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action against medical accidents

LAWYERS SERVICE NEWSLETTER

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EDITORIAL

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Welcome to the first Newsletter of 2015! So far it is clear that the challenges for the legal profession are set to continue. As you will be aware, substantial increases to the court issue fee became effective on 9th March. This is likely to have a considerable impact on firms, particularly those who routinely carry client disbursements; the cost of issuing a claim with a monetary value of £200,000 or more is going to rise from £1,515 to £10,000. Fees for claims worth in excess of £10,000 but less than £199,999 will be charged at 5% of the value of the claim.

In response to this staggering increase, a number of organisations including the Law Society and ourselves have been looking at judicially reviewing the Government's action. A pre-action protocol letter has been sent which, amongst other things, challenges the Government's power to raise fees to make departmental savings and alleges that the Government is proceeding without evidence to justify the increases. All of the allegations have been rejected by the Government; we will keep you up to date with developments.

We are grateful to all of you who have sent in evidence of how the increase in fees will impact on practice and access to justice generally. We are forwarding the information we receive to the Law Society who are collating a body of evidence. There are currently further proposals to increase other court fees, in particular general applications in civil proceedings. The proposal is that the cost of these applications will increase by 100% from £50 to £100 for an application without notice or by consent and £155 to £255 for an application on notice which is contested. There are some applications which will be excepted from these increases if they come in, however the only exception applicable to clinical negligence practice will be that applications for a payment to be made from funds held in court will be exempt. It is not too late for you to contact your MP and express your objections to these increases and the following link will take you to a pro forma letter you can adapt for you MP http://www.lawsociety.org.uk/policy-campaigns/documents/template-letter-for-mps . We still welcome your views on how you believe the increases will impact on your business and/or your clients; these can be emailed to Norika@avma.org.uk .

AvMA has been in contact with the Legal Aid Agency (LAA) to seek confirmation that the financial limits on legal aid certificates will be increased to accommodate the rise in court issue fees. The LAA responded on 17th March saying ***"The LAA is reviewing the operational implications of the new court fees for money claims and will update providers on any changes in due***

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course". AvMA has invited the LAA to state when a decision might be made; we have also asked for some indication on whether, if the increases are agreed, the decision will be applied retrospectively to cases issued between 9th March and the date of the LAA's decision. For those practitioners who need to issue proceedings imminently we have sought clarification on whether the LAA expects those firms to make an application for prior authority to incur the fees and increase the financial limits on the certificates. We have not yet received a response to these questions.

Staying on the subject of legal aid, tenders for LAA clinical negligence contracts closed on 23rd January 2015. We remain conscious that practitioners find it very difficult to find key experts willing to work at Legal Aid rates especially in neurological injury cases where parties tend to be fishing from the same small pool of experts. AvMA wrote to the LAA on 26th November raising concerns about the rates and in particular how it has created a lack of parity between parties; our letter to the LAA can be found at page http://www.avma.org.uk/pages/publications.html
We also raised the issue of "topping up" and as we reported in the December Newsletter, the LAA response was clear: "topping up" is not compliant with the regulations.

However, our concerns on expert rates were referred on to the Ministry of Justice (MoJ) who have now responded stating that they are not aware of any specific shortages or body of evidence which supports difficulties in obtaining experts in clinical negligence cases. However, the MoJ does acknowledge that there is a particular issue around remuneration to obstetricians. In light of this they have agreed to review the rates payable to obstetricians to identify whether "market dynamics" have changed since their last review in 2011. The MoJ has agreed to meet with AvMA to look at this issue further; they have also given permission to publish their response. The content of their e-mail can be found at this link: http://www.avma.org.uk/pages/publications.html

The meeting between the MoJ and AvMA has not yet taken place; there have been some delays owing to a change of personnel at the MoJ. In the mean time, it will be very helpful if you could please **send us copies of any letters you have received from experts refusing to work at legal aid rates;** please feel free to scan in the letters and send them to us by e-mail to Norika@avma.org.uk if that is more convenient.

On a different note, the Medical Innovations Bill has stalled following the Liberal Democrats vetoing the proposal during its second reading in the House of Commons on 27th February. Norman Lamb commented ***"getting the law right in this area is incredibly important. We have to avoid the risk of unintended consequences"***. He went on to say that the best way to proceed was to ***"appoint an eminent person to examine what the barriers to innovation really are and how best to overcome them…such an examination of the issue should involve patient organisations, legal bodies, royal colleges and medical unions. This review could then lead to draft legislation, if it is deemed necessary"*** Clearly, The Bill has not gone away completely; it remains possible that this legislation could go through Parliament possibly later this year.

The Care Quality Commission (CQC) is currently conducting a thematic review of inequalities and variations in end of life care. They wish to hear from a range of people about their experiences of care and have developed an online survey in an attempt to reach as wide an audience as possible. The

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survey **closes on 1st May 2015** and we encourage you to refer your clients to it. A link to the survey is here: https://webdataforms.cqc.org.uk/Checkbox/endoflifecare.aspx

As many of you will be aware, AvMA has been working with the CQC to make the public more aware of the standards they are entitled to expect when receiving care. AvMA is pleased to announce that we have just agreed to continue working with the CQC over the next 12 months to promote this message. We will be contacting our lawyer service members in the next few months with a request that you publically display our jointly branded AvMA/CQC leaflets and encourage your clinical negligence clients to take one and submit details of their care to the CQC.

On a slightly more optimistic note, the successful JR brought by Joanne Letts may herald some better news for access to justice. When considering the guidance on exceptional funding for inquests, Mr Justice Green commented that the guidance set out in the 2012 Legal Aid Sentencing and Punishment of Offenders Act (LASPO) was ***"materially misleading and inaccurate".*** It is hoped that as a result of the ruling more bereaved families will be entitled to Legal Aid at Inquests. I take this opportunity to refer you to the article by James Robottom, barrister at 7 Bedford Row, which is included in this Newsletter; James examines funding for inquest and looks more closely at the effects of Master Rowley's judgment in **Lynch v Chief Constable of Warwickshire Police, Warwickshire County Council & Coventry & Warwickshire NHS Trust.** He also comments on the Letts case and offers practical guidance on how to maximise the recovery of costs of Inquest representation.

Many of you will be aware of the recent judgment given in the case of **Montgomery (Appellant) v Lanarkshire Health Board (Respondent) (Scotland)** handed down on 11th March 2015. The decision better reflects our modern society where patients are capable of understanding the risks associated with procedures and want the right to control their own life. The effect of this Supreme Court decision is to overrule the Siddaway case and to confirm that the Bolam test no longer applies in consent cases. In looking at what a patient should be told about his or her treatment it is no longer correct to reference this to what a "responsible body" of doctors would expect a patient to be told; the test is what the reasonable patient would want to know. It does, of course, remain to be seen whether this heralds the start of a move away from the traditional Bolam test when applied to standards of care more generally. The article by Tom Goodhead, barrister at 9 Gough Square explores whether the standard of care in Wales is different to that in England. Tom sets out his experience of whether a new standard may be evolving in his piece on "The NHS in Wales: devolution and divergence?".

We also have some excellent case reports and I particularly recommend that you look at the cases of **JM v Aylward and Others** and the case of **Millar v Imperial College Healthcare NHS Trust 2014.** Both cases illustrate how innovative and practical solutions can be used to overcome accommodation problems frequently thrown up by use of the conventional Roberts v Johnston formula. The reports have been kindly submitted by Chris Hough, Barrister at Doughty Street Chambers, who was counsel in both cases.

