2 (Summer 2009): 183-91.
6. Segal E. Religious objections to brain death. J Crit Care. 2014 Oct;29(5):875-7.
7. Re A (A Minor) [1992] 3 Medical Law Reports 303.

Access to Medical Treatments (Innovation) Bill

This is a private members' Bill introduced in the Commons by Chris Heaton-Harris MP. It is partly a re-production of Lord Saatchi's Medical Innovation Bill which failed to complete its passage in the last parliament. The Bill has progressed to the committee stage on a vote of 32 – 19 but the good news is that it is facing stiff opposition. Labour are opposed, as is the Conservative chair of the Health Committee, Sarah Wollaston MP. However, it has Government support, with a three line whip having been deployed, which is unusual for a private members bill. AvMA's briefing was circulated to all MPs and was widely quoted in the debate. AvMA is continuing to brief parliamentarians about the misguided nature and dangers of this bill and has helped build a strong alliance of fellow charities and other opposed to the bill. Members may wish to use whatever influence they have with politicians also.

Independent Patient Safety Investigation Service (IPSIS)

AvMA is involved in discussions about this service which was recommended by the Public Administration Select Committee earlier this year. The aim is to create a service (which will be part of the new body "NHS Improvement" which comes into being in April 2016), and which will improve the quality of NHS investigations. There are concerns about the degree of independence which IPSIS will enjoy and the limited capacity to conduct a large enough number of incidents. A key debate being held within the Advisory Group designing it has been whether IPSIS will guarantee full and unconditional disclosure to patients/families when information about their treatment is found by the investigations. There are those who feel this needs to be withheld in order to make witnesses feel comfortable about providing evidence. AvMA is arguing strongly against such an approach, which would be at odds with the Duty of Candour and the NHS Constitution. For details about IPSIS see: here

Duty of Candour

The Duty of Candour applying to NHS bodies in England is now one year old. We are aware of some difficulties with the implementation of it and there is quite a lot of misunderstanding or lack of awareness in the NHS about it, but our sense is that patients are being told much quicker and more often when something has gone wrong in treatment. We would be interested in members' feedback about their experience. In particular if you come across what appear to be breaches in the Duty of Candour we would be grateful if you could bring them to our attention. We can help ensure that the Care Quality Commission is aware of them and if necessary take action with the organisation concerned. Contact chiefexec@avma.org.uk .

Following AvMA's threat of a judicial review, the Department of Health are due to consult in December on new regulations which will create one definition of the Duty as opposed to the differing ones which currently apply to NHS Bodies as opposed to primary care providers, the private sector, and social care. Meanwhile, AvMA have given evidence to the Scottish Government which is legislating to create its own Duty of Candour. Wales and Northern Ireland are planning to do likewise.

Maternity Services Review

AvMA have had some input to the Maternity Services Review being chaired by Baroness Cumberlege. The review is due to report in January. We understand that the review may recommend a "no-

fault compensation scheme" for cases involving brain damaged babies. We have warned the review team of our concerns about so called 'no fault' schemes in other jurisdictions often being unfair and short changing injured patients and their families.

Patrons of AvMA

AvMA is please to announce that five leading figures from the world of patient safety and justice have become patrons of the charity. Best known to our members is probably James Badenoch QC, but he is joined by Baroness Masham; James Titcombe OBE; Professor Brian Toft OBE; and Dr Umesh Prabhu. For full details see here

Do you want to keep informed of AvMA's wider work

You may not be aware that in addition to this newsletter for our lawyer members, AvMA also publishes a bi-monthly e-newsletter to our supporters covering topical issues around patient safety and justice; our policy and campaigning and other work. We do not send it routinely to all our lawyer members as we do not want to overload you with emails, but if you would like to receive it for free simply sign up here. Past copies can be found here.

Peter Walsh

Chief Executive

CONFERENCE NEWS

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.

"Our Health; Our Health Service": does the Green Paper hail a new era for Patient Safety and Justice in Wales?

