action against medical accidents

LAWYERS SERVICE NEWSLETTER

DECEMBER 2014

EDITORIAL

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The end of the year is in sight but there are still some important matters to be aware of before we take advantage of a few days rest over Christmas. Of particular significance is that the Legal Aid Agency (LAA) has announced that it intends to open the tender process for clinical negligence contracts from 1st December, the process will close on 23rd January 2015. Information on the forthcoming contracts was issued on 25th September, details of the announcement can be found at the following link:

https://www.gov.uk/government/publications/civil-tenders

AvMA is aware of the difficulties with running cases funded by legal aid due to the low hourly rates allowed for expert's fees. AvMA has written to the Legal Aid Agency and requested clarification of their position on top up. LAA has responded pointing out that they take their direction from the MOJ who consider that **"topping up" is not compliant with the regulations**.

AvMA considers that there are arguments in favour of allowing "top up" - **I emphasise this is AvMA's position, not the LAA.** We have set out our views in a letter which has been forwarded to the MOJ legal aid policy team for consideration. We will let you have details of the MOJ's response when it is received. In the meantime there is nothing to prevent lawyers seeking prior authority to incur rates in excess of those prescribed by the Remuneration Regulations in the usual way.

In relation to cases that fall within the current scope of legal aid, AvMA considers that it is in a client's best interests to be referred/ signposted to firms who are able to offer them the full range of funding options. Despite the difficulties with expert's fees, on the face of it, it does appear that legal aid funding does continue to offer the client significant benefits; the fact that legal aid funding does not provide for any money being deducted from a claimant's damages is a very significant factor.

On the subject of applying for legal aid in clinical negligence matters, I take this opportunity to draw your attention to the "*Lord Chancellor's Guidance under Section 4 LASPO 2012*" which was issued in June 2014, for ease of reference a copy of the Guidance is available on the AvMA website and the link is as follows: http://www.avma.org.uk/pages/publications.html

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The Guidance is important as it makes clear that when making an application for legal aid in a clinical negligence case, whether for an investigative or full representation certificate, the general merits criteria apply in full (paragraph 7.31(i) Guidance). The general merits criteria can be found at Regulations 39 – 44 *Civil Legal Aid (Merits Criteria) Regulations 2013.* Regulation 39, says that an individual will qualify for legal aid if the case is unsuitable for a conditional fee agreement.

The test for unsuitability for CFA is an objective one, rather than whether a provider is willing to act under a CFA or not. Paragraph 7.17 of the Guidance sets out that a non-family case may be considered suitable for a CFA if:

- The prospects of success are at least 60%;
- The opponent has the means to meet any costs or damages which may be awarded;
- After the event (ATE) insurance can be obtained by the applicant;

AvMA's view is that most of the cases which fall within the existing scope of legal aid will be difficult to assess at the outset. It will therefore be unlikely that at the time of making the application firms will be able to assess the prospects of success at all, let alone assess them as having a 60% chance of success. In light of that, AvMA would expect that legal aid will continue to be available in the majority of clinical negligence cases that fall within the current scope of legal aid.

It is worth pointing out that the test for suitability of a CFA is not whether the provider would prefer legal aid but whether the case could realistically be brought under a CFA (see paragraph 7.20 Guidance).

We are pleased to confirm that David Keegan of the Legal Aid Agency will be attending the panel meeting on 4th December and hopefully this will provide you with a good opportunity to put your questions to him.

If you have experienced any difficulties with running clinical negligence cases with legal aid funding then please let us know about them by emailing your concerns to norika@avma.org.uk

AvMA is pleased to welcome Aisha Ansary who joined us in early November and is our Marketing and Communications Officer. Aisha and I are looking at ways to improve the Newsletter and take this opportunity to encourage you to contribute to it. We are particularly keen for you to send in any interesting legal practice points, experiences, case outcomes or articles arising out of your work which you would like to share with your colleagues. We know that practices can vary from one region to the next and it can be helpful for you to share those experiences with other practitioners. If you would like to contribute to the Newsletter, please send your articles to Norika@avma.org.uk.

I look forward to seeing as many of our panel members as possible at the meeting on 4th December and wish you all a happy Christmas holiday.

Lisa O'Dwyer

Director Medico Legal Services

AVMA POLICY & NEWS

PETER WALSH, CHIEF EXECUTIVE

DUTY OF CANDOUR COMES INTO FORCE

The statutory Duty of Candour applying to all NHS trusts came into force on 27th November. Compliance will be monitored and regulated by the Care Quality Commission (CQC). The wording of the regulations and the full guidance can be found through this link:

http://www.cqc.org.uk/sites/default/files/20141120_doc_fppf_final_nhs_provider_guidance_v1-0.pdf

You will note that the definition of a 'notifiable safety incident' includes incidents with the potential to lead to moderate harm or that 'appear' to have caused moderate harm. This point is quite crucial. Patients should be told about the potential harm and have the opportunity to influence any investigation rather than that relying on the firm conclusions of an investigation. Although the duty may not be worded and designed exactly as AvMA would have liked, we still believe this is a massively important development and potentially the biggest advance in patients' rights since the creation of the NHS. The duty is framed as a standard against which the organisation is measured. A single egregious breach of the standard or a pattern of breaches or failure to do enough to ensure the standard is achieved can result in regulatory action. We want to monitor how well CQC regulates this and would be grateful if you advise us of any breaches you come across. We can ensure that such examples are brought to CQC's attention and monitor what happens as a result. Contact chiefexec@avma.org.uk .