The statutory Duty of Candour came into force for NHS trusts in November 14. The duty comes into force for primary & social care in April. However, it does appear that due to the way The Health & Social Care Act (Regulated Activities) has been drafted, some notifiable incidents may fall outside of the statutory reporting requirements for primary care. The duty on NHS Trusts is to report a "notifiable safety incident" where the incident "could result in, or appears to have resulted in" significant harm. This wording is absent from the regulations relating to NHS primary care providers or private

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healthcare providers. Norman Lamb has written to Peter Walsh and confirmed that the definitions are different and that this was intentional; Peter has taken this up with various MP's and continues to lobby for the same standard to apply to primary care and private care as it does to NHS Trusts.

More generally**, please let AvMA know of any instances of actual or potential breaches of the statutory duty of candour you have witnessed with NHS Trusts**; this will help us monitor how the obligation is being managed by Trusts. In light of the difficulties with a variation in standard for primary care **it would also be of considerable assistance if you could let AvMA have details of any case examples of incidents that would not be captured by duty of candour in primary care and private healthcare settings**. Again, please send in any examples you may have to Norika@avma.org.uk.

Although the market for clinical negligence practitioners remains difficult and uncertain there continues to be movement with firms merging and individuals moving on. From time to time this has caused difficulties for clients who have built up a relationship with their lawyers and who may wish to move with the individual who has been handling their case. Understandably, firms who have bank rolled the disbursements on these cases are unwilling or reluctant to let the clients go, especially if they are on a CFA. We are very grateful to **Roger Mallalieu, barrister at 4 New Square** for offering his advice on some of the issues which commonly arise when situations of this nature unfold. It must be emphasised that Roger's article is meant as a guide; the article does not seek to consider all matters relevant to such situations, and anyone who finds themselves in such a situation should seek their own independent legal advice. However, the article does address some commonly asked questions such as: can you assign a pre April 2013 CFA? When does a client lose their qualified one way costs shifting (QOCS) protection? Is ATE insurance transferable between firms? As well as in this Newsletter, the article can also be found on the members' only section of the AvMA website.

If you have any cases which have recently settled which have unique or interesting features whether in relation to practice, procedure or outcome please do submit them. Again, these can be emailed to Norika@avma.org.uk

Best wishes

Lisa

Lisa O'Dwyer
Director Medico-Legal Services

An Analysis of 'Lynch' and an update on 'Letts'

James Robottom, 7 Bedford Row

Introduction:

The recent Senior Courts Costs Office judgment of *Master Rowley in Lynch v Chief Constable of Warwickshire Police, Warwickshire County Council, and Coventry and Warwickshire NHS Trust*, 14th November 2014, has been heralded in some quarters as ushering in a new era of scrutiny regarding the recoverability of inquest costs in civil proceedings. This article will question the veracity of such assertions, assess the decision's implications for future claims, and offer practical guidance on how to maximise the subsequent recovery of the costs of inquest representation. It will also consider the availability of legal aid for representation at Article 2 clinical inquests.

A decision on its own facts:

The most important aspect of the Lynch decision is set out in its first three paragraphs. Master Rowley emphasised that in assessing the recoverability of inquest costs in the civil claim he was applying the general principles derived from the High Court decision of Davis J in *Roach v Home Office* [2010] QB 256. In *Roach*, Davis J, whilst confirming the general principle that inquest costs are recoverable as costs *'of and incidental to'* the civil proceedings under s.51 of the Senior Courts Act 1981, specifically declined the request of the Defendant to lay down guidelines for the assistance of costs judges, stating that the discretionary costs regime would not be advanced by doing so, and that *"each case should be decided by reference to its own circumstances."* (para.62). In Lynch Master Rowley emphasised that he was doing just that:

> *There have been a number of decisions at first instance by costs judges which have put these principles into practice. This decision is simply a further examination of a particular set of circumstances. The factor which takes this decision into seemingly uncharted waters is the issue of disclosure which took place prior to the inquest. The coming into force of the Coroners' (Inquests) Rules 2013 on 25 July 2013 means that disclosure is now a regular part of the inquest process. That was not the case when the inquest to be considered here took place. It is not for me to lay down any form of general guidelines and the conclusions in this case relate to this case alone….*

Lynch then, is expressly not a precedent for how the recoverability of inquest costs should be approached in future cases. It is a case on its facts alone, and as we shall see, those facts were far removed from an inquest which might require attendance and representation prior to a more typical clinical claim.

***Roach* and General Principle:**

The starting point then remains Davis J's judgement in *Roach*. *Roach* followed *The Bowbelle* [1997] 2 Lloyds Rep 196 and *Re Gibsons's Settlement Trusts* [1981] Ch 179. Davis J approved the reasoning of Megarry VC in *Gibson* to the effect that there are 'three strands' of reasoning to be applied to the question of recoverability, those are:

1. Proving of use and service in the action;
2. Relevance to an issue;
3. Attributability to the paying parties conduct.

There will, of course, as Master Rowley observed in *Lynch*, be overlap between those three strands, but they remain the yardsticks of recoverability.

In *Roach* at first instance Master Hurst had considered that the purpose of lawyers attending the inquest had fallen into “two equal parts” (para.56) that of assisting the Coroner (which could not be recovered for) and that of obtaining evidence necessary to pursue the civil claim (which could). Master Hurst had accordingly halved the Claimants’ legal team’s bill. Davis J, however, disapproved this approach, stating *“[p] urpose will no doubt be a relevant consideration, but I do not see how in this context it can be decisive”* (para.57), and that to render it so would not be consistent with the objective language of costs provision in s.51 of the Senior Courts Act.

One argument made in favour of the recoverability of inquest costs has always been that it can lead to early settlement, in *Roach* Davis J seemingly approved a submission to this effect on behalf of the claimants. He stated (at para.48) that the claimants *were “entitled to observe… that it was open in the instant case to the Home Office likewise to seek to avoid liability prior to the inquest”* and *“also entitled to observe that the inquests here in practice seem to have an the effect of causing the civil proceedings thereafter relatively speedily (and thereby in a way saving of some costs) to be compromised.”*

Finally, though obviously a pre-Jackson case, Davis J in *Roach* did emphasise the importance of proportionality, stating that:

> *There may well be cases (I think it better to say nothing myself as to whether either of these two cases do or do not fall into such a category: it was and is a matter for the costs judge) where the costs of antecedent proceedings claimed as incidental costs are so large by reference to the amount of damages at stake and/or the direct costs of the subsequent civil proceedings, if taken entirely on their own, that a costs judge will wish to consider very carefully the issue of proportionality. This situation is provided for in the Rules by CPR r 44.4(2)(a) (and also rule 44.5). If an assessment of disproportionality is made then costs will only be allowed if they were necessarily incurred and reasonable in amount. The observations of the Court of Appeal in Lownds v Home Office (Practice Note) [2002] 1 WLR 2450 will need to be borne in mind in this context. So here too there is another safeguard for paying parties.*

Lynch:

Lynch was indeed an exceptional case. It concerned a mother who was killed by her ex-partner, whose mental health had deteriorated. Prior to Ms Lynch’s death she and her family had sought help from the police, social services and mental health services (the three defendants in the civil claim), which raised serious concerns regarding state failings which were investigated at the Article 2 inquest into her death. Prior to the inquest there were independent investigations conducted by the IPCC, and the Strategic Health Authority. Both those bodies found that a series of failings had taken place. The investigations also led to the availability of the evidence regarding the conduct of social services.

