action against medical accidents

LAWYERS SERVICE NEWSLETTER

PRE-CONFERENCE JUNE 2014

EDITORIAL

INSIDE THIS ISSUE

Much has happened since last year's conference. The end of 2013 saw several significant mergers and sadly some administrations but there has been a sense that firms are at last, beginning to settle down and come to terms with the raft of changes introduced last year.

Increasing number of lawyers are reporting their experiences of costs budgeting and completing the horror that "Form H" has shown itself to be. Anxieties have been heightened by the severe decision in "Mitchell" whilst the seminal case on proportionality continues to be awaited with anticipation and at least a smattering of fear!

AvMA is also very mindful of the difficulties arising on running cases on legal aid due to the low hourly rates allowed for expert's fees. The situation appears to be compounded by the fact that there is a lack of clarification on the effect "topping up" those rates may have on a firms' continued eligibility for a legal aid franchise. We are trying to open up dialogue with the Legal Aid Agency and seek clarity upon the issue once and for all.

We are also seeing more firms moving into the clinical negligence market, many of which have little or no previous experience in clinical negligence litigation. AvMA remains consistent in its view that accreditation remains a powerful weapon in ensuring members of the public receive good representation and advice from solicitors who have both experience and expertise in this highly specialised area.

On the subject of experts, we are pleased to draw your attention to the article on **"Experts' Literature – An undervalued resource?"** by Tom Gibson and Will Young of Outer Temple Chambers in this edition of the Newsletter

We are fast approaching a year since the introduction of the new Coroner's Rules: The Coroner's (Inquest) Rules and The Coroner's (Investigation) Rules 2013 together with the implementation of the Coroner's & Justice Act 2009. The new rules do appear to have succeeded in ensuring that generally cases are being heard more quickly, however we have growing concerns that the need for speed has in some cases compromised the investigation. Julia Cotterill, one of AvMA's Medico-Legal Advisors has provided details of two case studies, the

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case of XY is particularly a case in point. We also draw your attention to Frances McClenaghan's article on points to note on pre-inquest reviews coming out of the case of **Brown –v- HM Coroner Norfolk**

Melina Padron of Doughty Street has written up the case of **Dunhill v Burgin** for the Newsletter. This is an important case which looks at the relevant test for assessing a client's mental capacity to conduct legal proceedings. The case concludes by setting out five important lessons and is one that all practitioners should be mindful of.

In the face of this fast moving environment it is important to take time out and perhaps take the opportunity to do Charles Bagot's "**Expresso Quiz on Secondary Victims**". A number of you may have attended Charlie's presentations on secondary victims at our recent Lawyers Support Group Meetings (LSGs). His interactive format has been very well received and considered fun! Answers to the quiz are included in the newsletter but no cheating!

Lawyers doing clinical negligence work recognise the need for good client care, Dr Dawn Benson's article on "**Birth Injury, Disabling Families and Enabling Human Factors**" looks at litigation from the perspective of parents and carers of children who have a neurological injury as a result of clinical negligence. Dr Benson has also been through the litigation process as a litigation friend on behalf of her son who suffered avoidable injury at the time of his birth, she has first hand experience of the effects of the litigation process on a family bringing a claim. This is important and interesting work and I recommend this piece to you.

There is also an interesting article entitled **"Patient Safety – A Junior Doctor's Perspective",** by Charlotte Connor, AvMA's in house doctor.

We continue to work on ways to create improved forums to bring the more junior end of the legal profession together in a supportive and collegiate environment. If you have any particular views on this or would like to feedback on any or our services then please do not hesitate to contact me by emailing norika@avma.org.uk.

AvMA is pleased to announce a pilot between ourselves and the CQC due to commence on 1st July. This will involve AvMA feeding back to the CQC information gathered from consenting members of the public to help identify whether NHS Trusts are meeting requisite standards of quality and care. Through the pilot the CQC aim to increase public understanding and awareness of the standards they have the right to expect whenever they receive care. To assist with this pilot we are currently recruiting for a **Data-Administrator/Case-Worker**. This is likely to be a temporary position for about six months, full details are on the AvMA website. **Closing date for applications is Friday 27th June with interviews fixed for 2nd July.**

AvMA has undergone some changes internally with a fusion of the Lawyers' Services Department and Client Services. Now that we have bedded down with the changes we are looking to recruit two people: a **Medico-Legal Advice Worker and a Medico-Legal Co-Ordinator,** outline details are in the Newsletter with a link to the AvMA website where the full job description, person specification and ap-

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plication form can be found, **closing date for applications is Thursday 17th July, with interviews on 23rd and 24th July.**

The AvMA Annual Conference is being held in Brighton on 27th and 28th June, kick-off is on the evening of Thursday 26th June. It is one of the largest conferences ever with close on 500 delegates. It promises to be an excellent couple of days with expert speakers and highly relevant topics. We look forward to welcoming you then.

Lisa O'Dwyer

Director Medico-Legal Services

AVMA POLICY & NEWS

Fiona Freedland

We are sad to announce that Fiona Freedland, much loved and respected ex-Legal Director of AvMA, died on 28th May after a long and brave fight against cancer. Fiona was an inspirational colleague and friend to all at AvMA, and a passionate and effective champion for patient safety and justice. She will be sorely missed. Our thoughts are with her family, Robin, Beth and Ellie.

Duty of Candour to go "live" in October

AvMA's long campaign for a statutory Duty of Candour is soon to be realised. The duty will form part of statutory regulations setting out the "fundamental" standards which any provider of healthcare who has to be registered with the Care Quality Commission has to meet. These are due to come into force on 1st October. Even after AvMA had secured the Government's agreement to introduce a statutory Duty of Candour, which had been strongly opposed by successive health secretaries, we had to fight a rear-guard battle to persuade Jeremy Hunt not to limit the duty to when death or severe permanent disability was known to have been caused. It will now apply to any significant harm. We are yet to see the final regulations. AvMA did raise concerns about the version which was consulted upon earlier this year. We pointed out that if interpreted literally, the duty would only apply to actual harm which had already materialised. We think that the duty should apply to incidents where something has gone wrong, for example at childbirth or in a diagnostic procedure, where there is a likelihood of future harm as a result, but the "harm" is not yet known. We eagerly await news as to whether this point has been agreed and will also be working on guidance with the CQC.

AvMA is also in discussion with the Departments of Health in Scotland, Wales and Northern Ireland about possible adoption of a duty of candour in those countries.

CQC's Ratings and Inspection System

AvMA has responded to the CQC's consultation on its approach to inspections and rating providers of healthcare. Whilst we think there has been a massive improvement in the way that the CQC works over the last year, there are still adjustments to be made. One of our strongest recommendations is that it should not be possible for an organisation to have a rating of "good" overall if it is found to "require improvement" with regard to patient safety. Currently, there is no extra weight given to patient safety. In April St Georges NHS Foundation Trust in South London was given a rating of "good" overall in spite of being found to "require" improvement when it came to patient safety. AvMA also recommended ways of monitoring compliance with patient safety alerts and the duty of candour, and improvements to involving patients. You can see AvMA's full response here http://www.avma.org.uk/data/files/CQC_Consultation.pdf

AVMA POLICY & NEWS

The Medical Innovation Bill (The "Saatchi Bill")

This Bill was introduced in the Lords on 5th June 2014 by Lord Saatchi. Its stated purpose is to promote "innovation" in medical treatment. It is based on the premise that innovative and potentially life-saving treatment is being denied to patients because of fear of clinical negligence litigation, and seeks to protect doctors from a finding of negligence, whatever the outcome, provided they have consulted colleagues and obtained the patient's consent. There is no requirement for the proposed treatment to have been approved by anyone other than the individual doctors – even if all the advice, guidance and evidence was against going ahead with the treatment. The Bill itself can be found here http://www.publications.parliament.uk/pa/bills/lbill/2014-2015/0004/15004.pdf

Although the Bill has been introduced privately by Lord Saatchi, both David Cameron and Jeremy Hunt have previously voiced support for it. There is a huge media campaign being conducted in support of it. Media coverage focuses on terminally ill patients being permitted to receive experimental treatment when there is no other hope. However, the Bill as drafted would apply to any kind of medical treatment, in any circumstances.

The Department of Health has conducted a consultation on a previous draft of the Bill. The responses have not yet been analysed and the Bill did not feature in the Queen's Speech. However, that does not mean that the Government will not support it. AvMA is campaigning to try to ensure this Bill does not get through. AvMA CEO, Peter Walsh, took part in media interviews on 5th June explaining why it is so dangerous. We would urge all our supporters to take a close interest and use their influence to prevent this Bill becoming law.

The AvMA Panel / discussions re "joint" panels

No further progress has yet been made on discussing the possibility of combining specialist panels of clinical negligence solicitors into one panel. AvMA remains committed to trying to ensure that members of the public can recognise a genuine specialist and to maintaining, developing and promoting its own panel quality mark for that reason.

After consultation with AvMA panel members, it has been agreed to continue to promote the AvMA panel at grass roots level with advice agencies and through working with the media. AvMA was also investing in a Marketing Officer and in optimising their 'Find a Solicitor' website. Other opportunities to promote the AvMA panel may be explored in the future.

Peter Walsh, Chief Executive

Experts' Literature—An Undervalued Resource?

Tom Gibson and Will Young, Barristers, Outer Temple Chambers

Introduction

Experts' literature is an area that is often overlooked in clinical negligence cases – at least until a trial is almost upon the parties. However experts' literature deserves more attention in the earlier stages of cases because of the devastating effect that it can have at trial, as the recent High Court case of *Sardar v NHS Commissioning Board* [2014] EWHC 38 (QB) demonstrates.

This article reviews the law and procedure on experts' literature and examines the practical use of experts' literature at trial in *Sardar v NHS Commissioning Board*, before drawing conclusions applicable to all clinical negligence practitioners.