Meanwhile the GMC and NMC are consulting on their draft guidance on the professional duty of candour in their respective codes. The consultation closes on the 5th January and we would encourage our members to respond. Details of the consultation can be found here: http://www.nmc-uk.org/Documents/Consultations/2014/duty-of-candour-consultation.pdf AvMA's draft response setting out our main concerns and recommendations can be found here: http://www.avma.org.uk/data/files/DRAFT_RERSPONSE_TO_GMCNMC_GUIDANCE_CONSULTATION.pdf

MEDICAL INNOVATION BILL—UPDATE

Lord Saatchi's Medical Innovation Bill (discussed in previous newsletter) is due to have the report stage debate in the House of Lords on 12th December before proceeding to the Commons in the New Year. There is a distinct possibility that this misguided and dangerous piece of legislation may become law, in spite of the objections by the vast majority of medical, medico-legal and patients' organisations. AvMA is doing all it can to raise awareness of the dangers and misconceptions of the Bill. We would encourage all our members to use what influence they have with MPs to do the same. If you know of MPs who are opposed to the Bill we would be grateful if you could let us know (chiefexec@avma.org.uk) . Useful briefings and information on what other organisations are saying can be found here: http://www.stopthesaatchibill.co.uk/

AVMA POLICY & NEWS

PETER WALSH, CHIEF EXECUTIVE

NHS COMPLAINTS REFORM / THE OMBUDSMAN

AvMA is monitoring progress on improving NHS complaints since the Government response to the Francis report and the Clwyd/Hart review of complaints. It is painfully slow. The role of the Parliamentary & Health Service Ombudsman is also coming under intense scrutiny. We would welcome feedback from members on any instances they come across of mismanagement of the complaints process. We would particularly like to know if you come across examples of:

- NHS bodies telling complainants (wrongly) that their complaint can not be investigated if they are pursuing a clinical negligence claim. This is not the case and AvMA forced the Department of Health to issue clarification on this to all NHS bodies or face judicial review.
- The Ombudsman telling complainants that they cannot or will not investigate complaints brought to them either because a clinical negligence claim is being pursued or if the complainant has referred a doctor/nurse to the GMC/NMC and they are investigating. This should not be the case and the Ombudsman has assured us they will advise all their staff about this after we reported examples of this happening. The Ombudsman's regulations only preclude her from investigating if a suitable "alternative remedy" is available through another process. They have agreed in principle that the remedy being sought by people bringing a complaint to them is not available through these other procedures.

If you have examples please contact chiefexec@avma.org.uk

ARTICLE:
REGULATING SURROGACY IN IRELAND
ALICIA HAYES, MEDICO-LEGAL CASEWORKER

Infertility is a difficult problem which can have a devastating effect on couples. The advent of assisted reproduction techniques in medicine has opened up previously closed avenues for partners, who are unable to conceive naturally, to have children. With these welcome advances comes the need to regulate both the processes of assisted reproduction and the legal challenges that they give rise to.

Ireland has been very slow in devising a legal framework to deal with this burgeoning area. In 2005, the Irish Government commissioned a report on the regulation of assisted reproduction. The Commission on Assisted Human Reproduction made a number of findings and recommendations but in the nine years since its publication, the whole area still remains unregulated. This includes the practice of surrogacy, whereby a woman agrees to carry a child for another person, on the understanding that she will relinquish the child to that person upon birth.

It goes without saying that the current position is very unsatisfactory. The fact that surrogacy arrangements are unregulated does not mean that Irish citizens do not enter into them, both at home and abroad. The exact number of babies born to Irish 'parents' as a result of surrogacy is unknown but there is little doubt that many couples are choosing it as a method by which to have a baby.

The lack of legislation to govern the issue means that children born following a surrogacy arrangement are caught in a regulatory vacuum and, along with their parents, face legal uncertainty. Further, parents who engage a surrogate abroad face numerous problems and complications in seeking to establish a legal relationship with the baby they bring home.

So, it is no great surprise then that when in 2014 draft heads for a proposed 'Children and Family Relationships Bill' covering among other matters, surrogacy and surrogacy arrangements, were announced by the Irish Government, the step was widely welcomed.

The draft Bill for the most part proposed a system very similar to that which exists in the UK. It was proposed that the birth mother would be deemed to be the legal mother of any child born as a result of a surrogacy arrangement. It was also proposed that a legal parental relationship with the child could only be established by making an application to a court seeking a 'declaration of parentage'. This would be similar to an application for a 'parental order' pursuant to section 54 of the Human Fertilisation and Embryology Act 2008. One of the persons making the application for a 'declaration of parentage' would be required to be genetically related to the child born. Commercial surrogacy or any payment made in consideration of a surrogacy agreement, aside from the payment of reasonably incurred expenses, was to be strictly prohibited. However, unlike the positon in the UK, the Irish Government proposed that commercial surrogacy be prohibited by the criminal law.