The inquest into Colette Lynch’s death took place over 38 working days. Protective civil proceed-

ings were issued prior to the inquest. The inquest was conducted by a high court judge with the assistance of counsel to the inquest. The family's inquest team comprised leading counsel (who attended on 23 days), junior counsel (38 days), a partner from the solicitors firm (31 days) and a trainee solicitor (38 days). The costs of attendance at the inquest were in the region of £600,000, and once pre-inquest preparation was taken into account, the Defendants put the total inquest costs at around £750,000. Perhaps most crucially, due to the intensity of the pre-inquest state investigations and disciplinary proceedings, much of the evidence that was heard at the inquest, and which formed the basis of the civil claim, was available prior to the inquest commencing. Indeed, at the costs hearing in *Lynch*, the Defendants' counsel was able to go through the eventual pleadings of the Claimants in the civil claim, and state that they had the evidence and information necessary to plead nearly the entire case prior to the inquest.

Although the eventual agreed damages awards were apparently unusually high for an Article 2 ECHR claim, Master Rowley nevertheless found the costs claimed in respect of the inquest to be globally disproportionate, and therefore applied the necessity test under *Lownds v Home Office* [2002] EWCA Civ 365. A higher degree of scrutiny was thus applied to the inquest costs than would be the case in a more proportionate case.

The potential importance of the *Lynch* decision for the vast majority of shorter inquests, where the content of the subsequent pleadings cannot be identified prior to the hearing, lies in the approach taken by Master Rowley to elements of the representation that he denoted as *'irrelevant to the civil claim'*. Those included attendance during previous pre-inquest review hearings, housekeeping matters such as opening and swearing in a jury, summing up, submissions on verdict, and the consideration of Regulation 28 matters. Here two contrasting approaches were urged upon the Master by the Claimants and Defendants. The Defendants argued that the attendance of the representatives should be divided strictly into periods which could be defined as assisting and not assisting the later civil claim. The Claimants relied upon the decision of Master Campbell *Wilton v Youth Justice Board* [2010] EWHC 90188 (Costs), where he stated that in his judgment *"it is unreasonable to suppose that at the moment the last witness completes his or her evidence, a guillotine falls and that an interested party's legal team … must then pack its bags and leave court for good."* Master Campbell gave several reasons for this, not least that verdicts, whilst not pleadable, were likely to be relevant to the civil claim, and that one reason for assisting the Coroner during the post-evidence period was to ensure that his or her decisions were correct and not susceptible to judicial review.

In *Lynch* Master Rowley preferred the submissions of the Defendants on these points, and adopted the general approach of dividing the inquest up into its constituent parts for costs purposes. Articles have appeared elsewhere summarising the elements of the inquest representation which Master Rowley excluded as not being of and incidental to the civil claim. These included time where witnesses statements were read, the categories he identified as 'irrelevant' to the civil claim as set out above, and also 'hand holding' or providing support for the bereaved family. For the periods he did hold recoverable the Master disallowed the costs of leading counsel, but did award the costs of attendance and representation of junior counsel. It is noteworthy, however, that even on his restrictive approach, he allowed recovery for the following categories of evidence (para.86):

- Witnesses who instructed the Claimants team
- Witnesses who were asked no questions by the Claimants' team
- Witnesses who were said by the Coroner not to be directly involved

- Witnesses whose evidence related to the systems of the three Defendants

In relation to witnesses who had given evidence at the previous police disciplinary hearing (not a category that is likely to exist in a clinical case), Master Rowley held that only the costs of a trainee solicitor to take a note should be awarded.

Discussion:

Lynch is a first instance decision based on exceptional facts, which is likely to be of only limited relevance to the vast majority of clinical cases. Reasons to distinguish it from more common types of clinical case include the following:

- The high levels of fees claimed and the finding of global disproportionality.
- The length of the hearing (which the possible exception of long Article 2 mental health cases).
- The presence of counsel to the inquest.
- The fact that the majority of the evidence relevant to the civil claim was available prior to the hearing.
- It is not relevant to a clinical case where attendance is provided in large part order to ascertain the medical cause of death, or to question an expert on causation. The inquest representation could not thus be argued to be necessary in order to investigate the claim as is common in clinical cases.

Importantly, *Lynch* also remains a first instance decision, and is unlikely to be appealed. As such it carries equal weight as the decision in *Wilton*, which as noted above, took a more holistic (and some would say realistic) approach to the inquest process in relation to civil claims. It is also open to parties to run the argument that the inquest assisted the civil claim in encouraging settlement. This submission was rejected by Master Rowley in *Lynch*, but as set out above, was endorsed by Davis J in *Roach*.

Where *Lynch* does provide genuine food for thought for claimant clinical solicitors, is that it represents an example of a high level of scrutiny being applied to inquest costs in terms of proportionality. Claimant clinical negligence lawyers post-Jackson, however, are accustomed to such an approach. Further, in terms of representation provided by way of CFA, recoverability would always, in principle, have been limited to that which could legitimately be held to have been undertaken in respect of the later civil claim in any event.

It remains to be seen whether *Lynch* encourages more defendants to attempt to settle claims pre-inquest in an attempt to avoid paying the costs of representation. Where that does occur, however, it is submitted that the reasonable costs of representation at the inquest of the deceased's dependants under the Fatal Accidents Act 1976, can legitimately argued to be recoverable as damages under s.3 of that Act, proportioned to the injury to the dependents resulting from the death. This is because they cease to be costs of the civil claim and to be covered by the rule in *Cockburn v Edwards* (1881) 18 CH D 449, and become rather an expense caused by the loss. Attempting to secure the costs of representation of the family at the inquest, perhaps as legal aid rates, should thus form part of any pre-inquest settlement negotiations.

Practical measures which might be taken to mitigate the any lowering of costs bills on detailed assessment include private payment of expenses and in certain circumstances pre-inquest hearings, carefully assessing the size of the team necessary to provide effective representation a different stages of the inquest, considering whether submissions can be made in writing, and during long inquests, considering which representatives need to attend at which stages of the inquiry. Detailed attendance notes should be taken, setting out why certain decisions were taken in respect of attendance and the subsequent civil claim, and recording when evidence was elicited which assisted the claim.

Legal Aid:

In an Article 2 inquest, a further consideration is whether to apply for exceptional inquest funding for family representation under s.10 of the Legal Aid, Sentencing and Punishment of Offenders Act 2012 ('LASPO'). In the welcome recent decision in *R (Letts) v The Lord Chancellor (Equality and Human Rights Commission intervening)* [2015] EWHC 402 (Admin), Green J. held that the Lord Chancellor's Exceptional Funding Guidance for inquests was unlawful, because it failed to recognise that there are categories of Article 2 death – suicides in custody and mental health detention- where the investigative duty under Article 2 ECHR arises automatically, and not only on it being established that an 'arguable breach' of one of the substantive duties to protect life has taken place.

The measures put in place to remedy the guidance remain to be seen. However, representatives in mental health detention death claims, in voluntary psychiatric cases where the conditions for the engagement of Article 2 set out in *Rabone v Pennine Care NHS Foundation Trust* [2012] 2 AC 72, are met, and in cases where there have been arguable systemic breaches Article 2 breaches in a healthcare context, should encourage coroners to make decisions on Article 2 at an early stage, and consider applying for legal aid to secure funding for the representation of the family at the inquest. A grant of legal aid does not prevent the later recovery of the costs of representation at the inquest which were of and incidental to a subsequent civil claim. In *Roach* Davis J expressly rejected the submission (at paras.50-51) that the costs of representation at an inquest cannot be recovered under a civil claim where legal aid has also been provided for attendance. That must be right bearing in mind the practice of the Legal Aid Agency to enforce the statutory charge in respect of inquest costs where there is subsequent recovery of damages. A grant of legal aid may thus provide a degree of security for both client and representatives; particularly in cases where the prospects of success in a civil claim are uncertain. Inquest funding under LASPO is granted by virtue of the requirement under the Convention that in all Article 2 investigations, *"the next-of-kin of the victim must be involved in the procedure to the extent necessary to safeguard his or her legitimate interests"* – *Edwards v UK* (2002) 35 EHRR 487 at 73. Solicitors making applications for exceptional inquest funding may gain some assistance from the principles set out as relevant to the necessity of legal representation for the family at an Article 2 inquest in *Khan v Secretary of State for Health* [2003] EWCA Civ 1129.