Experts' Literature – The Law and Procedure

What happens (in theory)

In theory, all literature should be served with an expert's original report. The CPR is clear that:

> *"An expert's report must… give details of any literature or other material which has been relied on in making the report" [PD 35, paragraph 3.2(2)]*

> *"Experts should take into account all material facts before them at the time that they give their opinion. Their reports should set out those facts and any literature or any other material on which they have relied in forming their opinions…" [Protocol for the Instruction of Experts, paragraph 4.5 ('Duties of Experts')]*

Also, the author(s) of the literature and their approximate qualifications/status should also be given – presumably to help a judge weigh how authoritative any literature is:

> *"Where experts rely in their reports on literature or other material and cite the opinions of others without having verified them, they must give details of those opinions relied on. It is likely to assist the court if the qualifications of the originator(s) are also stated." [Protocol for the Instruction of Experts, paragraph 13.8 ('Reliance on the work of others')]*

But – what happens in reality!

However, in reality, experts can often produce literature to bolster their reports much later in the day. In the authors' anecdotal experience, some experts have a tendency to produce large amounts of new literature (or even a whole new report) in the last day or two before trial, once it dawns on them that a particular case (unlike many others) will not settle, so that the expert's time in the witness box is imminent!

Experts' Literature—An Undervalued Resource? .....Cont.

Tom Gibson and Will Young, Barristers, Outer Temple Chambers

To avoid last-minute rushes (and ambushes) like this, case law suggests that 1 month is the latest cut-off point by which all parties should have served their relevant literature. The useful commentary at paragraph 35.10.5 of the White Book says:

> ***"35.10.5 Literature to be served with reports***
>
> *Wardlaw v Farrar [2003] EWCA Civ 1719 decided that in clinical negligence claims being conducted in the county courts or District Registries, the judges should adopt the standard direction of the Queen's Bench Masters that any material or literature upon which an expert wished to rely must be served either with their report or at the latest one month before trial. Permission would be needed from the trial judge before an expert witness could introduce additional material at trial. The point of principle is applicable to experts' reports in any discipline.*
>
> *Any literature relied upon by one party's expert should be reviewed by the other party's expert and be available for the trial judge. In Breeze v Ahmad [2005] EWCA Civ 223 the claimant was able to show that the literature relied upon by the defendant was "unwittingly portrayed inaccurately and/or incompletely" which led the judge to place more reliance upon it than he should have done—a retrial was ordered." [emphases added]*

In the post-Mitchell world, parties would be well-advised to serve their literature in good time, rather than to risk the complaints of the other side and the wrath of the trial judge when an expert turns up to court clutching the fruits of their researches from the night before trial.

Experts' Literature at Trial – a Recent Case Study

The case of *Sardar v NHS Commissioning Board* [2014] EWHC 38 (QB) gives some very interesting and potentially helpful insights into the way Courts view experts' literature. *Sardar* was a shoulder dystocia case concerning the allegedly negligent delivery of the Claimant in 1989. The trial was on liability only, with quantum having been agreed at £450,000.

The Issues and Facts

The main issue in the case was whether the Claimant's shoulder injury was caused by the normal and natural forces of maternal propulsion, or whether there was excessive forceps traction by the Defendant's clinicians. In part, this depended on whether the Claimant's injured right shoulder had been the anterior shoulder at the time of birth, and was injured against the mother's symphysis pubis, due to excessive traction, or whether it was the posterior shoulder, injured against the sacral promontory, by maternal forces.

Experts' Literature—An Undervalued Resource? .....Cont.

Tom Gibson and Will Young, Barristers, Outer Temple Chambers

The position of the fetus at the time of delivery was agreed to be OP (*occipito posterior*, i.e. with the back of head facing backwards). However there was a factual dispute as to whether the fetus was "ROA" (*right occipito anterior*) on admission to hospital or "LOP" (*left occipito posterior*) on admission.

This was an important factual point: the former scenario (ROA on admission to OP on delivery) would have involved more rotation during labour, from ROA to OP, whereas the latter scenario (LOP on admission to OP at delivery) would have involved less rotation by the fetus.

The Parties' Arguments

At trial, the Defendant argued for the former factual scenario, with more rotation (ROA to OP). This was because more rotation meant (in very simple terms) that the baby's shoulder had probably rotated under the mother's sacral promontory, where it was probably injured non-negligently by maternal forces.

The Claimant argued for the latter scenario, with less rotation (LOP to OP). This was because less rotation meant (in very simple terms) that the baby's shoulder had probably not rotated under the mother's sacral promontory – so it was more likely to have been the anterior shoulder, and injured by excessive traction.

The Claimant's case was that it was "most unlikely" that the fetus would have rotated the larger distance from ROA to OP during labour (as the Defendant contended). This was a position taken by all three of the Claimant's experts, in midwifery, obstetrics and paediatrics.

The Defendant's Experts' Literature – the Gardberg Paper

The Defendant relied upon a paper: *Intrapartum Sonography and Persistent Occiput Posterior Position: A Study of 408 Deliveries*; Gardberg, Laakkonen and Salavara, 1 May 1998 ("the *Gardberg* paper"). This reported that only 21 of the 408 deliveries studied were delivered in an OP position, but of those 21, 13 (i.e. 68%) were in an OA position initially and developed a persistent OP position on delivery through a mal-rotation during labour.

Thus the paper appeared to show, albeit based on a small sample, that the Claimant's suggestion that a rotation during labour from ROA to OP was "most unlikely" was not supported by the only available empirical evidence. Given that the Claimant was accepted to have been born OP, the study appeared to show that it was in fact relatively likely (13 out of 21 cases in the study as opposed to 8 out of 21) that he had been ROA on admission, and had rotated during labour.

The Trial – and the Experts' Evidence

Experts' Literature—An Undervalued Resource? .....Cont.

Tom Gibson and Will Young, Barristers, Outer Temple Chambers

The Claimant's experts were not considered by the Court to have dealt with the *Gardberg* paper with any degree of success. Indeed:

> The Claimant's expert midwife was criticised for *"disingenuously"* seeking to argue that rotation from ROA to OP was rare, which ignored the combination of the agreed finding of OP position at birth and the recorded numbers in the *Gardberg* paper.

> The Claimant's obstetrics expert was "*most unsatisfactory*". He "*appeared to forget his duty to the Court and seemed illegitimately to stray into creative advocacy for the Claimant's cause. He tailored his evidence to argue the case for "LOP" on admission. He sought to side-step the evidence… He asserted that it was "really most unlikely" that the fetal position could change from "OA" to "OP" but equivocated when confronted with the clear conclusion of the Gardberg paper that the majority of "OP" babies on delivery started from "OA"*".

> The Claimant's paediatrics expert sided "*uncritically*" with the obstetrics expert and failed to deal adequately with the contrary suggestion contained in the *Gardberg* paper.

The Defendant's midwifery and obstetrics experts were, on the contrary, commended, respectively, by the Court for their *"magisterial grasp"* of the subject and "*palpable integrity"*. No criticism was allowed of the fact that the Defendant's obstetrics expert had been introduced to the *Gardberg* paper by the expert midwife, who "*candidly admitted*" that she had indeed introduced the *Gardberg* paper, which had been circulated to the obstetrics expert.

The Judgment

While the rotation issue was not the only issue in the case, it was a very important part of the Claimant's case. Overall, the Judge (Haddon-Cave J) held that the Claimant's case on rotation had been "*comprehensively demolished by the Gardberg paper*".

For this reason, amongst others, the Claimant's claim was dismissed.

Conclusions – Practice Points

- Experts' literature is a valuable and perhaps undervalued resource. It can make or break cases at trial!

- Judges and lawyers may, in general, find written evidence and sources (including experts' literature) more persuasive than 'pure' oral evidence. Therefore literature – whether in the form of a surgical textbook, a paper written for medico-legal purposes, or any academic study – can be crucial in bolstering an expert's opinion, and persuading a judge that your expert is the one to be preferred.

Experts' Literature—An Undervalued Resource? .....Cont.

Tom Gibson and Will Young, Barristers, Outer Temple Chambers

- Anyone can search or prompt a search for literature. What a piece of literature says, and whether it helps the trial judge (and your case), is more important than the motive of the person who looked for it!

- Experts' literature should, ideally, be searched for as early as possible in a case. It is better to find sources that support (or weaken) your case as soon as possible, rather than to risk either (1) a nasty surprise as the opposition discovers something important closer to trial, or (2) a difficult procedural/costs issue when your expert reviews their own work (much more thoroughly) the day before trial and comes up with new literature that the opposition has not seen.

Are we doing enough to protect "protected parties"?

Lessons for personal injury lawyers from the Supreme Court Judgment in *Dunhill V Burgin*

Melina Padron, Barrister, Doughty Street

Introduction

"Policy arguments do not answer legal questions", said Lady Hale before finally concluding her lead judgment in *Dunhill v Burgin* dismissing the Defendant's appeals. When reading the judgment, however, one cannot help but conclude that policy reasons were firmly in the Justices' minds when they answered the legal questions posed by these appeals.

Facts

The case concerned Mrs Dunhill, who in 1999 suffered brain injuries after being struck by a motorcycle driven by Mr Burgin. In 2002 she issued proceedings against Mr Burgin for damages for personal injury not exceeding £50,000 in value.

Negotiations took place at the door of the court and, after advice from her then lawyers, Mrs Dunhill agreed to settle her claim for £12,500 plus costs. That settlement was embodied in a consent order which was put before a judge, although the settlement itself was not approved by the court.

Dunhill V Burgin ...Cont.

Melina Padron, Barrister, Doughty Street

In fact, Mrs Dunhill had suffered very serious injuries, which meant she had settled her claim very significantly under value. On the assessment of her new lawyers, her claim was valued at £2,000,000 on full liability, whilst Mr Burgin's lawyers estimated it at £800,000.

Mrs Dunhill instructed her new solicitors in 2006 and it was apparent that she required a litigation friend. An application was then made for a declaration that she had not had mental capacity at the time of the settlement in 2003 and that the consent order embodying the settlement should be set aside with directions for the future conduct of the claim.

Issues

The new claim raised two key issues:

1. What is the test for deciding whether a person lacks the mental capacity to conduct legal proceedings on his/her own behalf (in which case the Civil Procedure Rules ("CPR") require that he/she has a litigation friend to conduct the proceedings for him/her)?
2. What happens if legal proceedings are settled or compromised without it being recognised that one of the parties lacked that capacity (so that he/she did not have the benefit of a litigation friend and the settlement was not approved by the court as required by the CPR)?