The proposed Bill was criticised by a number of commentators during a formal process of public consultation, criticisms with which I agree. Although the regulation of surrogacy arrangements in Ireland is a step to be welcomed, the draft Bill and the way in which it proposed to deal with the issue of sur-

rogacy was in my view disappointing and lacked innovation. It failed in particular to acknowledge the difficulties that the UK has had in effectively banning commercial surrogacy.

As already mentioned, commercial surrogacy is prohibited in the UK. Pursuant to Section 54(8) of the Human Fertilisation and Embryology Act 2008 the courts will not grant a parental order unless it is satisfied that no money or other benefit (reasonably incurred expenses excepted) has been given or received for or in consideration of the making of the surrogacy agreement, consent to the agreement or the making of the parental order.

The UK courts however have an inherent discretion to grant a parental order even where payments made have exceeded 'reasonably incurred expenses' by retrospectively authorising payments made in surrogacy arrangements. The discretion to authorise (unlawful) payments made has been exercised in all of the cases which have come before the courts. The sums paid to surrogates and subsequently authorised by the courts (section 54(8) notwithstanding) are increasing exponentially also. This trend seems set to continue given the recent case of *J v G*[i]. The court in that case authorised a payment of $56,750.00 (circa £34,000) made to a Californian surrogate who gave birth to twins for a same-sex British couple. According to Gamble & Associates (the solicitors representing the applicants) it was 'the highest ever payment for overseas surrogacy authorised by the UK courts.'

A review of the recent UK case law reveals that despite large amounts of money being paid in surrogacy arrangements, parental orders are being granted nonetheless. The courts however are faced with little other choice, as to refuse to grant the parental order would result in the baby being stateless and parentless, which needless to say could never be deemed to be in the best interests of the chid.

In any event, it seems that any criticism of the Irish Bill has now become moot. Rather unexpectedly the Irish Government in September 2014 made the decision to completely remove the heads relating to surrogacy from the forthcoming Children and Family Relationships Bill. As of now, it is not clear when Parliament will consider surrogacy. The Executive has however been urged to address the matter by the Chief Justice following a Supreme Court decision this November on a case which sought to determine the legal mother of twins born following a surrogacy arrangement. It was determined by the Supreme Court, by a margin of 6:1, that the principle of '*mater semper certa est'* (the mother is always certain) remains the prevailing principle in Irish law unless or until otherwise determined by the legislature. This means for the time being that the birth mother (the surrogate) notwithstanding whether or not she is the genetic mother, is the legal mother of any child born following a surrogacy arrangement.

It is disappointing that nearly 10 years after the Report on Assisted Reproduction that Ireland still has not legislated for this issue. It is hoped, however, that when legislation is enacted it will reflect the lessons learned from experiences in other jurisdictions, and in particular the UK.

[Alicia Hayes joined AvMA in September 2014. She worked as a Barrister in Ireland for 8 years before moving to the UK and being called to Middle Temple in 2013. She has just completed an MA in Medical Law at King's College London].

[i] J. v. G. [2013] EWCH 1432

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Case Review of Inquest touching the death of Mrs B O'B

By Alicia Hayes, Medico Legal Caseworker

Issue: National Early Warning Score

It goes without saying that early detection and timely clinical response to acutely ill or deteriorating patients is critical in terms of patient care. A failure to detect when a patient is deteriorating and respond appropriately can often result in deaths, which may well have been avoidable. In an effort to address this problem, healthcare systems across the world have developed what are known as Track and Trigger systems or Early Warning Systems. These Early Warning Systems are tools used by medical staff to identify critically ill patients and to dictate the appropriate medical response required. In 2012, the National Early Warning Score or NEWS was introduced nationwide in hospitals across the UK.

Under the NEWS system, a score is attributed to a patient's vital signs such as systolic blood pressure, oxygen saturations, heart rate and respiratory rate. The cumulative score determines the care or escalation thereof required. Patients are given a score for each observation and if the score comes to a cumulative '5 or more' or a single score of '3', specific actions must be taken and concerns escalated appropriately in line with the protocol guidance. The NEWS system in theory is certainly a good one but whether it is working well in practice is difficult to discern. Certainly in one case which we recently dealt with as part of Pro Bono Inquest Project, there seemed to be a systemic failure to calculate the NEW score correctly and/or escalate care appropriately as required.

The Case

Mrs B O'B, who had a complex medical history, was admitted to Princess Alexandra Hospital in Essex on 8 January 2013 having been diagnosed with Lobar Pneumonia. Her expected mortality rate upon admission was stated to be 3%. Over the course of her stay in hospital her NEW score was either miscalculated, which occurred on numerous occasions, or when it was correctly calculated, her care was not escalated. The NEWS protocol was not followed and the appropriate escalation of care did not occur. She sadly died on 13 January 2014.

The Inquest into her death heard that on 11 January 2014, despite a total of 10 occasions where her NEWscore was calculated as being 5 or more, the appropriate action (hourly observations) was not taken. As Mrs B O'B deteriorated, a doctor was paged to attend, which was the correct action in the circumstances. However, Mrs B O'B waited a total of 15 hours to be seen by a doctor, again failing to abide by the NEWS protocol. When a Doctor did attend, her care was not escalated.