26 November 2015, Park Inn by Radisson, Cardiff

"Our Health; Our Health Service" sets out Welsh Government's agenda for quality and governance, following a host of high profile problems with patient safety and the aftermath of lapses in safety in the Welsh NHS. Following hot on the consultation, this one day conference will explore various stakeholders' aspirations and fears about the new agenda, and the opportunity it provides to develop a health service that is safer and fairer, where patients and their families can access justice.

The conference will present viewpoints from the Welsh Government, the Deputy Chief Medical Officer, Health Inspectorate Wales, the NHS, the Board of Community Health Councils in Wales, patients, patient safety organisations and lawyers.

AvMA Specialist Clinical Negligence Panel Meeting & Christmas Drinks Reception

3 December 2015, De Vere Holborn Bars, 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 Thursday 3rd December - registration and a networking lunch will commence at 12.30, with the meeting starting at 13.30 and closing at 17.30.

AvMA's Christmas Drinks Reception, which is also open to non-panel members, will take place immediately after the meeting, also at De Vere Holborn Bars. The event provides an excellent opportunity to catch up with friends, contacts and colleagues for some festive cheer!

Medico-Legal Issues in Accident & Emergency Care

10 December 2015, Doubletree by Hilton Hotel, Leeds

Emergency Care Services are facing intense pressures to sustain its high-quality urgent and emergency care system (The King's Fund, 2014). With the current changing NHS climate there is a vital need to continually monitor these services and ensure high quality care remains consistent throughout all NHS Trusts. With this in mind, this conference will examine the current standards, issues, roles and responsibilities, investigations and management of key areas in accident and emergency care.

Medico-Legal Issues in Orthopaedic Surgery

21 January 2016, De Vere Holborn Bars, London

CONFERENCE NEWS

This essential one day conference brings together leading experts in the field of orthopaedics and gives you an in-depth insight into the conditions relevant to your caseload. 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 will be looked at within each area as well as highlighting where negligence may occur within each condition. This popular conference is not to be missed and is ideal for solicitors and barristers with a limited or intermediate knowledge of orthopaedics who wish to expand and update their expertise in this area.

Clinical Negligence: Law Practice & Procedure

28 - 29 January 2016, Copthorne Hotel, 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. Places are limited to ensure a focused working group.

Legal & Ethical Issues in Consent: Montgomery Six Months On

4 February 2016, De Vere Holborn Bars, London

Following the Montgomery Case in March 2015 all doctors must now make "reasonable care to ensure that the patient is aware of any material risks involved in any recommended treatment, and of any reasonable alternative or variant treatments." This conference will carry on the debate and raise issues on the case law and its application in a clinical negligence setting. Extensive duty of care of 'the curious patient' will be highlighted, as well as ensuring standards are met in expert reporting. The Training and Guidance framework will be explained by the General Medical Council and illustrated case studies from the ward will enable you to put theory into practice and consolidate your learning.

Who should attend? Claimant solicitors and barristers involved in clinical negligence, doctors involved in medico-legal reporting, as well as healthcare professionals involved in clinical governance.

Medico-Legal Issues in Gastroenterology

11 February 2016, Manchester Conference Centre

Leading experts will discuss the delay and the failure to diagnose in gastroenterology, negligent and non-negligent surgery of the upper GI tract, medico-legal issues in colorectal surgery and gastro-oncology and medico-legal issues arising in paediatric surgery. The programme will be available and booking will open in November.

CONFERENCE NEWS

Medico-Legal Issues in Ophthalmology

25 February 2016, De Vere Holborn Bars, London

This conference provides an excellent opportunity to update your knowledge on current medical and surgical treatments in the field of Ophthalmology. You will learn from leading experts on neuro-ophthalmology, cataract surgery, diseases of the eye (including types of glaucoma and its risk factors), retinal detachment, paediatric ophthalmology and laser treatment. Ophthalmic and the failure to diagnose and treat appropriately will also be covered. The programme will be available and booking will open in November.