In relation to the first issue, Silber J at first instance decided that Mrs Dunhill did not lack mental capacity. The Court of Appeal found that she did, and remitted the case back to the High Court. In his judgment on the remitted case, Bean J found that her lack of capacity meant the settlement agreement was void for lack of approval by the court as required by CPR 21.10. The Defendant appealed to the Supreme Court against these findings. The Supreme Court unanimously dismissed both appeals.

The test of capacity

It was agreed by the parties that the relevant test of capacity to conduct legal proceedings was to be judged by reference to one's mental capacity to make the decisions likely to be required in the course of proceedings – a test established in the judgment of Chadwick LJ in *Masterman-Lister v Brutton & Co (Nos 1 and 2)*. The issue was therefore what was meant by "in the course of proceedings".

The Defendant's lawyers argued that "proceedings" meant the proceedings Mrs Dunhill had actually brought, on the advice of her solicitors. More specifically, the question was whether she had capacity to understand matters well enough to accept the settlement offer made in 2003.

Mrs Dunhill's lawyers argued that "proceedings" related to the proceedings as they might have been brought had her previous lawyers given her different advice.

Dunhill V Burgin Cont.

Melina Padron, Barrister, Doughty Street

According to the medical evidence, Mrs Dunhill would have clearly lacked capacity to conduct proceedings if these related to proceedings as they might have been brought on different legal advice. Both parties accepted this evidence.

Lady Hale assessed the law on the test of capacity as it was at the time of the settlement, and as it currently stands following the coming into force of the Mental Capacity Act 2005 ("MCA 2005") and amendments to the CPR. She found that the test of capacity under the MCA 2005 did not introduce any differences between the old and new tests.

Having considered CPR rule 21, Lady Hale concluded that [15]:

> *Read as a whole, therefore, rule 21 posits a person with a cause of action who must have the capacity to bring and conduct proceedings in respect of that cause of action. The proceedings themselves may take many twists and turns, they may develop and change as the evidence is gathered and the arguments refined. There are, of course, litigants whose capacity fluctuates over time, so that there may be times in any proceedings where they need a litigation friend and other times when they do not…But a party whose capacity does not fluctuate either should or should not require a litigation friend throughout the proceedings. It would make no sense to apply a capacity test to each individual decision required in the course of the proceedings…*

Lady Hale recognised that there were statements in other cases which might suggest a different approach to the test of capacity. In *Masterman-Lister*, it was suggested that, once a litigant identifies a problem and goes to a lawyer, all that is needed is the capacity to understand and make decisions based upon the actual advice given by that lawyer.

However, she found that this approach could not be right. It would create the outcome that litigants in person and those who received no advice at all would be found to lack capacity to make the decisions required by their claims, whilst those who received bad advice would be found to have that capacity on account of that advice.

Lady Hale therefore held that the test of capacity to conduct proceedings for the purpose of CPR Part 21 is the capacity to conduct the claim or cause of action which the claimant in fact has, rather than to conduct the claim as formulated by her lawyers. Under this test, Mrs Dunhill did not have the capacity to conduct her claim and should therefore have had a litigation friend appointed as required by CPR 21.2(1).

Effect of incapacity

Although the Court had the power to validate the settlement retrospectively, it found that it would have been unjust to do so, given the fact that it had not been subject to court approval in 2003.

In light of the finding of Mrs Dunhill's incapacity, Lady Hale considered whether this automatically meant that the settlement and court order were of no effect pursuant to CPR 21.10(1). This rule, known as "the compromise rule", requires that a court approve a settlement made by or on behalf of a patient (now "protected party") for it to be valid.

Dunhill V Burgin Cont.

Melina Padron, Barrister, Doughty Street

The Defendant argued first, that the compromise rule only applied where the patient (or "protected party") had a litigation friend, as it is only then that the other party is put on notice that the settlement requires the approval of the court.

Lady Hale rejected this argument for two reasons:

1. The words of CPR 21.10(1) hint at the reverse, as they refer to a claim made "by or on behalf of" a patient or protected party; and
2. If the "claim" in CPR 21.10(2) predates the commencement of proceedings, there is no reason why the "claim" in CPR 21.10(1) should not also do so. If there are not yet any proceedings, there can be no litigation friend.

The Defendant's second and related argument was that this interpretation of the "compromise rule", capable of invalidating this settlement, would be *ultra vires.* It would involve the CPR's changing a rule of substantive law in *Imperial Loan Co Ltd v Stone,* which it is not permitted to do unless expressly permitted by statute: see *In re Grosvenor Hotel Ltd (No 2)*.

Following *Dietz v Lennig Chemicals Ltd* and the its reading of paragraph 1 Schedule 1 to the CPR 1997, the Court rejected the Defendant's further argument.

The Court decided at paragraph 30 that "*Given that [the compromise rule] applies to claims compromised before proceedings are brought, it is carving out a substantial but quite specific exception to the common law rule in* Imperial Loan*."*

Policy arguments

Insofar as policy arguments are concerned, the Defendant advanced the following reasons militating against having the settlement set aside:

- The need for finality in litigation;
- The stresses and strains which prolonged litigation places upon both litigants and the courts;
- The difficulty of re-opening a case such as this so long after the event; and
- The alternative protection given to the parties by their legal advisers, who should bear the consequences of their own mistakes.

The Claimant on the other hand argued that:

- There were disadvantages to claims for professional negligence when compared with claims for personal injuries;
- Lack of insight is a common feature in head injury cases, so that the parties should be encouraged to investigate capacity at the outset; and

Dunhill V Burgin Cont.

Melina Padron, Barrister, Doughty Street

– The legal position cannot differ according to whether or not a party is, or is not, represented by lawyers.

The Court, however, found that the policy underlying the CPR was clear: that children and protected parties require and deserve protection, not only from themselves but also from their legal advisers.

Conclusion of the Supreme Court

The Court therefore found that Mrs Dunhill's incapacity, along with the lack of a litigation friend and court approval, rendered the settlement invalid. The agreement was set aside and the claim remitted to the High Court for trial.

Lessons for personal injury lawyers

This judgment confirms that the protection afforded by the CPR to children and protected parties is robust. It acknowledges that those who lack capacity are at the mercy not only of the litigation process as a whole and of other parties to litigation, but also of incompetent or unscrupulous legal advisers. In this sense, this judgment is a welcome step in the right direction.

The full impact of this judgment for day-to-day personal injury practice remains to be seen, but some lessons/warnings can already be drawn from this decision:

1. The test of capacity will be a harder one to fulfil: it will likely involve considering all issues and eventualities likely to arise in a given case.
2. Lawyers should be more proactive in seeking assurance in respect of their clients' capacity to conduct proceedings where there are grounds for concern.
3. In less clear-cut circumstances where it may be difficult to suggest capacity is at issue, seeking such assurance may prove tricky. It would be prudent to keep the question of the client's capacity under review through the course of litigation.
4. Defendants' lawyers are likely to be more assertive in seeking assurance of claimants' capacity to conduct proceedings.
5. It is not unusual for early settlement offers to be made before the claimant's capacity is assessed and/or the claim is fully investigated. This may now arguably constitute a risk to defendants, who consequently may refrain from making such offers or make them conditional on the issue of capacity being determined.

Questions remain as to the impact, if any, that this judgment will have on the usual presumption of full mental capacity.

Dunhill V Burgin Cont.

Melina Padron, Barrister, Doughty Street

[1] [2014] UKSC 18.

[2] Joanne Dunhill (a Protected Party by her Litigation Friend Paul Tasker) v Shaun Burgin [2011] EWHC 464 (QB).

[3] Joanne Dunhill (a Protected Party by her Litigation Friend Paul Tasker) v Shaun Burgin [2012] EWCA Civ 397.

[4] Joanne Dunhill (A Protected Party by her Litigation Friend, Paul Tasker) v Shaun Burgin [2012] EWHC 3163 (QB); [2012] 1 WLR 3739.

[5] [2002] EWCA Civ 1889, [2003] 1 WLR 1511.

[6] Kennedy LJ, [18] and Chadwick LJ, [75].

[7] [1892] 1 QB 599, which established that a contract made by a person who lacks capacity remains valid unless this fact was or ought to have been known by the other party to the contract.

[8] [1965] Ch 1210.

[9] [1969] 1 AC 170, which rejected this same argument in the context of a settlement involving a child.

[10] As conferring an express power to make rules of court modifying the substantive law to the extent that the previous rules did so.

[11] Chandler, S., *Case note: the test for litigation capacity following Dunhill v Burgin*, P.C.B. 2014, 3, 157-161.

Expresso Quiz on Secondary Victim Claims

By Charles Bagot, Barrister, Hardwicke

A quick Q&A and True or False Quiz to test you over a quick cup of coffee. One point for each correct answer (bonus point available on Q1) to a maximum of 11 points. Answers at the back:

Q1. What is the difference between primary and secondary victims? Give yourself a bonus point if you can name the case or Judge who highlighted the distinction.

Q2. True or false: Special legal principles apply to determining secondary victim claims arising out of clinical negligence as opposed to those arising out of other accidents.

Q3. True or False: The 'control mechanisms' are used for deciding whether someone is a primary or a secondary victim.

Q4. Name two of the control mechanisms.

Q5. In what year did the event take place which gave rise to the seminal House of Lords cases on secondary victims?

Q6. True or false tongue twister: You can have a successful primary victim claim without a successful secondary victim claim but not a successful secondary victim claim without a successful primary victim claim.

Q7. Is there a set period of time within which a loved one has to arrive to come within the 'immediate aftermath' of an incident?

Q8. Does the Court focus on a single moment in time when looking for the relevant shocking event which caused the secondary victim's psychiatric injury?

Q9. True or false: It is sufficient for a person to witness the traumatic death of a loved one, provided it is caused by the original negligence, to have a potential claim as a secondary victim, even if they did not witness the negligent event/accident or its immediate aftermath.

Q10. True or false: There have been lots of calls to relax the strict control mechanisms and it is only a matter of time before the Supreme Court does so.