The NHS in Wales: Devolution and Divergence?

Tom Goodhead and Tom Mountford

9 Gough Square

The performance of the NHS in Wales is a political hot potato sure to be debated in the run up to the General Election on May 7th, 2015. The Conservative Party claim statistics demonstrate a systemic mismanagement of the NHS in Wales by the Labour-controlled, Welsh Government whereas the Labour Party claims that a like-for-like comparison between Wales and England is invalid.

Of course, there are tremendous difficulties in comparing healthcare systems domestically and internationally. Wales, in particular, faces general problems of public health associated with deindustrialisation. However, growing calls for a Francis-style Inquiry into the NHS in Wales and waiting time statistics released by the Welsh Audit Office in January 2015 suggest that the issue will remain firmly at the centre of political debate.

Against this backdrop, a curious point was taken by the Defendant in the case of *Maytum v Abertawe Bro Morgannwg University Health Board* (November 2014, Cardiff District Registry). The Claimant (represented by Nigel Poole QC and Tom Goodhead; instructed by Javid Asharaf of Beers LLP) claimed damages for a five and a half month delay in diagnosis of breast cancer. Breach of duty was admitted at the end of day one of the trial and the action was compromised on extremely favourable terms to the Claimant at the end of day four.

In reply to pleaded allegations of breach of NICE guidance, the Defendant sought to argue that NICE guidance had a different legal effect in Wales to England. Initially, the Defendant's defence was pleaded as stating *"the two-week rule for review of suspected cancer cases does/did not in 2010 apply in Wales"* and then was amended to state *"organisation of breast cancer services at the Third Defendant's Princess of Wales Hospital was based on the Rules for Managing Referral to Treatment Waiting Times and not the NICE guidance."*

The pleading, by inference, raised a novel issue for determination of whether the applicable standard of care in Wales was different to that in England? Guidance is, of course, only guidance but NICE guidelines have consistently been held by courts at first instance be indicative of the standard of care. Such treatment by the courts should not be surprising given their role as consensus statements systematically developed on the basis of the best available evidence. It would be curious if courts rejected such evidence-based practice on a whim.

At first blush, the Defendant's argument appears absurd. The Welsh Government has contracted with NICE to provide clinical guidance to the NHS in Wales and the Welsh Government expects NHS bodies in Wales to take full account of NICE Guidelines when commissioning and delivering services.

However, whilst the argument may appear unattractive, could it reflect the divergence between England and Wales in the delivery of healthcare services? With devolution of responsibility for the NHS, it is inevitable that different decisions will be made in respect of funding priorities and alloca-

tions. Such has already been evident from decisions taken in respect of the provision of free prescriptions in Wales and the choice not to replicate the NHS England Cancer Drugs Fund.

Welsh Defendant Health Boards may have far better prospects of defending claims on the basis of proactive choices of resource allocation rather than arguments of geographical/national diversions in the standard of care. So-called resources defences have a mixed history of success (*Ball v Wirrall HA,* [2003] Lloyd's Rep. Med. 165, *Bull v Devon AHA,* [1993] 4 Med.L.R. 117) but where a Welsh Health Board has made a decision to expend resources on one area of care, rather than another, inconsistency with England will be unlikely to give rise to negligence (save a *Bolitho*-type challenge from a Claimant).

American courts have frequently grappled with such issues and whilst the applicable standard of care has usually been found to be universal across the United States (see *Hall v Hilbun,* 466 So.2d 856 SC Mississippi cited in *Health Law, 2nd* Ed, 2000), pursuant to the *Restatement (Second) of Torts, ss 229A "Allowance must be made also for the type of community in which the actor carries on his practice. A country doctor cannot be expected to have the equipment, facilities, experience, knowledge or opportunity to obtain it, afforded him by a large city."*

The Welsh Government may well be correct in asserting that the NHS in Wales has simply not received the same level of funding as in England and Scotland due to the peculiarities of the devolution funding arrangements. Practitioners should be conscious, therefore, when bringing claims against Welsh Health Authorities to consider the wider political context.

Divergence in practice between England and Wales is likely to feature in further clinical negligence cases. The authors of this piece have already had the similar argument made by a Defendant Welsh Health Board in another case (and rejected by a Coroner). It was suggested, in the context of submissions as to whether Article 2 was engaged in respect of the death of a 93 year old lady at the University Hospital of Wales, that an admitted breach of NPSA guidance was irrelevant because of an alleged difference between England and Wales in the applicability of such guidance.

Practitioners must, therefore, be conscious of differences between England and Wales and be prepared to fight claims defended by resource-stretched and politically pressured Defendants.

JM v 1) Aylward, 2) Invent Health Ltd, 3) Great Western Ambulance Service, 4) Ambition 24 and 25 and 5) NHS Commissioning

Chris Hough

Doughty Street

Approval hearing 2nd March 2015, HHJ Robert Owen QC sitting as Deputy HC Judge

This case gives rise to four interesting issues

i) A structure for buying and adapting a property which avoids the disadvantages of Roberts v Johnstone in cases where there is a short life expectancy

ii) Use of a PPO for multiple heads of claim

iii) Consideration of the legal solution where a Claimant has extensive pre-existing needs

iv) Despair at the reluctance to accept responsibility by private companies supplying nurses in fulfilment of local authorities statutory duties

Background

JM suffered very severe injuries in a road accident in 2002, which rendered him tetraplegic. He sustained a C6/7 spinal injury. Whilst in Hospital, he became a C1 complete. He had no voluntary movement from the neck downward.

He was tetraplegic and ventilator dependent. The medical records show that he was fed through a gastrostomy tube, and had no bladder or bowel control.

However, he was mentally alert. There is no evidence that he sustained any neuro-cognitive or neuropsychological impairment as a result of the RTA.

He had capacity. He was able to communicate with others, both vocally and by using a computer, and (for example) was able to shop on-line. He was able to e-mail, browse web-pages and operate a computer using voice recognition system. He took an active (and critical) interest in his care package. He was able to deal with complex issues and deal with outside agencies. His communications with his medical support team reflect a very high level of planning, organising skills and reasoning.

He had been provided with voice recognition software, which he used with a microphone connected to his lapel or pillow. The voice activated system appeared to be successful and adequate for his needs.

The fact that he was able to face such profound disability without developing any significant adjustment of psychological problems attests to his remarkable resilience and strength of character

He needed care and protection of his limbs, bowel and bladder care, help with all transfers and all

aspects of personal care. Of most relevance to this action, he needed ventilation to maintain his breathing.

His care was provided for 24 hours a day, paid for by the Wiltshire PCT (now the NHS Commissioning Board), and provided by staff supplied by Ambition 24 Group and Allied Healthcare, under the overall management of Invent Health.

Up until January 2009, the Claimant had normal cognitive ability and was able to manage his care, engage with the outside world and use assistive technology. He lived in a “sheltered” residential facility, with his own flat in a development called Crammer Court in Devizes. This was close to his former partner, son, many friends and within regular visiting distance for his wider family.