In the final hours before she passed away her NEWscore continued to climb but the appropriate action was not taken and her care was not escalated. On Sunday 12 January 2014, her NEW score was calculated correctly as '8' which according to the NEWS protocol demands that the medical team be informed immediately, an assessment by clinical team with critical care competencies and consideration of whether the patient ought to be transferred to ITU or HDU. None of the appropriate actions

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took place and on the morning of 13 January 2014, Mrs B O'B collapsed and although CPR was attempted, it was unsuccessful.

At the Inquest into her death HM Coroner McGann found that the NEW scores had been miscalculated and the Trust's protocol had not been followed. She expressed concern at how it arose that 'simple numbers' were not added up correctly. The Inquest heard that several members of staff made mistakes in relation to the NEWScore and on numerous occasions. In fact, 80% of the time the score was miscalculated. HM Coroner McGann enquired as to whether there was a 'culture of fear' amongst nursing staff about 'calling on doctors in the middle of the night'. Whilst evidence was given on behalf of the Trust that was not the case, the Inquest also heard that several measures have been put in place since Mrs B O'B's death to ensure that 'nursing staff feel supported and assured' in their decisions to escalate care.

Following the Inquest she concluded:

'[Mrs B O'B's] NEW score was at times miscalculated and even when calculated correctly the appropriate action was not taken. Her case was not escalated and because of this an opportunity was missed to undertake further treatment, although I cannot say that this would have saved her life.'

Although the Coroner did not include in her conclusion whether or not the failures in relation to the NEWScore would have saved Mrs B O'B, it is quite clear that in this case the NEWS system did not operate as it was intended. The Trust's NEWS protocol was not followed and the standardised care envisaged by the introduction of this system did not materialise in this case. The Coroner felt in the circumstances that a Prevention of Future Death report was not necessary. This was in light of the evidence she heard from the Trust about all of the staff at the hospital having been re-trained in the NEWS protocol and other steps which have been taken to ensure that care is escalated when necessary. We that said, AvMA do not have the authority or ability to monitor the success of such retraining. There is no way to ensure that such retraining is effective in achieving its aims in terms of preventing future mistakes, something the family of Mrs B O'B were very mindful of during this process. The family of Mrs B O'B were pleased with the conclusion of the Coroner however in the sense they feel the Inquest highlighted the failings in Mrs B O'B's care whilst in Hospital.

Mrs B O'B RIP.

Representation was provided by Kate Lumbers, counsel at 7 Bedford Row chambers.

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Inquest touching EMF

By Julia Cotterill Medico Legal Co-ordinator

This was EC's first pregnancy. She was assessed as being at low risk and attended all of her antenatal appointments, at which all observations and tests were normal. Her estimated date of delivery was 10 April 2012. On 7 April 2012, EC began leaking clear fluid and experiencing pains which she thought were contractions and contacted the hospital for advice. She was advised to remain at home, take paracetamol, go for a walk and have a bath and to go in if her contractions reached 1:2-3. The contractions subsequently slowed and stopped and EC noticed that foetal movements were less strong. EC recalls that she informed her midwife of the contractions, leakage and reduced movements at an appointment on 12 April 2012, although this was not reflected in the antenatal records and the midwife stated in evidence that she did not recall this discussion. A stretch and sweep was performed on 16 April 2012, and induction of labour was arranged for 23 April 2012.

EC arrived at hospital at approximately 08.00 on 23 April 2012. A deceleration was noted on the CTG at 09.12, but after 30 minutes of normal trace the CTG was discontinued. A Registrar attempted to rupture the membranes at 11.15, but this was unsuccessful and EC was advised to mobilise with a view to attempting the rupture again two hours later. The Registrar successfully ruptured the membranes at 13.10, although the midwife noted some concerns that the Registrar had used an orange needle for this purpose, which is not usual practice. The midwife wrote in her statement that she had been concerned by the method used to perform the membrane rupture but, so as not to alarm anyone, she did not document this in the patient's records but reported her concerns to the coordinators and kept her own record on the Trust's computer. Very little liquor drained, and EC recalls telling the Registrar that there would not be any waters present, as they had already broken some two weeks previously. CTG monitoring was commenced, and the Registrar planned for EC to mobilise for a further two hours and, if contractions did not start, to start Syntocinon.

A further deceleration of the foetal heart to 80bpm was observed at 13.48, and EC was placed in the left lateral position. The Registrar was informed and planned for EC to be transferred to the delivery room for STAN monitoring, which monitors the S-T portion of the foetal ECG. At 14.20, the CTG was discontinued after it had been reassuring for 30 minutes. Syntocinon was started at 16.40 and the dose increased over the following four hours. A deceleration to 87bpm was noted at 17.07, variable shallow decelerations at 17.30 and variable decelerations with good recovery from 18.35. The Registrar reviewed EC at 19.30 and carried out foetal blood sampling at 20.05, which was reassuring. At 20.14, uterine hyperstimulation was present and EC was contracting 1:1. The Consultant reviewed the trace and advised to continue with Syntocinon.