Brown v HM Coroner for the County of Norfolk: recent guidance on pre-inquest reviews

Frances McClenaghan, Barrister

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Introduction

Across the country, coroners have different styles of management. Practitioners will know some who formerly required advocates to robe, those who allow the family considerable latitude with witnesses and others who tightly control the issues and evidence they wish to hear. Provided the inquisitorial process is fair and the verdict reached is reasonable, such differences should not be unduly troubling, however

In *Ernest Andrew Brown v HM Coroner for the County of Norfolk v Chief Constable of Norfolk Constabulary* ([2014] EWHC 187 (Admin), "Brown"), regrettably the process was not demonstrably fair. The High Court therefore quashed the inquest and ordered a fresh investigation. In doing so, the Chief Coroner gave guidance as to good practice at pre-inquest review hearings.

Background facts

The case concerned the inquest into the death of Joanne Foreman. The Coroner reached a narrative verdict, which left the cause of death open. He recorded that there existed a real possibility that Joanne, who was not a diabetic, had self-injected insulin and consumed alcohol in combination which may have caused her death. Subsequent enquiries effectively eliminated the possibility that the taking of insulin could have made any significant contribution to death, however. This error arose because at the pre-inquest review the parties operated on the mistaken assumption that although the precise cause of death could not be ascertained, the self-ingestion of insulin and alcohol may well have been the cause.

Guidance on pre-inquest reviews

The Chief Coroner made the following recommendations:

1. Rule 26 of the Coroners (Inquests) Rules 2013 requires a coroner to make and keep a recording of a pre-inquest review hearing. This requirement means that a coroner should take reasonable steps to ensure that the recording equipment is working well and that those who speak in court do so in such a way that the recording can be transcribed with accuracy and in full ([38]).

2. The coroner should ensure that all interested persons have sufficient notice of the matters to be discussed at the pre-inquest review hearing ([39]).

3. Coroners should provide a written agenda in advance and, if appropriate, express provisional views so that agreement or opposition can be expressed ([39]).

Brown v HM Coroner ...Cont.

Frances McClenaghan, Barrister, 1 Chancery Lane

4. The agenda should include:

   a. a list of interested persons;

   b. a proposed list of witnesses identifying those who may be called and those whose statements may be read;

   c. the issues to be considered at the inquest;

   d. the scope of the evidence;

   e. whether a jury will be required;

   f. whether Article 2 of the European Convention on Human Rights is engaged;

   g. any issues of disclosure; and

   h. the date of the final hearing ([40]).

5. In a difficult investigation interested persons should be invited to respond to the coroner's agenda in advance of the pre-inquest review hearing in writing, stating what they agree with and what they do not agree with ([40]).

6. The coroner should also ensure that interested persons have sufficient disclosure of relevant statements and documents before the pre-inquest review hearing so as to be able to address the agenda on an informed basis ([41]).

7. Coroners should avoid giving the impression at a pre-inquest review hearing that the findings and conclusions of the inquest are in any way pre-determined, even when the evidence points substantially in one direction. It may be necessary to explain in clear language to unrepresented families that there is a difference between seeking to identify the key issues and coming to a final conclusion ([42]).

8. Coroners should at all times take care in their dealings with interested persons not to give the impression of bias or favouritism ([43]).

9. A coroner should be careful in correspondence with an interested person, such as the police, not to appear to be too familiar or close to the correspondent and not encourage the same from the correspondent. The use of first names may not look good to an outsider ([44]).

Conclusion

It is to be hoped that, if the Chief Coroner's guidance is followed, although the parties may not always be satisfied with the outcome, they will at least consider that a fair investigation has been conducted.

Pro Bono Inquest Service Case Studies

Julia Cotterill, Medico-Legal Advisor, Avma

Inquest touching the death of MDL

MDL was a 74 year old man with a history of hypertension, solar keratosis, macular degeneration and possible pulmonary fibrosis. He underwent a total hip replacement on 7 December 2011. He was given Enoxaparin (Heparin) at the time of surgery and was discharged on 9 December 2011 on 10mg daily of Rivaroxaban. On 3 October 2011 a blood test had shown that MDL's platelet count was 156 x 10^9/L (normal range 150-400 x 10^9/L) and on 8 December 2011 it was 128 x 10^9/L. A few days after discharge, MDL developed a rash below his knees, followed by blood blisters in his mouth and a blood blister on his right hand.

On 25 December 2011 MDL called the out of hours GP service complaining of tiredness, bleeding from his gums, nose and rectum, a rash on his legs and blood blisters in his mouth. The out of hours GP who attended MDL was unaware that he had complained of rectal bleeding on his initial contact. She diagnosed an allergic reaction to Rivaroxaban and changed the medication from oral Rivaroxaban to injections of Clexane, which were to be administered daily by the district nurse. However, she prescribed the therapeutic dose of 75mg rather than the prophylactic dose of 40mg in error.

The district nurses attended from the following day, and on the first day administered 80mg rather than 75mg in error. On 27 December 2011 the nurse was concerned about the dose prescribed by the out of hours service and raised this with MDL's GP. MDL contacted his regular GP on 28 December 2011 to request a further supply of injections, when his GP reduced the dose further to 60mg on the basis of the previous reaction. On 30 December 2011 MDL collapsed and was admitted to hospital in the early hours of 31 December 2011. A CT scan revealed a subdural bleed, cerebral oedema and brain stem herniation and MDL died the same day. At the time of his death, his platelet count was 1 x 10^9/L. The post mortem report concludes that the cause of death was:

1a. Subdural haematoma;

1b. Acute thrombocytopaenia

The family were represented through our Pro Bono Inquest Service by Maria Roche of Doughty Street Chambers. An expert haematologist gave evidence at the Hearing to the effect that there were two potential pathologies operating concurrently: a low platelet count and an allergic reaction to Rivaroxaban. In any event, he considered that if the low platelet count had been detected before the severe bleed during the night of 30-31 December 2011 and a platelet infusion administered, the death would have been avoided. He did not consider that the incorrect dose of Clexane materially contributed to the outcome.

The Coroner made two Reports to Prevent Future Deaths. The first was to the effect that the out of hours GP may not have familiarised herself with the information provided by MDL to the out of hours service before carrying out her visit. The second was in connection with communication between the out of hours GP service and the district nursing service, in that the out of hours doctor had been unable

Pro Bono Inquest Service Case Studies ...Cont.

Julia Cotterill, Medico-Legal Advisor, Avma

to contact the district nurses on 25 December 2011 and the only means of making contact was to telephone. The Coroner considered that improved methods of both oral and written communication must be put in place.

In response to the Coroner's reports, the out of hours service reported that it had reminded its clinicians of the importance of assessing all available notes, although it also considered that it could do no more than make the information available and that it was for the individual clinician to read the notes. With regard to communication between the out of hours service and the district nurses, the Trust advised that a team mobile, a landline and a generic email address were available and that these details had been provided to the out of hours service.

RE: XY Dec'd - Case Study

Our inquest service is looking into the case of a 24 year old gentlemen (here referred to as 'XY'), who sadly passed away while in recovery following surgery to his knee. The Coroner has decided not to hold an inquest into the XY's death, a decision which AvMA hopes to invite him to reconsider.

Although we do not currently have the full medical records for XY, his family have kindly provided such information and documentation as is available. Prior to his surgery, XY had a history of neurological episodes, following two minor injuries to his head, which led to a weakness in his right arm, loss of vision and slurred speech. However, an MRI scan of XY in 2000 was observed to be normal. XY later had a seizure at school in 2003, which resulted in slurred speech and a headache. Given that there were only two neurological episodes falling three years apart, prophylaxis was not considered to be of benefit or necessary.

The hospital states that the general anaesthetic was properly administered and recovered from before XY's death, alongside the completion of a relatively straightforward surgery to his left knee. The post mortem report concludes that the cause of his death was an ischemic stroke due to a basilar type (complicated) migraine. Yet the family of the deceased are adamant that on the day of his death, their son did not have a migraine or any form of neurological episode.

Following his surgery, XY presented symptoms which were observed to include spasms in his foot and an inability to move his leg that had been operated on, with further abnormal swelling of the leg to approximately three inches larger than the other leg. Compartment syndrome was excluded. Matters are further complicated by the fact that on the day of his death, XY's family were told by medical staff that XY died due to his heart stopping.

This is a very exceptional and tragic case, given that few young, healthy patients die in recovery following knee surgery. AvMA considers this to be case with unexplained aspects that merits full investigation by experts and ultimately the Coroner. To date the coroner has refused to hold an inquest on the basis that the deceased died of natural causes. However we have recently obtained a pro bono expert view which confirms that a specialist orthopaedic surgeon shares our concerns that the circumstances of the death are unclear. We intend to communicate with the coroner on the family's behalf with a view to securing an inquest into this young man's death.

Patient Safety—A junior doctor's perspective

Charlotte Connor, Medico Legal Advisor, (AvMA)

I began working at AvMA as a medico-legal advisor in July 2013 following relocating to London from Perth, Western Australia. I qualified as a Doctor in Australia in 2011 and subsequently worked as a junior doctor in a number of teaching hospitals in Perth. My role at AvMA has definitely enabled me to gain a new perspective on the issue of patient safety. I have been able to reflect upon my own experience in clinical practice and identify important areas that myself and other junior doctors could improve upon in order to provide safer and more effective patient care.

During medical school and working as a doctor I was always told about the importance of documentation, writing clear and accurate notes in patients' medical records and the need for good communication. My work at AvMA has highlighted the need for these skills to be employed, especially as I have witnessed first hand many instances when a patient's care has been compromised as a result of doctors not documenting a clear care plan or handing over that care plan to other clinicians.

As a junior doctor I was rostered to work one after hours shift per week, this involved covering patient care on approximately 6 wards from 5.00pm-10.00 pm. This shift took place after I had already completed a full day's work, I invariably had no previous contact or knowledge of the majority of the patients I was responsible for on the after hours shift.

On my first ever after hours shift as a doctor I was paged to attend to a patient who had not passed urine for approximately 4 hours. Given this patient's presenting symptoms and circumstances this was a worrying feature and one that can have a number of life-threatening causes. Before attending to the patient I obtained the medical notes in order to ascertain the patient's history and in particular their presenting complaint to hospital and the treatment plan that the treating team had in place. I could see from the medical records that the treating team had been aware of the patient's diminishing urine output as a junior member of their team had been asked to review the patient earlier in the day. However there was no treatment plan documented in the notes or that had been handed over to the nursing staff looking after the patient.