The negligence

On the 9th January 2009, his ventilator was turned off by Ms Aylward, a nurse supplied by Ambition 24, and working in accordance with the care plan agreed between Invent Health Ltd and the PCT. Ms Aylward did not have the appropriate training to manage this patient (and should not have been acting as his carer). She was unable to reconnect the ventilator. A 999 call was made, and a paramedic (Mr Crawford) arrived, but he failed to take the appropriate steps to reconnect the ventilator (and made a statement which was deliberately misleading).

The damage

JM had no oxygen supply for about 14 minutes, which led to brain damage and severe cognitive damage.

He clearly demonstrated an extended period of reduced awareness and arousal consistent with a presence of severe anoxic acquired brain injury.

As a result of the negligence he now has profound mental disability. In broad summary, the experts instructed by all parties agreed:

a. Pre-injury functioning within the upper half of the average range of intellectual ability
b. Unimpaired effort and engagement
c. significantly spared areas of intellectual functioning
d. severe impairment to both visual and verbal memory consistent with the presence of an amnesic syndrome
e. unimpaired understanding of language but significant impairment in terms of verbal fluency and speech reproduction
f. some impairment in alternating attention
g. substantially spared areas of executive functioning in terms of problem solving, deductible and abstract reasoning
h. the presence of an aboulic syndrome characterised by reduced energy, impaired self-initiation of activity and choices and reduced insight

i. marked and severe general levels of emotional distress with a degree of suicidal ideation
j. significant degree of fatigue
k. significant and intrusive auditory hallucinations
l. post injury epilepsy, nystagmus and dizziness
m. significant impairment to ADL as a result of both the spinal injury and his inability to use an Environmental Control System

There is no prospect of any significant improvement. Life expectancy was reduced to about 57 (a further 15 years)

Liability

Both the nurse and paramedic were disciplined by their professional organisations. Despite the professional proceedings being brought against Ms Aylward and Mr Crawford, liability remained unresolved:

a. Violetta Aylward was clearly negligent, but the Royal College of Nurses repudiated their indemnity and she was, effectively, uninsured;
b. Invent Health and Ambition 24 both denied liability, and blamed either each other, or Ms Aylward (who they claimed was acting as an independent contractor);
c. The Ambulance Trust admitted liability and some causation, but also blamed Ms Aylward;
d. The PCT/CCG/NHS denied liability;

The legal principles for determining liability (considering control, management, supply of tools, devising work patterns and so one) went back to the building site cases (Lane v Shire Roofing) and the “bouncer cases” (Hawley v Luminar Leisure Ltd and others 2006 EWCA Civ 18)

It is a sad development when organisations supplying carers pursuant to statutory obligations behave like dodgy scaffolders/bouncers, and refuse to accept responsibility along with the profits they generate.

Quantum

The Defendants’ primary case was that, in a case where a man required 24 hour care when living in sheltered accommodation, there was no measurable loss attributable to the negligence.

At an RTM in September 2014, three of the Defendants accepted that there was a need for Case Management and a Team leader attributable to the negligence, but maintained the position that there was no claim for accommodation or a more extensive care package.

This RTM led to agreement on the following heads:

PSLA including interest	£103,960
Past family care/travel	£91,040

At all times, the Claimant was being provided with 24 hour care. We argued that the family offered companionship which should be recovered relying upon Warrolow v Norfolk and Norwich NHS Trust 2006 EWHC 801 per Langstaff J.

Therapies	£80,000
Aids and equipment	£200,000
Deputyship	£40,000 capital plus £9,000 pa (PPO)

This left care and accommodation to be resolved. Trial was listed for March 2nd 2015.

Accommodation

The Court of protection had determined that JM had capacity to decide where he wanted to live. He had been consistent in saying that he wanted to go back to Devizes. One of the

Defendants argued that this would not be in his "best interests" which were met by him staying in his residential nursing home.

The Roberts v Johnstone calculation left a significant shortfall in the accommodation claim. A suitable property in Devizes would cost about £300,000. With a multiplier of 11.94, and 2.5% of £300,000. JM would only recover £89,550. There was no obvious way to make up the "missing" balance, without compromising future equipment or therapies.

The solution was novel:

A commercial consortium agreed to buy the property in their name, and to grant JM a life time tenancy. He would pay for the adaptations required (agreed at a cost of £197,000 – three tenders had been obtained, and a contract signed for the work to start), using damages paid for by the Defendants. In return for his security of tenure, JM paid an enhanced rent.

The rent and the increased costs of living in a larger house, were paid for by a PPO. On his death, the consortium would take back the property, with any capital gain.

Care

The care experts and the Case manager agreed the costs of the annual package at £475,000 pa.

The approach put forward by all three experts has the following features:

JM should not use agency carers but employ his own team

This required a case manager

A trained nurse available 24 hours per day (possibly including a nurse awake at night)

A support worker available 24 hours per days (but sleeping at night)

A buddy (this was disputed)

A team leader and deputy team leader

We relied upon Sklair v Haycock 2009 EWHC 3328 per Edwards-Stuart J and Reaney v University Hospital of North Staffordshire Trust 2014EWHC 3016 per Foskett J in support of the following propositions:

a. A tortfeasor must take his victim as he finds him and if that involves making the victim's current damaged condition worse, then he (the tortfeasor) must make full compensation for that worsened condition (Reaney para 70)

b. The fact that the defendant's breach of duty has worsened an existing condition may lead to a higher assessment of the loss, since the consequences of the impairment may be greater (Reaney para 70)

c. The Defendants' negligence has made the Claimant's position materially and significantly worse that it would have been but for the negligence(Reaney para 71)

d. The Defendants have made a "material contribution" to the condition which has led to the need for extensive care, and that the lack of any joint or current tortfeasor as a potential direct compensator is no answer to a full award against the Defendant (Reaney para 71, citing Bailey v MOD 2007 EWHC 2913)

e. If a Claimant would have paid for the costs of care but for the negligent treatment, the costs of care that would have been incurred have to be credited Sklair para 74

f. If the "but for" costs would have been met by the local authority or some other body then no costs would have been avoided and there would be no costs for which to give credit Sklair para 75

g. Mr Justice Foskett agreed (Reaney para 72)

... with the sensible, compassionate and principled approach to this kind of issue taken by Edwards-Stuart J in Sklair

We acknowledged that there is powerful case law the other way – that a claimant cannot recover for a pre-existing condition (see for example, Murrell v Healy 2001 EWCA Civ 486) where Waller LJ was dismayed that a claim had been brought and held:

On any view Mr M's claim in relation to his injuries in the second accident should never have been quantified other than on the basis that some damage to his ability to work resulted from the first accident. The fact that it was not was in my view regrettable

The solution was to give credit for the social services payments (£320,000 pa) with a "Peters undertaking" by the professional Deputy to continue to claim for benefits, with the Defendants accepting liability for the balance between the £475,000 and the PCT payments of £320,000 of £155,000 pa.

The settlement

The final lump sum achieved was £925,000, with a PPO of £186,620 pa, the PPO including care and case management of £155,000 pa (to supplement the LA provision of £320,000 pa), rent and additional costs on the property of £22,620 pa and Deputyship costs of £9,000.

This was approved on March 2nd 2015

Christopher Hough instructed by Andrew Hannam of Foot Anstey for Claimant; Sarah Vaughan-Jones QC instructed by Defendants 2,3 and 5, and Caroline Harrison QC for Ambition 24.

Miller v Imperial College Healthcare NHS Trust 2014

Chris Hough

Doughty Street

In January 2007, Mrs Miller attended Accident and Emergency Department at the Hammersmith Hospital complaining of increasing pain in her leg, which was cold, blue and white in appearance. She lacked pulses in the ankle and foot.