A 'biphasic STAN event' was observed at 20.30, and the midwife caring for EC sought assistance. However, all of the doctors were in theatre carrying out a caesarean section. The midwife was able to obtain advice from the Consultant at 20.36, who instructed her to discontinue the Syntocinon. The de-

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cision-making process then becomes unclear. A decision to proceed to a category II caesarean section is recorded in the notes as being made by the night Registrar at 21.20. However, the midwife co-ordinator who started her shift at 9pm said in evidence that when she arrived she understood that EC was to have a caesarean section. The indications for the caesarean section were recorded as 'Suboptimal CTG failure to progress.' Another patient was already in theatre, and the Registrar did not consider that there was a need to proceed to a category I caesarean section, which would involve opening a second theatre and mobilising surgical teams from elsewhere in the hospital.

The expert instructed by the Coroner, Mr Malcolm Griffiths, then notes bradycardia on the trace from 22.31. This was not identified by the Registrar, who does not appear to have reviewed the trace again after making the decision to carry out the caesarean section. The procedure started at 22.43 and was carried out by an ST2 obstetric Registrar under supervision from the specialist Registrar. The head was delivered at 22.49, but the ST2 then had difficulty in delivering the shoulders and the Registrar took over. Delivery was achieved at 22.52. Baby EMF was delivered in very poor condition and resuscitation was commenced. There was some uncertainty about the Apgar scores, which were recorded as 2, 4 and 4 at 1, 5 and 10. Within the records, a '1' appears to have originally been entered for a heart rate of below 100 but a '2' superimposed for a heart rate above 100. Both Mr Griffiths and the Consultant Paediatrician who gave evidence at the inquest commented that in a baby with a heart rate of above 100, they would not expect to see Apgar scores of zero for the other parameters, as was documented in this case. The paediatric Registrar arrived when EMF was six minutes old and took over resuscitation. EMF was transferred to the Neonatal ICU, and the Consultant Paediatrician came in from home, but after several episodes of bradycardia requiring chest compressions, her parents were advised that treatment be withdrawn. They consented to this, and EMF sadly died at 00.44 on 24 April 2014.

In light of the unexpected nature of the death, the case was reported to the Coroner and an inquest opened. A post mortem examination identified neuronal apoptosis suggestive of around 12 hours of hypoxia. This would also be suggested by stress related changes in the thymus. The pathologist noted that the placenta was small with delayed maturation and the feto-placental ratio high. The pregnancy was almost 42 weeks by the time of delivery, and there was partial hypercoiling of the umbilical cord. There were also changes in the placenta and pancreas suggestive of maternal glucose intolerance. The cause of death was:

1a. Cardio-respiratory arrest

1b. Severe metabolic acidosis

1c. Intrauterine hypoxia

1d. Almost post term delivery in a baby with a small placenta with delayed maturation and high feto-placental ratio

The inquest was listed to take place on 8 September 2014. In the meantime, the Coroner instructed

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Mr Griffiths to prepare a report, which was received in late August 2014. The family contacted AvMA, and we agreed to arrange representation at the Inquest through our Pro Bono Inquest Service. Mr Griffiths' report identified a number of issues regarding the intrapartum care provided to EC, and on the basis of the report we invited the Coroner to call additional witnesses who would be able to give evidence on the points identified by Mr Griffiths. We also requested that the Trust provide copies of any relevant guidelines to be incorporated into the bundle. The Coroner agreed to request the guidelines but not to call the additional witnesses.

On Friday 5 September 2014, the last working day before the Hearing, the Trust disclosed a number of documents, which included some guidelines but also a 'First Draft' Root Cause Analysis Report and documents relating to meetings which had been held to discuss the circumstances of EMF's death. The family had not been provided with the documents or informed that the investigations had been carried out. The Trust's own investigation identified a number of issues, many of which were consistent with those identified by Mr Griffiths. In light of this, we submitted that the Hearing listed for 8 September 2012 should be converted to a Pre-Inquest Review, as the Coroner would be unable to fully investigate the death without additional evidence. However, by the end of the day on Friday 5 September 2012 it remained unclear whether any evidence would be heard.

On Monday 8 September 2014, the witnesses attended and the Trust submitted that the Coroner did have sufficient evidence to answer the four statutory questions. The Trust's representative acknowledged the lateness of the disclosure, apologised to the family for any distress caused and explained that the processes for disclosure of Root Cause Analysis reports at the Trust is now more robust. The Coroner decided not to proceed with the inquest, as this would incur the risk that the family would feel that the Coroner had not heard from all appropriate witnesses. The Coroner agreed to call further witnesses, asked the Trust to produce further information and documents and invited the parties to submit any further questions to Mr Griffiths. The Inquest was listed to take place on 17 and 19 November 2014. However, the listing was amended once again shortly before the Hearing, and the Inquest took place on 17, 19 and 20 November 2014.