Following a thorough history and examination of the patient, I then checked for any imaging results. The results showed that a scan had confirmed a large obstruction essentially completely blocking the patient's kidney (the patient only had one kidney due to a previous nephrectomy). I immediately referred the patient to the on call Urology team who urgently reviewed her and arranged for her to be taken to theatre that same evening.

In this case the junior doctors on the patient's treating medical team had failed to document in the notes that they suspected renal obstruction nor that they had organised a scan. They also failed to hand over this information to the nursing staff or document that the scan was urgent and needed to be followed up by the after hours doctor. Therefore there was a delay of approximately 2 hours between confirmation of the obstruction and referral on to the Urology team. Delays of 2 hours can potentially be life threatening and compromise patient safety. This example certainly highlighted to me the importance of thor-

Patient Safety—A junior doctor's perspective ...Cont.

Charlotte Connor, Medico Legal Advisor, (AvMA)

ough documentation and communication between treating clinicians.

One of my roles at AvMA is to work as part of the pro-bono Inquest Service. There are a number of Inquest cases that I have worked on where the deceased's care was compromised in some way due to poor documentation or lack of documentation. One example is the case of an elderly gentleman who was admitted to hospital following a fall at home. He suffered from a subdural haemorrhage and required an evacuation of the bleed. Whilst in hospital (a week or so after his initial admission) it was noted that the patient had been taking Naproxen (a non-steroidal inflammatory drug) due to arthritic pain on mobilisation in his hip for a number of years. A junior doctor therefore prescribed Naproxen to the patient. The junior doctor did not document in the notes whether he assessed the patient and his suitability to be prescribed Naproxen. There was no evidence to suggest that he had taken into account that the patient was not experiencing pain as he was not mobilising, that the patient was eating and drinking minimal amounts and the fact that the patient had also been taking Omeprazole for a number of years (a proton-pump inhibitor or PPI often co-prescribed with Naproxen to try to prevent stomach/duodenal ulcers). When the Naproxen was prescribed there was also no note in the prescription to give Naproxen with food. There was also no evidence in the medical notes as to whether other clinicians acknowledged or reviewed the administration of Naproxen.

It is widely known that Naproxen given without a PPI and given with minimal food is a major cause of gastro-intestinal bleed. Sadly this patient went on to develop such a bleed and passed away.

Another example is the case of another elderly gentleman who presented to A&E with hip pain. Following examination by a Registrar the patient was sent for a plain x-ray to assess for a neck of femur fracture. The x-ray showed no obvious fracture. The patient was therefore sent home, however in the medical notes there was no documentation as to whether the patient's mobility was assessed. According to the patient's family he required a wheelchair in order to leave the A&E department. It is known that not all hip fractures show up on plain x-ray and given that the patient was not mobilising at all due to pain that further imaging could have been performed to rule out fracture.

The patient continued to suffer from hip pain and his general condition gradually deteriorated over a number of weeks. He was finally diagnosed as having a hip fracture some time later but by this point he was too unwell to undergo surgery and sadly passed away.

Working at AvMA I have also realised the importance of documentation not only to improve patient safety but also from a medico-legal point of view. Medical records are always requested when a potential clinical negligence claim is being investigated and doctors' notes are closely analysed. As a junior doctor the importance of accurate and thorough medical records was highlighted to me from a legal point of view when I was asked by the Hospital's legal department to prepare a report for a patient who was making a personal injury claim following a motor vehicle accident. I had reviewed the patient in A & E so that hospital had provided me with the notes that I had written after reviewing the patient. My notes were very clear and showed important negative findings such as no numbness/parasthesia in the arms/hands as the patient was complaining of pain in her neck secondary to a 'whiplash' injury. I was

Patient Safety—A junior doctor's perspective ...Cont.

Charlotte Connor, Medico Legal Advisor, (AvMA)

then able to complete the report confidently and accurately due to my detailed notes.

Working at AvMA has definitely given me further insight into ways that I can develop my own clinical practice to improve patient safety, one of the most straightforward ways this can be done is to ensure that I make thorough and accurate medical notes and to communicate properly with my patients.

Birth Injury, Disabling Families & Enabling Human Factory

Dr Dawn Benson, Lecturer, Researcher at Northumbria University & Speaker

Clinical negligence has a place, either at a major or minor level, across many disciplines although most of the literature which supports the reasons why people pursue a claim, is located in either medicine or law.

Accounts of the injured parties, or their primary carers, have only been documented through speculative perspectives and occasional case studies. There are a few researchers who have looked at the relationship between the complaints process and injured parties but little or nothing on litigation from the claimant's perspective. As the parent of a child who was avoidably injured around the time of birth, I was shocked by the lack of information available and so decided to explore this further and use it as the focus of my PhD research.

The purpose of the study was to raise the previously seldom heard voices of parents who, like me, had pursued clinical negligence litigation on behalf of their children who had been avoidably harmed through medical error. I was specifically interested in:

- why parents of children avoidably injured at or around the time of birth pursue claims of clinical negligence on behalf of their child or children and what they hope to achieve,

- what parents think of the process of completing a claim and their relationship with professionals before, during and after the birth injury event.

The research was qualitative and combined the data and analysis of my own autoethnographic account and the interview data from eight parents of six children who were avoidably damaged through medical error. The project was initially located within the sociological field of Disability Studies in recognising the social origins of inequality which frequently shape the lives of families which include a disabled person.

In addition to the data content it became clear that there were some striking commonalities between the participant families:

- all but one of the injured children were the mother's first born,

- all of the critical incidents which took place in a maternity setting did so across the weekend

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period,,

- three of the families made contact with their solicitor through AvMA,
- all but one of the parents used English as their first language,
- two of the fathers left their jobs and became full time carers for their disabled child,
- five of seven families moved to adapted accommodation following the completion of litigation,
- other than myself, who had no formal education at the time of initiating the claim, all of the families had at least one parent who had a minimum of a university degree or professional equivalent,
- the children had collectively attended a mix of mainstream, segregated/'special' schools and mixed placements and shared a sense that their education was fluid and could change at any point depending upon resources.

Findings show that parents whose children have been avoidably injured at or around the time of birth want to focus on the detail of the medical error or errors. They want to examine the sequence and escalation of events which culminated in damage to their child. They wanted to be able to make sense of their own experience; not necessarily with an individual blaming intention, but to get honest explanations.

Why Parents Pursued Litigation

The parents offered a variety of reasons for bringing litigation and those reasons did not necessarily remain the same throughout the process of the claim. In fact motivations for pursuing litigation typically changed as parents gained experience of bringing up their birth-injured child. Usually they had experience of the same motivations as each other only at different points in their individual litigation journeys. The data also suggests that partners may differ in their motivations for pursuing litigation and have distinctive hopes and expectations of what the process could achieve.

Parents specifically identified seeking explanations, resolution and outcomes which would protect others as initial reasons for pursuing the claim. However as time moved on it became apparent that a deep fear of dependency upon the state increasingly strengthened their motivation, in all cases this is what the families focused on towards the end of the litigation process, usually at this point they had given up hope of achieving any of their other aims. Parents wanted:

- answers about what had happened, to find out the truth
- lessons to be learned to protect others in the future
- to achieve some form of resolution
- to be financially independent of the state for support services.

Whilst many, but not all, parents expressed feeling some form of initial anger towards maternity professionals they eventually developed their own complex narratives around the birth injury event and in doing so made sense of the events in ways which dissolved any desire for individual blame. Rather they recognised that systems, technical skills and above all cultures were responsible for the errors which contributed to the circumstances of their child's injury.

After completing litigation parents were left with a sense that they had not resolved their anxieties; that litigation in itself does not provide all the answers they seek, although it does go some way to securing

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their child's future in making them financially independent of the state; neither does it promote professional learning.

> We insured her future with the claim, we ensured she's got money to provide for whatever she needs for the rest of her life but I don't think we made any progress in getting any answers or changing anything for anyone else, which I had hoped.
>
> Susan – interview data

Messages to Legal Professionals

The data reveals that, for parents of children avoidably injured at birth life is shaped by a discourse of disabling reductive constraints as their lives become dominated by the involvement of, and surveillance by, others. Families who have contributed to the research depict professional intervention as often diminishing, rather than enabling; of the chance to build family life in ways of their own choosing and makes clear there can be no doubt that having a child disabled through avoidable birth injury completely alters a family's life trajectory.

Parents identified aspects of the litigation process which were particularly difficult for them and they offered messages to legal teams, expert witnesses and deputies which expose inconsistencies and opportunities to improve practice.

- **The process of litigation was like living in a goldfish bowl** – parents are concerned that their home and their lifestyles become a project for expert witnesses as well as statutory sector service professionals and they lose their privacy.

> The other side's technical expert came in and said "Oh, you know, I think that you are overly bonded with your daughter and you need to set some boundaries and some distance." I really felt like I wanted to stick two fingers up at them and tell them where to go. But, you know, I didn't. I sat there and smiled politely and said yeah, this is because just so that you know why I'm overly bonded with her, is because one of us sleeps with her. She has epilepsy. We know she has constant seizures when she's asleep from her last EEG, and I know too many children that have died, I don't care if you think I'm overly bonded with her…
>
> Clare – interview data

- **Expert witnesses: do your homework** - read the notes before the visit. Parents have been traumatised and reliving the birth event with expert witnesses sets them back in their recovery.

> I had to tell it so many times that I just sort of - it also means you have less closure on it 'cos you're constantly having to tell the story over again. Do they really need to know this, three speech therapists do they really need to know about his birth? It's the endless going over.
>
> Victoria – interview data

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- **Minimise the number of appointments** – generally parents want single experts.

> The amount of time spent doing assessments, well it didn't warrant it. We both needed to take a couple of days off work each that's four days pay lost and then we needed to take her little brother and stay in a hotel.
>
> Janet – interview data

- **Show Empathy** – a positive outcome in terms of litigation is not necessarily what parents want. They are often torn between recognising that their child will need the financial award and being disappointed with the knowledge that the event was avoidable.