Reasonable management in this situation required urgent vascular review, administration of heparin and surgery.

In fact, she was discharged. By the time, she returned to Hospital a few days later her condition had deteriorated to the extent that the opportunity for successful treatment had been lost. In February 2007, she underwent a below-knee amputation, which was not successful, and, a few days later, a further above-knee amputation was performed. At the time of her treatment and amputation, she was aged 63.

Over the next few months and years, Mrs Miller struggled to overcome the devastating effects of the disability, receiving physiotherapy, a series of prosthetic limbs and counselling.

Funding problems were such that, although she was offered a trial of a computer enhanced C leg, the Trust were unable to afford providing her with an up-to-date leg.

The tantalising prospect of a better leg led her to complain to the Trust. In an internal e-mail, the complaints department described the management as “medically-legally indefensible”. In a meeting with Mrs Miller, the Trust’s management apologised for the breach of duty. In response to Mrs Miller’s question as to whether her limb would have been saved with competent management, the Trust promised to investigate and get back to her.

The admission of breach did not change the decision to provide her with a C-leg. Eventually a nurse suggested that she might take legal advice.

By that time, it was early 2012, over 4 years after the negligent treatment. No less than 6 firms turned the case down on the grounds that it was outside the limitation period.

Towards the end of 2012, she was introduced to a seventh solicitor who agreed to look at the papers, and to accept the case, funded by a CFA.

Within the complaints documentation we found the e-mail trail that flowed from the acceptance that the case was indefensible, and the failure to tell Mrs Miller whether the outcome would have been different.

We formed the view that this failure to provide information was a breach of the Trust’s duty of can-

dour (see **Lee v South West Thames RHA** 1985 1WLR 845 and **Naylor v Preston** 1987 2 All ER 353), might well represent concealment for the purposes of section 35 of the Limitation Act (see **Williams v Fanshawe** 2004 EWCA 157and probably amounted to equitable fraud (see **Cave v Robinson** 2002 UKHL 18, citing with approval Lord Denning's observations in **King v Victor Parsons** 1973 1WLR 29).

We issued a protective Claim Form and sought vascular advice on causation. As the validity of the Claim Form approached, we sought an extension of time to plead the case. This was refused. I was asked to draft Particulars on the basis of the papers, without expert evidence. Hours before the deadline, a "bullet-point" report was provided by a vascular surgeon expressing the view that the leg could have been saved with competent management.

The Defence admitted (at last) that competent management would have avoided the above knee amputation, but pleaded a Limitation Act defence. At the same time, the Trust offered to settle for £300,000.

At a CMC, against the Trust's wishes, the Master ordered a preliminary hearing on limitation. That was fixed for October 2013 with a time estimate of 2 days. A few days before the hearing, the limitation defence was abandoned.

In September 2013, the Claimant made a Part 36 offer to settle the whole of the claim for the sum of £1 million net of CRU (a further £16,350). This was rejected. The principal heads of claim were the needs for future prosthetics (by this time, we were asking for the relatively new and expensive genium leg), and accommodation. It was accepted that her present flat was unsuitable and that she would need to move somewhere which was wheelchair compatible (the expert evidence was that whichever limb as used, there would be blistering and stump problems which would prevent using the prosthesis).

The **Roberts v Johnstone** formula failed to offer a practical solution for a woman aged 70 at the date of trial and with London house prices being as high as they now are. The claim we made was for the difference in renting a suitable property and the previous rent Mrs Miller had been paying (she lived in her daughter-in-law's flat paying a nominal rent). There were smaller heads of claim for loss of earnings, therapies, care and aids and equipment.

The Trust's position in relation to the leg was that Mrs Miller could cope with the less advanced, and much cheaper, Orion leg (which she had trialled and liked), and that as she grew older, she would struggle to cope with a heavier computer limb (whether genium of orion) and would have to downgrade to a lighter "basic" leg.

In relation to accommodation, the Trust argued that she had to buy, using the R v J formula.

Using an interim payment, Mrs Miller bought the genium leg. She found the leg to be a considerable improvement on anything she had before. This subjective impression was reinforced by a DVD of Mrs Miller on slopes, stairs, uneven ground, grass and the flat, with footage comparing the genium and orion leg in relation to all activities.

The difference was obvious. Tug tests, measuring the speed with which she could do various normal activities (getting in and out of a chair for example) provided further objective evidence that the genium leg was better than the Orion.

Despite this evidence, the Trust continued to argue that she had acted unreasonably in buying the genium leg.

Negotiations continued. At an RTM, a figure of £875,000 was agreed, but this was considerably more than the Trust had authority to offer. The NHSLA refused to go above £825,000.

Shortly before the assessment hearing, the Trust increased its offer to £870,000, and served amended Counter Schedules, which reduced the valuation from £680,000 to £470,000.

Mrs Miller held her nerve and went to hearing.

At the assessment hearing, the judge accepted her evidence in its entirety as to the benefits of the genium leg, that she wished to rent rather than buy, and of her employment plans. The judgment is interesting for a number of aspects:

a. the judge rejected the argument that there should be deduction of 50% to reflect the Claimant's age (she was70 at trial). He accepted that injury to an older person may have more serious consequences, and may ruin the plans for retirement, that age has a double-edged aspect and that injury to someone beyond the prime of life might lead to an increase in the award

b. damages for past care were assessed at aggregate rates, on the basis that the care was provided at night, at weekends and holidays. The judge accepted that an appropriate discount (allowing for tax and NI and reflecting that much of the care was provided by the son who lived next door) should be 20%. The judge had the recent decisions supporting a 25% reduction and accepted that changes in personal allowances and tax bands justified a lower deduction.

c. He accepted Mrs Miller's evidence that she would have worked full time until the age of 75, but would now stop working (everyone was amazed that she was still working part time on the shop-floor at John Lewis).

d. The judge agreed that he was not obliged to assess accommodation needs on the basis of purchase, and awarded the rental differential

e. In relation to the leg, he held that it was reasonable to buy the genium leg, which he described as enabling the Claimant to walk more naturally and comfortably, was least tiring, safer, gave her greater confidence and prevented her from falling when, for example, she stepped backwards.

   In cross-examination, Professor Hanspal (who had advised the Trust) eventually accepted that the genium was a "much better leg".

The judge emphasised repeatedly that he had gained particularly helpful information from the DVDs, which had a commentary provided by the physiotherapist Pam Barsby and, to a lesser extent, the Tug tests. This demonstrates the advantages of both an interim payment, and providing the court with as much “objective” evidence as possible.

f. In relation to the future, he adopted a percentage approach based on “loss of chance”, with 100% of the genium leg at 76, 60% at the age of 82 and 20% at the age of 88, with corresponding percentages for the costs of the lighter limb

The judgment sum was £1,037,188.

Mrs Miller had thereby beaten her Part 36 offer made in September 2013. The judge ordered enhanced damages of £62,500, penalty rates of interest of 7.5% on past damages, 4% above base on PSLA and 5% above base interest on costs, as well as indemnity costs (all sanctions provided by CPR Part 36 rule 14).

Possible ramifications for clients on CFA when seeking to move firms

Roger Mallalieu

New Square

This short piece seeks to address a situation which occurs not infrequently, namely where a client has entered into a retainer – commonly a Conditional Fee Agreement ('CFA') with a firm of solicitors (Firm A) and, having done so and having established a sound relationship with a particular conducting fee earner (X) then finds that X, for whatever reason, is leaving Firm A and moving to Firm B.

The client wishes to move with X. What are the implications for the client in doing so and, in particular, what are the risks to X – but also to Firms A and B – in X seeking to do so.