Mr Griffiths produced a supplementary report addressing the queries of the parties, and subsequently amalgamated the reports into a single composite report, which also addressed the witness statements provided since the Hearing on 8 September. Mr Griffiths concluded that the decision-delivery interval 'may well have been prolonged' for a category II caesarean section, which according to the NICE Guidelines is to take place within 75 minutes. He also advised that, although in his opinion the bradycardia observed on the CTG trace from 22.31 was a terminal bradycardia, if it was accepted that the baby's heart rate was over 100 as documented in the Apgar scores, it would instead represent a continuing bradycardia which was 'somehow alleviated' prior to birth. Mr Griffiths concluded that EMF had died of 'an acute hypoxic-ischaemic brain insult that commenced around twenty minutes before she was born and which continued from birth until she ultimately died.' Mr Griffiths' evidence to the inquest was that an apparent recovery in the foetal heart rate prior to delivery was likely to be a mechanical

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artefact of the CTG and not a true reflection of the foetal heart rate. He also considered in his report that 'had this bradycardia been recognised it might have prompted greater urgency in the delivery.' In this regard, the night Registrar who gave evidence at the inquest informed the Coroner that in her experience it is possible to deliver a baby within one to three minutes.

The evidence of witnesses who attended the inquest was that the department was short-staffed on the day of EC's admission. The midwife who noticed the STAN event went in search of assistance, but all of the doctors were in theatre. Whilst she was out of the room, she heard the emergency buzzer sounding in another room and went to assist another midwife. She explained that ideally each woman in labour would be attended by a single midwife but that on the day in question this was not possible. Doctors also gave evidence to the effect that one Registrar was covering the entire department, including the gynaecology wards and delivery suite. The Director of Midwifery gave evidence as to the changes that have been made to staffing arrangements, including increasing staffing levels to enable midwife coordinators to focus on overseeing work within the department.

With regard to the decision-delivery interval, Mr Griffiths, who is a member of the committee that drafted the NICE Guidelines, clarified that the time limits set out in the Guidelines are audit standards rather than mandatory targets. Therefore, Trusts would audit their units on the percentage of deliveries achieved within 75 minutes of the decision being made. However, that the decision-delivery interval in this case exceeded 75 minutes did not concern Mr Griffiths, and he considered that the explanation of another patient being in theatre was satisfactory. He also explained, however, that in his hospital they maintain two open theatres, so that the team can move from one theatre to another cleaned and ready theatre when a procedure is completed, avoiding the need to wait until a single theatre is sterilised before beginning the next operation. He was critical that the decision was not clearer and that EC was not informed earlier that she would be having a caesarean. Mr Griffiths also commented that there was no point in doing a CTG if attention is then not paid to it and noted that the key person, the night Registrar, was unaware of the bradycardia.

Mr Griffiths also identified a 'grey area' in CTG interpretation. Despite the steps taken to induce labour, EC was never actually in labour. Mr Griffiths commented that her CTG would have been suspicious in labour and quite abnormal antenatally.

The evidence of the pathologist was that there was an underlying vulnerability to injury, as the foetus would not have had the reserves of a healthy baby before undergoing the stressful process of labour. However, Mr Griffiths was of the opinion that for EMF a marginal delay of 15 minutes or even less would have made a difference to the outcome.

The Coroner reached a narrative conclusion, which incorporated that the bradycardia was missed but noted that she was unable to say whether this altered the outcome.

Representation was provided by Rory Badenoch, Counsel at 12 Kings Bench Walk

AVMA ACCREDITATION
LIZ THOMAS
POLICY AND RESEARCH MANAGER

Are you or members of your team ready for AvMA Accreditation?

The AvMA panel was the first accreditation scheme of its type, its hallmark is its commitment to client care which is why it continues to set itself aside from other schemes. As a result, the AvMA panel attracts the leading clinical negligence lawyers, those who pride themselves on their excellence and dedication to achieving justice for their clients.

AvMA is committed to supporting the next generation of specialist clinical negligence practitioners. This is to ensure that patients and their families will continue to have access to practitioners who are committed to providing specialist clinical negligence services which focus on the client's needs - and who are prepared to go that extra mile. This has been the trademark of the AvMA Panel.

If you are approaching 4 - 5 years PQE and are considering specialist accreditation, do come and talk to us about preparing for AvMA panel membership. We are happy to give advice about the timing of applications, the type of experience AvMA is looking for, and to discuss queries about the criteria. Our aim is to support you through the process. For further details contact Liz Thomas policy@avma.org.uk .

The AvMA Panel accreditation forms can be found on AvMA's website at: http://www.avma.org.uk/pages/application.html

VOLUNTEERING FOR AVMA
A PERSPECTIVE — CONWAY CASTLE-KNIGHT

November 5th 2014 was the 10th anniversary of my starting with AvMA where I have been volunteering ever since. I am pleased to look back on ten years of interesting work and congenial colleagues. I have particularly enjoyed the Awaydays and socials of various natures.

I was touched, in particular, by a person visiting me when I was in hospital (and the card that had been signed), and recently when my ten years was celebrated. If I may say so myself, it is good to know I am appreciated here. Thanks.

Another thing I am grateful for is how accommodating AvMA people were when a team came to film me - this was a couple of months before AvMA's move, so as a bonus it gave me footage of working at 44 High Street.

I know that some people have been with AvMA a lot longer than me – but long may my time with AvMA continue, I hope.