> They came into this very room. *"Oh, hello, lovely to see you. Congratulations."* And I just felt it was so inappropriate, because, really? What – congratulations they've admitted that somebody was wrong and ruined my life.
>
> Clare – interview data

- **Parents also experience harm** – although the child has been physically injured parents are psychologically harmed through the birth injury event which impacts upon their ability to trust professionals to care for their child.

> …it all made me think about not ever trusting anyone to look after him, I think I am like my friend….who, her daughter was starved of oxygen and they used the same solicitors as us. She is very overprotective and can't let other people do the looking after. I think I am like her and it's strange that other parents for special needs kids aren't the same; maybe it's just us after we have been through this thing. We can't trust anymore… I am in a permanent state of anxiety.
>
> Alysha – interview data

- **Be realistic** - parents want litigation professionals to recognise that the award does not truly put them back in the position they would have been in but for the injury. It does improve life but quantum should take account of the child in the context of the whole family in all respects. Parents want honest discourse around quantum and either awards which enable inclusive lifestyles or acknowledgment that the award is not going to enable them the ordinary freedom which non-disabled families have.

> I got really annoyed throughout the claim at the game aspect of it…the solicitors they almost, in a funny kind of way enjoyed this element of the game, even our solicitors. To them it was them kind of doing their jobs and at times I got really upset and they say well that's just the way they play it. I said, I'm not playing a game, this isn't a game to me.
>
> To them, it really was. They'd be like, but that's just to be expected. It's like, well it might be to you because you do it day in, day out, this is your job. I've never done this before so I wasn't expecting this, we were told that we need to over egg our claim we were told 'you always ask for more than you want because you're not going to get it, and if you ask for what you want you're not going to get it so you ask for more than you think you're ever going to get because they're always

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> going to knock you down...can't we just sit around like sensible human beings and talk about what we really need? Yes be honest, not over egg this end and over egg that end, then meet in the middle. Let's cut all that out.
>
> Susan– interview data

The Deputy

It became apparent that parents were having different experiences of their relationships with the deputy and that parents are not aware of the different types of deputy. They are not really given enough information about the role of the deputy or indeed the options. Perhaps more concerning is the way parents all go through the same ordinary difficulties over for example holidays, housing and education. All things which deputies/private client departments have extensive experience of; there would appear to be many missed opportunities by deputies and indeed the Court of Protection for information sharing.

Messages for Health, Social Care and Education Professionals

After experiencing an avoidable, life threatening birth injury event parents have little choice but to learn quickly to become reliable parents and carers for their children, which they do by enacting the characteristics of what Weick and Sutcliffe (2007) call a 'mindful infrastructure'.

High Reliability Organisations (**HROs**) are organisations which have less than their share of errors. They understand that the factors which make people human can increase the vulnerability of their operations, they focus upon possibilities for failure and thereby mitigate against it.

Parents, like 'High Reliability Organisations' are concerned to make sense of their experience and do this by tracking small failures/errors, resisting oversimplification, remaining sensitive to operations, maintaining capabilities for resilience and taking advantage of shifting locations of expertise. Such characteristics exemplify 'mindfulness' and the capability to discover predict and manage unexpected events.

Narratives of parents involved in the research suggest that systems and cultures in health care settings and hospitals, where their children encountered birth injury, were not characterised by features expected of High Reliability Organisations. Moreover, health, education and social care services which parents went on to encounter also did not have in place systems to cultivate or sustain themselves as Highly Reliable.

The research suggests the response of parents to avoidable birth injury offers professionals a powerful resource for working towards High Reliability practices. It concludes that, it is over simplistic to see the pursuit of litigation as an instrumental manifestation of anger, distress or denial following avoidable damage to a child. Rather, the experience of parents who pursue litigation adds considerable understanding to the complexity of disabling consequences of birth injury and how these can be minimised.

The families who took part in this study look back at avoidable birth injury as a tragic event knowing that if the organisations had put the right people in the right place at the right time they and their children would not have been harmed; they want High Reliability principles to surround childbirth.

The NHS Complaints Procedure—Getting It Right

Lisa O'Dwyer, Director Medico-Legal Services

It does initially appear surprising that such a straightforward and apparently simple concept as an accessible, user friendly complaints procedure continues to confound NHS Hospital Trusts. It is of course true that some NHS Trusts are better than others at handling complaints. Very often it is the better performing trusts who have the most effective complaints system, but even these trusts have room for improvement. At the heart of this lies the inevitable question: why do Trusts find complaint handling so difficult?

The NHS constitution is clear. The NHS is accountable to the public and the patients it serves. The constitution unequivocally states that any complaint made about NHS service is to be properly investigated and that there is a right to compensation when patients have been harmed by negligent treatment. It pledges that when harm has been caused whilst receiving health care, appropriate explanations are provided and lessons will be learned to help avoid a similar incident occuring again. All NHS bodes are required to take account of the NHS constitution. A copy of the NHS Constitution can be found at the following link:- https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/170656/NHS_Constitution.pdf

The Local Authority Social Services and NHS Complaints (England) Regulations 2009 set out a framework for how trusts are to comply with their obligations to provide a complaints procedure. The framework applies to all trusts and includes details on the mandatory need to provide a person responsible for ensuring compliance with the regulations as well as the need for a complaints manager to manage the procedure for handling and considering complaints in accordance with the regulations. The regulations can be found at the following link:- http://www.legislation.gov.uk/uksi/2009/309/pdfs/uksics_20090309_en.pdf

On the face of it, the regulations appear comprehensive:-

Regulation 5: Identifies who is entitled to complain. The complainant is not restricted to a person who is receiving or who has received services from the NHS but applies to anyone who is affected or likely to be affected by the act, omission or decision of the NHS which is the subject of the complaint. It also extends to anyone appointed by the person receiving or who has received care to complain for them.

Regulation 7: Makes clear that the provisions apply to primary care as well as hospital trusts;

Regulation 13: Complaints can be made orally and/or in writing (including electronic written communications)

Regulation 14: The investigation must be carried out in a manner appropriate to resolve the complaint speedily and efficiently. The complainant must be kept informed about the progress of the investigation and a written response must be sent setting out the conclusions reached including any remedial action to be taken.

In March this year the Department of Health (DoH) published a clarification note in their Clinical Com-

The NHS Complaints Procedure—Getting It Right ..../Cont.

Lisa O'Dwyer, Director Medico-Legal Services

missioning Group bulletin confirming that: "where a complainant is taking, or plans to take legal proceedings, a complaint may only be put on hold where there are exceptional reasons to justify it"

Experienced clinical negligence lawyers are not shy to recognise the importance of a good, effective complaints procedure, more importantly the correlation that exists between a poorly handled complaint and litigation.

It is no accident that the Pre Action Protocol (PAP) for the Resolution of Clinical Disputes comments that ***"sometimes patients may pursue a complaint or claim which has little merit, due to a lack of sufficient information or understanding"*** (PAP 1.3). It goes on to say that ***"If mistrust is to be removed, and a more co-operative culture is to develop – healthcare professionals and providers need to adopt a constructive approach to complaints and claims. They should accept that concerned patients are entitled to an explanation and an apology, if warranted, and to appropriate redress in the event of negligence. An overly defensive approach is not in the long-term interest of their main goal: patient care"*** (PAP 1.5 – *My underlining*).

It might be thought that this information on its own would be enough to ensure that all NHS trust hospitals employed, at the very least, an adequate and effective complaints procedure, but clearly this is not the case. One need look no further than Robert Francis QC's report into Mid Staffordshire NHS Foundation Trust (February 2013) as well as the report by the Right Honourable Ann Clwyd MP and Professor Tricia Hart entitled "A Review of the NHS Hospitals' Complaint System Putting Patient's Back in the Picture" dated October 2013 to see that complaint handling continues to be a perennial problem..

Robert Francis QC said in his report that:

"A health service that does not listen to its complaints is unlikely to reflect its patient's needs. One that does will be more likely to detect the early warning signs that something requires correction, to address such issues and to protect other from harmful treatment.

A complaints system that does not respond flexibly, promptly and effectively to the justifiable concerns of complainants not only allows unacceptable practice to persist, it aggravates the grievance and suffering of the patient and those associated with the complaint, and undermines the public trust in the service"

More recently The Clwyd/Hart Report examined why people complain. Some of the common findings were:

a. **A lack of information** and accessibility in raising concerns or making complaints either for themselves or on behalf of friends and relatives; fear of reprisals, particularly that continued care will get worse;

The NHS Complaints Procedure—Getting It Right ..../Cont.

Lisa O'Dwyer, Director Medico-Legal Services

b. **A lack of compassion:** lack of sensitivity to their feelings once a complaint had been made

c, **A lack of dignity and care:** this was often compounded by staff attitudes

d. **Failure to assess the complaint:** That insufficient attempts had been made to understand their complaint or to assess how serious it was;

e. **The need for a prompt and clear process**; a seamless service;

f. **The need for support** to those who need and want it;

g. **That lessons had been learned** and that the complaint had made a difference.

The Clwyd/Hart report also made it clear that there was a need to improve the quality of care and in particular, patients should be helped to understand their care and treatment: discuss diagnosis, treatment and care with patients; revisit topics and include family and friends in discussions where appropriate.

Critically it noted that there should be improvements in the way complaints are handled: a need to develop appropriate professional behaviour in the handling of complaints, engaging in genuine openness, honesty and a willingness to listen.

AvMA recently responded to the Health Select Committee inquiry on complaints and raising concerns. Liz Thomas (Policy Manager) and I were subsequently called to give oral evidence to the Select Committee on this matter. We were able to refer to the fact that, despite the regulations, pre action protocol and recent detailed, not to mention expensive reports which had been prepared, we continued to receive as many enquiries (whether by way of the AvMA helpline or case work) as in previous years.

In consideration of our initial response to the Select Committee we reviewed six cases which had been referred to our Advice & Information and/or Inquest Service Department. In all six cases, the complaints originated no earlier than June 2013.

In only one of those cases was the complainant aware that complaints can be referred to the relevant NHS Commissioning Group (CCG) as part of the local resolution stage. The same complainant was also the only person to be aware that they could involve NHS England as part of the local resolution process (part of his complaint referred to services provided by his GP).