In considering these issues, this note will touch on matters such as the assignment of CFAs. It is important to note that these are complex issues where there is, at least at present, no clear and wholly reliable judicial authority. This note does not seek to consider all matters relevant to such matters and anyone considering such a course should consider seeking formal advice on the matter.

The hypothesis

The basic position is as set out above.

The assumption within the hypothesis is that the client is likely to have instructed Firm A on the basis of a CFA.

It will be necessary to consider below the differing implications depending on whether that CFA was entered into before or after the 1st April 2013.

However, the first point to note is that most standard CFAs (at least for personal injury use), whether pre or post April 2013 (and certainly the Law Society standard models) include a specific termination clause.

These generally provide that where a client ends the agreement before the claim is won or lost the client is liable to pay the firm's basic charges and disbursements at that point and then to pay a success fee in addition if the claim is won.

It should be noted that this is different to a number of other provisions in standard CFAs whereby, on certain events, the solicitor's firm is entitled to exercise an option – namely to charge basic fees and disbursements at the happening of the event, but nothing more later, or to charge nothing now (or disbursements only), but to charge basic fees and a success fee at the conclusion of the case if

the case is won.

In contrast to these clauses, the standard clause for termination by a client preserves the solicitor's full rights, without having to exercise any option. Basic fees and disbursements are due forthwith, no matter whether the case is won or lost. The success fee is then due in addition on success. This is an often overlooked in road into the concept that a CFA is 'no win no fee'.

It is also important to note that a client's contractual relationship is (usually) with a firm of solicitors and not with an individual fee earner. Accordingly, if X moves firms, that does not itself have any effect on the CFA between the client and Firm A, unless conduct of the case by X was a fundamental term of the retainer.

If the client wishes to move with X to a new firm – thereby depriving Firm A of the potential future costs of his or her case – Firm A is prima facie entitled to treat the same as the client repudiating or ending the retainer and to rely on the clause identified above. Firm A would, prima facie, be entitled to exercise a lien over the client's papers until the outstanding base costs and disbursements were paid (though in the face of ongoing litigation the court may be prepared to override this).

Obviously, it is to be hoped that in such a situation Firm A would adopt a sensible approach and, for example, agree to await payment until the end of the case and release the papers, subject to appropriate undertakings and safeguards from Firm B and, if it is sensible, asserting a charge over any damages or costs recovered on the client's behalf.

However, such an approach cannot be guaranteed.

The questions which follow are genuine questions which have been raised by others in this context. The answers seek to shed some light on the issues that arise.

If a client moves firms, are there risks or issues in relation to a pre April 2013 CFA being assigned to the new firm? Can you legitimately assign a pre-4.13 CFA? Is it likely to be open to challenge? Could the second firm be at risk of being without a valid retainer?

As noted above, this raises a number of complex and interrelated issues.

Firstly, can a CFA (or any solicitor-client retainer) be assigned at all? It is trite law that the benefit of a contract can be assigned but that the burden of a contract usually cannot:

> "*A debtor cannot relieve himself of liability to its creditor by assigning the burden of the obligation to someone else. This can only be brought about by the consent of all three, and involves the release of the original debtor.*"[1]

[1] Collins MR, **Tolhurst v Associated Portland Cement** [1902] 2 KB 660 at 668 (CA). Such a tripartite agreement would be a novation – in effect the ending of the 'original' agreement and the coming into being of a new agreement

Where a CFA is being assigned, the assignment is usually between Firm A and Firm B. The benefit to Firm A therefore of the CFA is, broadly, the right to payment for work done and to be done. The burden is the obligation to do the work. Accordingly, general contractual principles would suggest that Firm A could assign, or sell, to Firm B its right to payment (as, for example, happens commonly with the selling of debts) but that Firm A could not 'sell' its obligation to perform the work, which remains with it. This could only be achieved with the agreement of Firm A, Firm B and the client and would involve a novation of the agreement – in effect the ending of the existing and the making of an identical agreement between Firm B and the client.

This would lose the benefits of having the original CFA continue and would throw into stark relief the client's obligations to pay Firm A as set out above.

There is some limited authority to suggest that a CFA, in certain circumstances, forms an exception to the general principle that a CFA cannot be assigned – see **Jenkins v Young Brothers Transport Ltd** [2006] EWHC 151 (QB). However, although this case is widely relied on, its authority is limited. It was decided by reference to very specific facts, does not purport to set any wide principle and is regarded by some as being wrongly decided as a matter of law. It is only a High Court authority and it seems highly likely that the arguments on this issue will reach Court of Appeal level before too long.

The best that can probably be said is that there is a tolerable argument that a CFA may be assigned (subject to various legal formalities), but the issue is open to argument and challenge.

What would be the effect of the purported assignment of a CFA being successfully challenged?

The likely effect, though there are a number of possibilities, is that there has been a novation rather than an assignment and, broadly, that the first CFA is seen to have ended at that date of the purported assignment and a new CFA in the same terms created with Firm B at the same date. Another possibility is that the original CFA has ended, but that no new agreement is formally in place, though some implied retainer might well be.

Why does this matter? There are three main reasons.

Firstly, generally, if the first CFA has been ended – by Firm A by virtue of the purported assignment – in circumstances where the case has not yet been won, the question of its entitlement to payment up to that point might be in doubt. In addition, the fact the assignment has failed may raise questions about the terms of Firm B's retainer, which may raise indemnity principle issues.

Secondly, if the CFA was a pre April 2013 CFA and if it had been assigned successfully, it would be regarded in law (probably) as the same, original CFA continuing and this would have allowed for the continued between the parties recoverability (in principle) of the success fee without offending s.44(6) of the Legal Aid, Sentencing & Punishment of Offenders Act 2012 ('LASPO'). However, if the CFA is seen as not having been assigned, but rather as having been novated post April 2013, the effect in practical terms is that a new CFA has come into being and that, having been created

post April 2013, any success fee under the new CFA is (probably) irrecoverable in principle.

Thirdly, in the personal injury context, if the original CFA was a pre April 2013 CFA, without the 'LASPO' cap on success fees and if that CFA was not assigned (which would arguably have allowed the CFA to continue on the same terms without needing to include the LASPO cap), then the 'new', novated CFA will be unenforceable unless it includes the LASPO cap. Given that, on assignment, the usual aim is to simply keep the existing CFA going, without change, there would be a significant risk that the 'new' CFA did not include that cap and was, therefore, unenforceable.

This could, therefore, leave Firm B without a valid retainer.

These are complex issues and there are various steps that clients and firms can take to protect themselves in this regard.

QOCS – is it correct that if a client had a pre April 2013 CFA but then enters into a post April 2013 CFA, they have no QOCS protection?

Almost certainly, yes. QOCS is not available where the claimant has entered into a pre commencement funding arrangement (see CPR 44.17). The fact that that arrangement has now ended, and the client has entered into a new arrangement (of whatever type) does not appear to allow the client to now 'revise' QOCS. Once lost, it is lost for good.

This is an important factor when considering the assignment of CFAs. If the assignment works, the client keeps the benefit of between the parties recoverability of additional liabilities. He or she is not entitled to QOCS, but with ATE and between the parties recoverability of additional liabilities, may not be too concerned about this.

If, however, the assignment fails, not only does the client potentially lose the ability to recover, in principle, any success fee incurred after that date, but he or she does so without the compensating benefits of QOCS (or the enhanced general damages under Simmons v Castle [2012] EWCA Civ 1039).

A client must be advised of these issues. Any client with a pre April 2013 considering changing firms must be told – ideally by both Firm A and Firm B – of the risk of loss of between the parties recoverability of any future additional liabilities as well as the fact that he or she will not be entitled to QOCS or enhanced general damages.