Medico-Legal Issues in Cardiology and Cardiac Surgery

10 March 2016, Mercure Holland House, Bristol

This essential and popular conference is guaranteed to further knowledge on cardiology and cardiac surgery for your case load, helping you to represent your clients more effectively. Leading experts will cover all the key areas and the latest advances in the cardiology field, including medico-legal issues in cardiac surgery and the diagnosis of congenital heart disease, anatomy of the heart, the role of angioplasty in the treatment of heart disease and arrhythmia. Counsel will also cover quantum in cardiology and cardiac surgery. The programme will be available and booking will open in November.

Cerebral Palsy & Brain Injury Cases

16 March 2016, Foresight Centre, Liverpool

This popular AvMA conference comes to Liverpool for the first time on 16th March and will discuss and analyse the key areas currently under the spotlight in Cerebral Palsy and Brain Injury Cases so that lawyers are aware of the challenges required to best represent their clients. Determining causation, neonatal risk factors and intrapartum fetal distress and surveillance focusing on CTGs will be covered by leading medical experts. Guidance will also be provided on technological aids for children, case management and issues surrounding periodical payments and the discount rate, as well as looking at the current issues in CP and brain injury claims. The programme will be available and booking will open in December.

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.

CONFERENCE NEWS

Annual Clinical Negligence Conference 2016

1-2 July 2016, Hilton Brighton Metropole

The 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.

As ever, it will be an event not to be missed, with 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 and providing 10 hours CPD (SRA, Bar Council and APIL). 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. The programme will be available and booking will open in February.

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

CONFERENCE NEWS

WEBINARS

AvMA Medico-Legal Webinars

- Webinars tailored for the Clinical Negligence practitioner
- AvMA medico-legal format: combining medico and legal expertise
- The only webinar library with 100% Clinical Negligence focus
- Run by AvMA, with 30 years of excellence in Clinical Negligence events

Our webinars are designed to be a learning hub where you can watch high quality audio-video presentations at a time convenient for you. You can replay the sessions and also download speakers' notes and extra learning materials.

AvMA Medico-Legal Webinars are an excellent, cost-effective way to train and develop your Clinical Negligence team as it reduces time away from the office and fits around your working day. You can even transform your commuting time into a learning experience!

AvMA Lawyers' Service Rate:

Single Viewer	Multiple Viewer	Subscription
£49.00 + VAT	£150.00 + VAT	£1,200.00 + VAT
Webinar access for 60 days	Webinar group access for 60 days	Group access to all webinar library content for 12 months

Standard Rate:

Single Viewer	Multiple Viewer	Subscription
£65.00 + VAT	£195.00 + VAT	£1,900.00 + VAT
Webinar access for 60 days	Webinar group access for 60 days	Group access to all webinar library content for 12 months

WEBINARS

Medico-Legal Issues in Pain Management

According to the British Pain Society, "almost 10 million Britons suffer pain almost daily resulting in a major impact on their quality of life".

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

Available from: 30 November 2015

Medico-Legal Issues in Meningitis and Septicaemia

The Meningitis Research Foundation estimates that 3,200 people are infected bacterial meningitis and associated septicaemia in the UK each year, The failure to or delay in diagnosis and manage the treatment of meningitis in children is, unfortunately, a common cause of medico malpractice. 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

Available from: 30 November 2015

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Available from: 30 November 2015

Marketing for Lawyers

online seminar will give you an overview of what is marketing, why it is important and highlight the range of tools and tactics available to plan and implement a marketing strategy in order to run a successful clinical negligence practice.

Presented by: Andrew Jewitt, Associate Director of Marketing, Leigh Day

Available from: 30 November 2015

WEBINARS

Medico-Legal Issues in Laser Eye Surgery

Understand the issues surrounding Laser Eye surgery. This session will cover the types of laser surgery, contra-indications to treatment, consent issues, vision threatening complications and negligent and non-negligent treatment.