The review, coupled with details of information sought by the public from our Helpline, leaves us with

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the sense that difficulties with complaints are as prevalent now as they were two or three years ago. Largely the public remain unaware of the potential to involve either a CCG or NHS England. We would also suggest that trusts and primary care providers are unaware of the potential for them to be involved or are deliberately not involving these groups.

At the time AvMA's response was written at the beginning of March 14, none of the people seeking help from us on the complaints process were aware of or had received assistance from their Local Healthwatch. That may have improved slightly since then, but it remains the case that a number of Local Healthwatch groups do not appear to be offering advice on complaints at all.

Healthwatch is meant to be the new consumer champion, but the lack of awareness of the support they might provide suggests that the service is limited. We are conscious that the support which Healthwatch can provide varies widely according to which region they are in. The general lack of awareness of Healthwatch's existence does suggest that the service is not being properly advertised. This may be a funding issue.

As a body, Healthwatch does have the potential to develop into the patient's champion but to successfully achieve this it does need have the funding provided to local authorities for this purpose to be ring-fenced. There also needs to be consistency of approach and the same profile as say the Citizens Advice Bureau (CAB).

Consequently AvMA were not in a position to comment on whether Healthwatch organisations are requesting information from healthcare providers. Neither are we aware of how long it is taking healthcare providers to provide disclosure and whether this is being made within the 30 days stipulated.

Generally our clients do appear to have a greater awareness of the Patient Advocacy Liaison Services (PALS) and the feedback we have received is that the service offered by PALS varies widely. Some clients are happier with the service they receive than others. However there are some clients who have clear views that PALS is affiliated with the hospital trust

The public appear to have less awareness of the independent advocacy providers. This may be because they are not as visible as PALS. This is a missed opportunity, one factor which would improve complaints handling is the provision of effective and good support for complainants. A well formulated complaint can empower a complainant to ask the right questions and for many this will only happen with support. As it is, the independent advocacy providers are not well signposted and are often remote.

The six cases reviewed by us all had the following in common:

- **A lack of information**: There was a lack of information given during the critical period when care was being received. One of the comments made in complaints correspond-

The NHS Complaints Procedure—Getting It Right ..../Cont.

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ence was:

"Our family's concerns were belittled and dismissed by health professionals we put our trust in."

- **A lack of sensitivity:** In one case, a client's husband had fallen out of his hospital bed; she received a telephone call from the hospital advising:

"the old boy had taken it upon himself to fall out of bed"

- **The quality of the responses**: This varied considerably. In about 50% of the cases we reviewed, the trust had simply failed to address the complaints, concerns and issues set out in the letters of complaint. The clients felt that the response to their complaint had been inadequate and that the trust had failed to address some of the main issues.

We identified that, in some of the six cases, lengthy responses had been provided but despite this, the critical issues raised had not been addressed. In other cases the response was contradictory in many respects and failed to grasp the need for trusts to be open and honest and to be seen to be open and honest in respect of issues where there were failings.

For example, one of the cases we reviewed involved the death of a young adult with cerebral palsy. The deceased had been taken to hospital on a number of occasions prior to her death but was turned away by the hospital. The family of the deceased clearly set out their concerns which included poor communication between staff and the family and a lack of explanation about what was happening. The trust responded to the complaint by commissioning a 26 page report. The author of the report was a senior doctor not involved in the deceased's care, although still employed by the relevant trust.

The report did attempt to go through the family's concerns in a methodical way but there was no real attempt to explain the cause of the deceased's symptoms which had given rise to the original referral to hospital.

Between pages 12 - 26 of the report, we counted 26 separate written apologies. There was a strong sense that the word "sorry" was being used in a perfunctory and meaningless way. The impression was that there was a duty to apologise, rather than a genuine desire to recognise the injury which had been caused to the family.

Typically the apologies were expressed in a defensive way. The following are examples of the way the apology was expressed:

h. ***"we apologise to X and the family that they felt that this is not the case"***

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i. ***"we are sorry that the family have formed this view"***

j. ***"we are sorry that this appeared to be the case"***

k. ***"we are sorry that Ms S has formed the view that…".***

Apologies of this nature achieve little or nothing. Where failings were admitted, the admissions were often tucked away in the response letter, behind turgid language and difficult written expression.

It was only when you got to page 25 out of a 26 page report that there was recognition for the legitimacy of the concerns raised. This was expressed as ***"Ms S has raised some valid concerns"***. However the report failed to make clear what they considered the valid concerns to be, instead it went straight into the incident investigation review conclusions.

One of the family's key concerns had been the fact that it took the trust seven days to refer the death to the Coroner. Although the trust noted as part of their key learning / action points that timeliness of referral to the Coroner will be tracked corporately from April 1st, it did not begin to offer any explanation for the reasons for the delay in this case.

In another case the client wrote back to the trust after receipt of the response letter to say: ***"I am not complaining about J's death, but the way we were both treated".*** They went on to say: ***"…they have not answered any of my questions except to list his medical history"***

In yet another case the client wrote back to the trust saying: ***"I regret to inform you that I find it*** **[the response letter]** ***to be inadequate in the following respects…"*** The letter went on to identify 9 areas where the response was inadequate.

In one of the cases we assessed, the client made clear reference to simple, inexpensive and straight forward changes to the system which might considerably improve outcomes for women. The failure to give due acknowledgement to the suggestions led the client to conclude that there was a:***"culture of arrogance within your hospital"***. And perhaps most significantly and accurately she concluded: ***"I would like to remind you of the human cost of not challenging these dysfunctional systems and attitudes".*** As a result of the disappointment with the trust's letter of response the client unsurprisingly concluded: ***"I am currently seeking independent legal and medical advice…"***

Some Conclusions

Returning to the question of ***why*** trusts find it so difficult to operate an effective complaints department we would suggest that a large part of the problem is due to the culture which pervades NHS trust hos-

The NHS Complaints Procedure—Getting It Right ..../Cont.

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pitals. Based on the cases we have reviewed, the system appears to have altered little over the last twelve months. This is despite reports acknowledging the importance of the complaints process.

The need to properly respect the complaints process

Until NHS Trusts and indeed all hospitals wake up to the realisation that complaints can provide a good insight into how to improve patient care and properly invest in their complaints handling staff, then we think it unlikely that there will be any dramatic changes to the way in which complaints are handled. Professor Pattison, (New Zealand Ombudsman) is quoted in the Clwyd/Hart Report as saying: hospital boards need to ***"see complaints as treasure"***, we agree with this.

Any changes need to include an acknowledgement that the complaints department needs to be respected for what it can bring to the hospital service; it needs to be afforded a certain status and its importance recognised. It is also critically important that complaints staff are highly skilled and trained, that they are confident and empowered individuals who are able to seek and obtain proper answers from any doctors and medics complained about.

Training

Complaints managers are far too often junior and not sufficiently trained. Remedying this will inevitably require financial investment in the form of both good quality and appropriate training and keeping good staff, however it is likely to pay dividends in the long run.

Properly trained complaints staff are more likely to result in a well organised, effective complaints department. This in turn is likely to offer a valuable opportunity to detect trends and/or repeated mistakes being made by the trust's staff. Trusts should be prepared to rely on this information and make the requisite changes to stop or prevent poor treatment and improve outcomes. If trusts are prepared to respond to the findings from their complaints department then it will demonstrate that the complaint process has an integral role to play in patient safety issues.

Adequate Support for Patients

There is still inadequate support for patients who wish to make complaints or raise concerns and there appears to be a lack of clarity about how the complaint can be made.

AvMA considers that there is a clear need for a consistent and easily identifiable source of advice on accessing the complaints procedure. Currently, there is a maze of providers with varying levels of service, names, remits and resources. It is our view that the complaints support role needs to be clearly embedded within the local Healthwatch so that complaints can feed directly into monitoring services and early identification of problems.

Patients who do complain find the process exhausting. One of the complainants in the cases reviewed by us commented: "***"My experience of care at X Hospital has left me physically debilitated and***

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emotionally exhausted. I want to enjoy this precious time with my new baby instead of being continually forced to challenge incompetent, unfeeling and ineffective systems."

Access to Information

We also consider there to be a need for patients and/or their families to have access to relevant information such as copies of medical records and any Serious Incident Report (SIR) that may have been compiled, before the complaint is formulated. Access to this information may even head off a complaint. Where it does not, there is a greater chance that the information and advice will enable the patient/family to put their complaint in context, thereby enabling them to ask the right questions.

It is also the case that members of the public who use our advice and information services are often not aware of other agencies which may be able to provide assistance. This is further indication of a continued lack of support given to patients who wish to make a complaint.

Statutory Duty of Candour

The introduction of a statutory duty of candour provides a golden opportunity to promote a more frank and honest approach to complaints. However, it will only reach its full potential if the introduction of the statutory duty is accompanied by funding for proper staff training so that staff understand what it means for them and their patients in practice. In particular training needs to address when the statutory duty applies and how to manage the obligations that go with it; training will be key to its success.

Although the statutory duty of candour is to be limited to cases where moderate harm has occurred, recognition of its importance and for the need to be open generally must cascade down to the trust's complaints handling too. Even now, we all too often see cases where families are not aware of the existence of a Serious Incident Report (SIR) until sometime later on, often only after a legal representative has been appointed or through one of our caseworker's involvement.

A comment made by one of the clients reviewed was: ***"they have not answered any of the questions except to list his medical history. As for saying they did not wish to add to my distress, the only time I spoke to them they lied to me."***

Where clients do raise useful points in their letters to a trust there is often a reluctance to openly acknowledge that there had been shortcomings in care. Defects in care are still referred to in non-specific terms such as: ***"…there were aspects of the nursing care that fell below acceptable standards and for these we apologise".*** In this case the aspects of care referred to were not set out and were not obvious from the response.

Some trusts do appear to be taking the need for openness more seriously. By contrast, in another case where the client complained following dissatisfaction with an internal investigation, the trust acknowledged there had been poor quality of recording and incomplete processes and made clear that

The NHS Complaints Procedure—Getting It Right ..../Cont.

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this was "unacceptable". It then went on to clearly set out what the trust was doing to prevent the same mistakes occurring again in the future. The letter concluded with confirmation that it was going to action 7 recommendations and then, for the avoidance of doubt, set out each recommendation.