FUND RAISING

PHILIP WALKER, FUND RAISING MANAGER

Boogie Woogie Legal Choirs Bring the House Down

On the 15th of October 2014 at the Central Baptist Church in Bloomsbury five legal choirs competed in the final of the first ever AvMA Legal Choir Challenge. The evening was sponsored by Temple Legal Protection. This is a new music competition for all legal and medical firms and a great way for members of the legal and medical worlds to network and enjoy an evening of good music, hospitality and fun.

In addition to the five legal choirs special guest performers included Charlotte Collier from Absolutely Opera and rising jazz star Harriet Eaves with Nathan Jarvis

"We are an all-female choir who formed because of the AVMA Choir Challenge in 2013".

The words of Sue Prior, lead of the Shoosmiths Singers, joint winners of the 2014 AvMA Legal Choir Challenge

The Shoosmiths Singers (pictured left) along with Legal Harmony of Stewarts Law LLP won joint first prize, a performance at the prestigious Brandenburg Festival in 2015.

"We are a mix of people, some of whom have never sung before and have never sung in public at all, let alone in a competition" Continued Sue. "We rarely manage to get the whole choir together at once because of our work commitments and so we rehearse at lunch times with those who can make it on any given day! We have really enjoyed getting together though and are looking forward to the competition but with some trepidation!"

"Events that get people working together in a creative context always add an extra dimension to business" said David Pipkin, Underwriting Director at Temple Legal Protection 250 solicitors, barristers and supporters packed into the main auditorium at the Central Baptist Church to hear the five legal choirs compete for the joint first prizes. "What a great buzz, a great night" Terry Donovan senior partner and organiser of the Kingsley Napley Choir.

There were five finalists including the Irwin Mitchel choir formed like Shoosmiths out of last years'

FUND RAISING
PHILIP WALKER, FUND RAISING MANAGER

AvMA choir workshop and concert. “The Choir was established in January 2014, thanks to an inspirational evening at the AvMA Legal Choir Challenge in 2013” confirmed choir organiser Irwin Mitchel’s Anna Manning. “The Choir is made up of staff members of all levels from across the London Office” led by ‘Music in Offices’ conductor Hilary Campbell, the choir enjoys a wide-ranging repertoire from Motown to classical and pop.

The Dev Singers from Devonshires LLP were another finalist. They performed a medley of songs from the musical “West Side Story” and received great praise from the judges especially on the interchange of voices. Joint winners Legal Harmony of Stewarts Law LLP London offices also performed modern classics including John Lennon’s “Imagine” and Lenard Cohen’s “Hallelujah and were surprised and elated at winning a slot in the Brandenburg in March.

The fifth finalists were publishers The Lexis Nexis Singers who had formed a year earlier supported by City Music Services (CMS). Formed in 2013 by legal editor Sally Thomas “we thought it would be a great way of breaking down departmental barriers and giving people a tuneful outlet from the pressures of work” confirmed Sally. Led by CMS’s Andrew Sackett “our aim is to strike a happy balance between getting the best out of the singers and having fun!”

The AvMA Legal Choir Challenge is set to become a regular annual event in the legal calendar with plans to combine in a grand massed choir event at the Royal Albert Hall in 2016. The enjoyment and practical benefits of the evening were summed up best by David Pipkin from sponsors Temple Legal Protection "it is an opportunity for lawyers to connect with each other on a different level. We have been delighted to support AvMA and to see so many firms getting involved."

JOIN IN TH FUN – 26th February 2015

The next AvMA choir workshop will be held on the 26th of February 2015. If you are thinking of forming a choir in your firm, would like to join a choir or simply enjoy the fun of singing do join us. Top choir conductor Stewart Dunlop head of Music at the University of East Anglia will run the workshop.

“What a fab evening, I’ve not had so much fun in ages” said Jodi Newton Partner at Barker Gillette LLP after taking part in the last choir workshop in September. Even if you don’t want to be in a choir you can learn so much from Stewart”. Places are available to book for February. Price of tickets is just £25 for a full evening workshop.

To book contact Phil Walker 0208 688 955 or e-mail philipwalker@avma.or.uk

UNCLAIMED CLIENT MONIES

How Legal Firms can Help AvMA at Zero Cost

- **Do you have old client accounts with unclaimed funds?**

FUND RAISING

PHILIP WALKER, FUND RAISING MANAGER

- **Do you want to help AvMA support our families**
- **Raise the public profile of clinical negligence work**
- **Have you got five minutes to talk to us?**
- **Help AvMA by Donating Unclaimed Client Monies**

Many legal firms often find themselves holding monies for clients they cannot trace or accounts that have lapsed and normally solicitors cannot easily utilise this money. Both the Law Society and the Solicitors Regulation Authority (SRA) do allow donation of such funds to registered charities such as AvMA. The process is very simple, costs you nothing and involves no risk to the firm as indemnity is provided. These donations however small could make a big difference and if less than £50 you don't even need to contact the SRA. (see link to SRA regulation 22)

http://www.sra.org.uk/solicitors/change-tracker/accounts-rules/accounts-rules-b.page#r22-1-ga

If you wish to discuss unclaimed monies - contact me Philip Walker on 020 8688 9555 or e-mail me at philipwalker@avma.org.uk

AvMA's E-Bay Shop

Let us sell your unwanted Items for charity

- **Do you have any items you no longer need?**
- **Are they in good condition of saleable quality?**
- **Would you donate them to AvMA?**

Many of us have items at home or in the office we no longer use or want. As a charity AvMA can sell these items on E-bay for a minimal charge and raise funds for our Patient Safety work. One of our member firms has already donated used items and these have sold well on E-Bay. This has provided much needed funds to support our work with great success.