Presented by: Mr Damian Lake, Consultant Ophthalmic Surgeon, Queen Victoria Hospital, East Grinstead

Medico-Legal Issues in Maxillofacial Injuries

This webinar will give solicitors involved in medico-legal cases an understanding of the concerns in relation to maxillofacial surgery. This session will discuss nasal, cheek bone and orbital fractures and the failure to diagnose and treat appropriately as well as missed or delayed diagnosis of maxillofacial cancers.

Presented by: Mr Laurence Newman, Consultant Maxillofacial Surgeon, Queen Victoria Hospital, East Grinstead

Medico-Legal Issues in Anaesthesia

This webinar will discuss the issues surrounding the care of patients under anaesthesia and will cover pre-op checks, consent issues, anaesthetic awareness, patient monitoring and post-operative care.

Presented by: Dr David Levy, Consultant Anaesthetist, Nottingham University Hospitals NHS Trust

Understanding Biochemistry Test Results

This webinar will give solicitors involved in medico-legal cases an understanding of how biochemical test results are used to monitor patients' vital functions and how failure to request/monitor may impact on the patient's outcome.

Presented by: Dr Ken Power, Consultant in Anaesthesia and Intensive Care and Lead Consultant for Critical Care Services, Poole Hospital NHS Trust

Inquest - Post Mortem

New Coroners Rules and Regulations came into force in July 2013. Some of the issues affecting Inquests into death following medical treatment arise from changes related to post-mortem examinations, what is considered "natural death" and how this will affect further investigation. Watch this webinar to get some practical guidance on how to deal with the issue of post-mortem examination, when to request post-mortem imaging and how to fund it and what is considered "natural death".

Presented by: Professor Peter Vanezis, Professor of Forensic Medical Sciences; &

WEBINARS

Dr Peter Ellis, Barrister, 7 Bedford Row & Assistant Coroner, West London Coroners Court

Hospital Acquired Infections - the current state of play
This webinar will update solicitors on medico-legal challenges around hospital acquired infections. During the session you will hear about the common hospital acquired infections, pre-hospital admission monitoring, hospital infection policies/infection control meeting, new generation of antibiotics and issues surrounding delay in treatment.
Presented by: Professor Peter Wilson, Consultant Microbiologist, University College Hospital

Blood Pressure - Implications and Outcomes
Blood pressure is an important clinical measurement. This online session will give solicitors involved in medico-legal cases an understanding of what blood pressure is and why it is important to control it.
Presented by: Dr Duncan Dymond, Consultant Cardiologist, St Bartholomew's Hospital, London

Pressure Sores – A Nursing Perspective
According to research, the cost of treating pressure sores is higher than the national cost of heart disease; an astonishing finding when considering that 95% of pressure sores are avoidable. Understand the issues surrounding pressure sores, identify the risk groups for development of pressure sores and differentiate between negligent and non-negligent prevention and management of this life-threatening injury.
Presented by: Cathie Bree-Aslan, Tissue Viability Nurse & Expert Witness, Wound Healing Centres

How to Interpret Blood Test Results
This one hour interactive session provides an overview of the importance of blood tests when looking at medical records and to identify appropriate blood tests that should have been performed routinely with certain conditions.
Presented by:
Professor Samuel Machin, Consultant Haematologist, University College London

Oncology & GP Referral
This webinar will discuss the duties of a GP in the treatment of cancer patients. At the end of this webinar you will be able to identify when cancer should be suspected and when a referral should be made.
Presented by: Dr Nigel Ineson, General Practitioner

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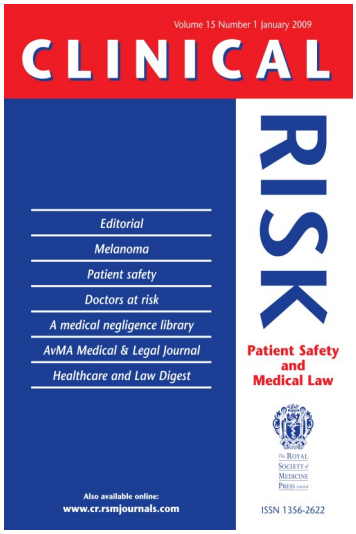

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