ATE insurance: if obtained by Firm A are there any problems in transferring case and insurance to another firm?

This is generally an easier matter to address. Many ATE policies will be tied to a particular CFA.

Even those which were not provided on a delegated authority basis commonly provide that the policy will end of the CFA with the solicitor is ended.

However, these conditions may be waived by the ATE provider. Whether it is willing to do so depends on the facts of any given case, though the ATE provider is likely to be keen to ensure recoverability of the premium on a between the parties basis and therefore has an incentive to assist.

Written confirmation of any such waiver – ideally by way of endorsement to the policy – should be obtained.

Since the ATE contract is (usually) between the client and the ATE provided – and not the firm of solicitors – no issue in relation to assignment arises and the fact of the client moving to Firm B does not cause the sort of contractual or LASPO transitional problems identified in relation to the CFA.

If they client has not already obtained ATE to go with a pre-4.13 CFA, can you still get it and will moving firms complicate that? Will it be recoverable?

The short answers to these questions are 'potentially yes' and 'no'.

Whether an ATE provider will, post April 2013, provide ATE cover to a pre April 2013 CFA client is a matter between the client, the solicitor and the ATE insurer. In principle cover is available. The problem lies in the question of who will pay for it.

This takes us to the second question. If ATE has not been taken out pre April 2013, the premium for any such ATE incepted post April 2013 will not be recoverable, even if the client entered into a CFA pre April 2013. The transitional provision for ATE policies under LASPO is discrete from that for CFAs. S.46(3) provides that the removal of between the parties recoverability does not apply where the policy itself was taken out prior to the 1st April 2013. The date of the CFA is irrelevant.

Where a policy was taken out pre April 2013, but a later staged or top up premium under that same policy is incurred, there is a good argument that these later premiums are recoverable between the parties, even if incurred post April 2013. However, there may be some cases where the court regards the intimal policy or premium as a sham to circumvent the transitional provisions. These matters will need to be addressed on a case by case basis.

If the client does chose to pay the basic charges and expenses to Firm A and is then successful with Firm B, will he recover expenses paid to Firm A or does he stand to lose money? Conversely, if the client pays Firm A and then goes on to lose the case, does Firm A have to reimburse the client for the basic costs he paid over, given that Firm A was acting on a no win, no fee basis?

As to the first question, it is important to remember that any claim for costs on a between the parties basis is the client's and not the Firm's. If the client wins, then the client is entitled to their reasonable and proportionate costs (on the standard basis and subject to any fixed costs rules).

If the client has, consecutively, instructed two firms of solicitors, then there is no reason in principle why the costs of both should not be recovered, in so far as those costs are reasonable and proportionate. However, in such circumstances experience dictates that there is nearly always a substantial element of duplication – Firm B 'reads in' to the papers, perhaps re writes the statements etc. In such circumstances, these elements of duplication are usually, though not always, regarded as being unreasonable on a between the parties basis. It is commonly, though not always, the latter, duplicated, costs that are disallowed and therefore it is more likely that it would be an element of the costs of Firm B, and not Firm A, that would be disallowed on this basis.

As to the second question, on the basis of a standard CFA and if it is the client that ends the retainer, then the client is liable to Firm A for the basic charges and the disbursements win or lose. If the client later loses the case, there is no contractual entitlement to reimbursement of the fees.

If, however, the CFA had been assigned (and therefore was continuing), any liability under the CFA would remain wholly or to the extent provided for under the CFA contingent on success.

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25 JUNE 2015, RUDDING PARK, HARROGATE, YORKSHIRE

The eleventh AvMA Charity Golf Day will take place on Thursday 25 June 2015 at the stunning Rudding Park in Harrogate. The Welcome Event for the Annual Clinical Negligence Conference will take place later that evening in Leeds (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 (total £117.60) per golfer, which includes bacon 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. Booking now open.

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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. The programme will be available and booking will open in September.

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!

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

CONFERENCE NEWS

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

On-demand 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
CPD Accreditation: 1 hour Bar Council & APIL

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
CPD Accreditation: 1 hour Bar Council & APIL

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
CPD Accreditation: 1 hour Bar Council & APIL

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
CPD Accreditation: 1 hour Bar Council & APIL

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; &
Dr Peter Ellis, Barrister, 7 Bedford Row & Assistant Coroner, West London Coroners Court
CPD Accreditation: 1 hour Bar Council & APIL

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
CPD Accreditation: 1 hour Bar Council & APIL

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
CPD Accreditation: 1 hour Bar Council & APIL

Understanding the Issue of Consent in Clinical Negligence
This webinar will discuss what constitutes appropriate consent in the healthcare setting and its legal implications.
Presented by: Joel Donovan QC, Barrister, Cloisters
CPD Accreditation: 1 hour non-accredited CPD

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
CPD Accreditation: 1 hour non-accredited CPD

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
CPD Accreditation: 1 hour non-accredited CPD

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
CPD Accreditation: 1 hour non-accredited CPD

Loss of Chance in Clinical Negligence

The aim of this webinar is to give you an understanding of pitfalls and limitations of the complex legal principle of loss of chance in clinical negligence. The session will discuss the scope of loss of chance in causation and the increased importance of loss of chance in quantification of damages, in particular in respect to loss of earning in clinical negligence cases

Presented by: Stephen Glynn, Barrister, 9 Gough Square Chambers

CPD Accreditation: 1 hour non-accredited CPD

Medico-Legal Issues in Foot and Ankle Surgery

This webinar will give solicitors involved in medico-Legal cases an understanding of the concerns in relation to foot and ankle surgery. This session will discuss the types of fractures and dislocation of the ankle and foot, achilles tendon disorders and the failure to diagnose and treat appropriately, foot surgery focusing on hallux valgus surgery, podiatric surgery and consent issues.
Presented by: Mr Bob Sharp, Consultant Orthopaedic Surgeon, Oxford University Hospitals
CPD Accreditation: 1 hour non-accredited CPD

Medico-Legal Issues Arising from Bariatric Surgery

The rising rates of obesity is being followed by raising levels of bariatric surgery which is reported to have increased 30 fold over the last 10 years. Currently, NICE recommends the procedure should be considered as first-line treatment option for adults with BMI of 50 plus.
Join the webinar to learn about consent issues, what is considered negligent and non-negligent bariatric surgery, what are the complications arising from the treatment and negligent aftercare.
Presented by: Mr Marcus Reddy, Consultant Gastrointestinal Surgeon, St George's Healthcare NHS Trust, London & Mr Omar Khan, Consultant Gastrointestinal Surgeon, St George's Healthcare NHS Trust, London

CPD Accreditation: 1 hour non-accredited CPD

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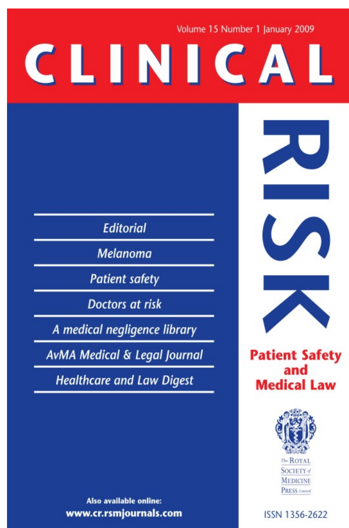

Clinical Risk is a leading journal published by the Royal Society of Medicine, which aims to give both medical and legal professionals an enhanced understanding of key medico-legal issues relating to risk management and patient safety. Containing authoritative articles, reviews and news on the management 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 a subscription form.

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 http://www.uk.sagepub.com/journals/Journal202179 or click here

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