If you could donate one item - even a modest sum raised can have significant impact for our work.

The process is simple. Contact us, tell us what you have to sell, provide a description and photo - we do the rest

If you wish to discuss our E-Bay Shop - contact me Philip Walker on 020 8688 9555 or e-mail me at philipwalker@avma.org.uk

CONFERENCE — FORTHCOMING EVENTS

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.

AvMA Specialist Clinical Negligence Panel Meeting & Christmas Drinks Reception

4 December 2014, 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 4th 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!

Clinical Negligence Issues in Neurosurgery & Neurological Disease

11 December 2014, De Vere Holborn Bars, London

Neurological injuries are amongst some of the most devastating clinical negligence cases. This new AvMA event will give you an in-depth insight into the conditions relevant to your caseload. Stroke medicine, spinal and cranial surgery and medico-legal issues in neuro-intensive care and neurological rehabilitation will all be covered by leading medical experts. Quantum in neurosurgery and neurological disease will also be examined.

Medico-Legal Issues in Cardiology

15 January 2015, De Vere Colmore Gate, Birmingham

At this essential AvMA conference, aimed at an intermediate level, you will hear from leading experts in the field of Cardiology. The speakers will also give you case examples from their clinics to assist you with your case load. The anatomy of the heart, including imaging procedures used in the diagnosis of heart disease, will open the conference, before we move onto the role of angioplasty; an update on arrhythmia, including interpreting ECGs; medico-legal issues in cardiac surgery and paediatric interventional cardiology.

CONFERENCE — FORTHCOMING EVENTS

Medico-Legal Issues in Accident & Emergency Care

22 January 2015, De Vere Holborn Bars, London

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, Action against Medical Accidents' new conference on **'Medico-Legal Issues in Accident and Emergency Care'** will examine the current standards, issues, roles and responsibilities, investigations and management of key areas in accident and emergency care.

Clinical Negligence: Law Practice & Procedure

29 – 30 January 2015, De Vere Colmore Gate, 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. The programme will be available and booking will open in October.

Medico-Legal Issues in Oncology

5 FEBRUARY 2015, MANCHESTER CONFERENCE CENTRE

This vital course will provide in-depth knowledge and understanding of Oncology in a medico-legal context relevant to your case load. The day combines a mix of presentations from leading experts to cover types of tumour; staging and classification; diagnostic tools and treatments; medico-legal issues in the delay of diagnosis; advances of surgery and causation issues arising in cancer claims.

Cerebral Palsy & Brain Injury Cases - Ensuring you do the best for your client

11 February 2015, De Vere Holborn Bars, London

This popular AvMA conference returns to London on 11th February and will discuss and analyse the

CONFERENCE — FORTHCOMING EVENTS

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.

Essential Medicine for Lawyers

11 March 2015, Marriott Royal Hotel, Bristol

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

AvMA Annual Charity Golf Day

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 will open in the New Year.

CONFERENCE — FORTHCOMING EVENTS

Annual Clinical Negligence Conference 2015

26-27 JUNE 2015, ROYAL ARMOURIES MUSEUM, LEEDS

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

The ACNC 2015 full conference programme will be available early in the New Year. 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).

There will again be discounts available for junior solicitors and barristers, paralegals and trainee legal executives to attend the conference, as well as greater savings for group bookings. 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.

Sponsorship and Exhibition Opportunities at ACNC 2015

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 2015.

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

AvMA Medico-legal Webinars

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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!

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AvMA Medico-legal Webinars

Our on-demand webinars are available now, to be accessed from your desktop, laptop, tablet or mobile phone.

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.

AvMA Medico-legal Webinars

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

AvMA Medico-legal Webinars

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

AvMA Medico-legal Webinars

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

AvMA webinars are kindly sponsored by:

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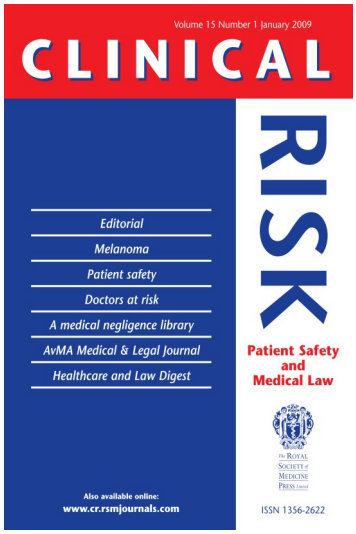

Clinical Risk is a leading journal published by the Royal Society of Medicine, which aims to give both medical and legal professionals an enhanced understanding of key medico-legal issues relating to risk management and patient safety. Containing authoritative articles, reviews and news on the management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