Key ingredients:

It is interesting to note that neither the NHS constitution nor the complaint regulations seek to define what a complaint is. Perhaps that is the right approach as it does enable common sense to prevail. However, if complaints handling to date is anything to go by, then one might be concerned about the fact that no definition exists.

What does appear to be clear is that it is easier to list the core ingredients for an effective complaints procedure than to routinely employ them in practice. AvMA considers that an effective procedure needs a structure which should be:

i. uncomplicated
ii. easily accessible to service users
iii. widely advertised to service users
iv. able to put service users at the heart
v. prepared to listen and learn
vi. accepting and embracing of criticisms
vii. self-critical
viii. open and honest
ix. willing to respond and make changes
x. Staffed by well-trained individuals
xi. Properly funded
xii. Given the respect it needs to enable it to thrive, grow and be effective

And with commitment to the process, proper funding and good training these goals are, or should be, very attainable.

The London Legal Walk—a retrospective

Phil Walker, Fundraising Manager, AvMA

Team AvMA Beat Their Target in the London Legal Walk

"It's going to be warm", was the announcement over the loudspeaker in a crowded Carey Street as thousands of lawyers gathered for the annual London Legal Walk on the evening of Monday 19th of May. The two figures in the "walking hedge" costumes were still buoyant despite it being the hottest day of the year. We made sure of registration and secured a free drink token for each member of Team AvMA, they were going to need it. Our brave troop of staff, volunteers and dog were ready for what would prove to be an outstanding challenge and most rewarding experience.

Part of Team AvMA Peter Walsh CEO (centre), Hugh Williams Deputy CEO and Lisa O'Dwyer Director of Medico-legal Services

As we headed off down Chancery Lane a sea of branded vests and shirts greeted an unsuspecting public making their way home on a balmy London evening. "What's all this then?" asked a passer-by "8,000+ lawyers on the march" we said, he hurried away terrified. The walk was a fantastic way to see London, through alleyways, along the Embankment, across three parks and back via The Mall and Trafalgar Square. My admiration for all those who took part was only surpassed by the absolute respect to the young lady in front of us who did the whole 10K in five inch stilettoes and never once stopped for a rest.

We were all pretty shattered by the end and Zimmee needed a decent lap of water, she was wearing a fur coat. The joy of the event was only topped by the knowledge that all these marvellous teams of legal people were raising a staggering amount for good causes.
In our case as a charity we had our own target of £1,200 – we've just reached that.

JOB OPPORTUNITIES AT AVMA

Job Title:	**Data Administrator/Case Worker (Joint AvMA & CQC Pilot)**
Accountable to:	**Director Medico-Legal Services**
Position:	**Temporary - Full time (35 hours per week)**
Salary:	**Circa £18,110 per annum (pro-rated)**
Responsible to:	**Director Medico-Legal Services**
Applications Due By:	**9.00 am Friday 27th June 2014**
Interview	**Wednesday 3rd July 2014**

Click here for job description and application form or please email office@avma.org.uk

Job Title:	**Medico-Legal Co-ordinator**
Salary:	Circa £33,000 (pro rata if part time) point 26 on the salary scale rising to point 29. Annual increments are paid until the top of the scale is reached. A discretionary cost of living increase is usually applied each year in addition.
Hours:	35 hours a week for full time. Part time working will be considered (minimum 28 hours p/w)
Responsible to:	Director, Medico-Legal Services
Location:	Croydon
Applications Due By:	**5.00 pm Thursday 17th July 2014**
Interviews Planned for:	**Wednesday 23rd and Thursday 24th July 2014**

Click here for job description and other information or please email office@avma.org.uk

Job Title:	**Medico-Legal Advisor**
Salary:	Starting at £29,326. Annual increments are paid until the top of the scale is reached. A discretionary cost of living increase is usually applied each year in addition.
Hours:	35 hours a week for full time. Part time working will be considered (minimum 28 hours p/w)
Responsible to:	Director, Medico-Legal Services
Location:	Croydon
Applications Due By:	**5.00 pm Thursday 17th July 2014**
Interviews Planned for:	**Wednesday 23rd and Thursday 24th July 2014**

Click here for job description and other information or please email office@avma.org.uk

CONFERENCE NEWS

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

If you have not already booked your place at the Annual Golf Day or Annual Clinical Negligence Conference you still have time to do so!

AvMA Annual Charity Golf Day
26 June 2014, **Mannings Heath Golf Club, near Horsham, West Sussex**
The tenth AvMA Charity Golf Day will take place on Thursday 26th June. The Welcome Event for the Annual Clinical Negligence Conference will take place later that evening at the Hilton Brighton Metropole so the Golf Day offers the perfect start to *the* essential event for clinical negligence specialists. The cost is only £98 + VAT per golfer, which includes breakfast baguettes on arrival, a round of golf and a buffet, drinks and prize-giving at the end of the day.

26th Annual Clinical Negligence Conference
27-28 JUNE 2014, HILTON BRIGHTON METROPOLE
AvMA's Annual Clinical Negligence Conference (ACNC) is ***the*** event that brings the clinical negligence community together to learn and discuss the latest developments, policies and strategies in clinical negligence and medical law. 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.

There are again discounts available for junior solicitors and barristers, paralegals and trainee legal executives to attend the conference, as well as greater savings for group bookings. The ACNC also offers excellent opportunities for networking. On the day before the start of the conference, we will be holding the AvMA Annual Charity Golf Day and the Welcome Event will take place later that evening. The Mid-Conference Dinner will be held on the Friday evening.

Clinical Negligence Issues in Neurosurgery & Neurological Disease
17 September 2014, De Vere Holborn Bars, London
Stroke medicine, spinal and cranial surgery and medico-legal issues in neuro-intensive care and neurological rehabilitation will be covered by leading medical experts. Quantum in neurosurgery and neurological disease will also be examined. The programme will be available and booking will open in June.

Medico-Legal Issues in Orthopaedic Surgery
2 October 2014, Marriott Hotel, Leeds
This essential one day conference brings together leading experts in the field of orthopaedics and gives you an in-depth insight into the conditions relevant to your caseload. Topics include upper limb surgery focusing on the shoulder, hand and wrist surgery, spinal, foot and ankle surgery, knee surgery as well as joint replacement of the hip and knee. Types of injury and fracture will be looked at within each area as well as highlighting where negligence may occur within each condition. This popular conference is not to be missed and is ideal for solicitors and barristers with a limited or intermediate knowledge of orthopaedics who wish to expand and update their expertise in this area. Booking now

CONFERENCE NEWS

open.

Medico-Legal Issues in Obstetric & Neonatal Care
9 October 2014, Radisson Blu Royal Hotel, Dublin
This popular AvMA conference is coming to Dublin for the first time. Leading experts will cover screening for fetal abnormality and examine how best to manage medical problems in pregnancy and labour, and issues in neonatal care and neurological birth injuries. Causation issues in obstetric and neonatal care will also be discussed, in what will be a key event to assist your caseload. The programme will be available and booking will open in July.

Best Practice in Quantum
23 October 2014, Manchester Conference Centre;
5 November 2014, Central London
This conference, which will be held both in Manchester and London, will cover all the key issues in quantum that you need to know. The programme will be available and booking will open in July.

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. 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!

Clinical Negligence: Law Practice & Procedure
29 – 30 January 2015, 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.

Complications in Pregnancy
11 March 2015, Marriott Royal Hotel, Bristol
Infection, genetic disorders, maternal health, cardiomyopathy, miscarriage, rhesus disease, obesity, multiple births, maternal age, fertility treatments and liver disease are among the topics to feature in this essential AvMA conference. The programme will be available and booking will open in December.

Details of further events for Winter 2014 and early 2015 available soon.

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

AVMA MEDICO-LEGAL WEBINARS

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Webinar access for 60 days	Webinar group access for for 60 days	Group access to all webinar content for 12 months

AVMA MEDICO-LEGAL WEBINARS

Blood Pressure - Implications and Outcomes

On demand webinar

When: available from 10 June 2014

Blood pressure is an important clinical measurement. In the community, high blood pressure is the main cause of concern; however, in hospitalised patients low blood pressure can indicate serious complications. This session will give solicitors involved in medico-legal cases an understanding of what is blood pressure and why it is important to control it.

Presented by: Dr Duncan Dymond, Consultant Cardiologist, St Bartholomew's Hospital

Location: Your desk

CPD points: 1 hour Bar Council & APIL

Medico-legal Issues in Laser Eye Surgery

On demand webinar

When: available now until February 2015

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

Location: Your desk

CPD points: 1 hour SRA, Bar Council & APIL

Medico-legal Issues in Maxillofacial Injuries

On demand webinar

When: available now until February 2015

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, check 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

Location: Your desk

CPD points: 1 hour Bar Council & APIL

Medico-legal Issues in Anaesthesia

On demand webinar

When: available now until February 2015

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

AVMA MEDICO-LEGAL WEBINARS

Location: Your desk

CPD points: 1 hour Bar Council & APIL

Understanding Biochemistry Test Results

On demand webinar
When: available from 20 February 2015
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.
Presented by: Dr Ken Power, Consultant in Anaesthesia and Intensive Care and Lead Consultant for Critical Care Services, Poole Hospital NHS Trust
Location: Your desk

CPD points: 1 hour Bar Council & APIL

Inquest-Post Mortem

On demand webinar
When: available now until March 2015
In July 2013 New Coroners Rules and Regulations came into force. 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
Location: Your desk

CPD points: 1 hour Bar Council & APIL

Hospital Acquired Infections - the current state of play

On demand webinar

When: available now until May 2015

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: Dr Peter Wilson, Consultant Microbiologist, University College Hospital

Location: Your desk

CPD points: 1 hour Bar Council & APIL

AVMA MEDICO-LEGAL WEBINARS

Understanding the Issue of Consent in Clinical Negligence

On demand webinar
When: available now until July 2014
Presented by: Joel Donovan QC, Barrister, Cloisters
CPD points: 1 hour Bar Council & 1 hour 30 min APIL

Pressure Sores – A nursing perspective

On demand webinar
When: available now until July 2014
Presented by: Cathie Bree-Aslan, Tissue Viability Nurse & Expert Witness,Wound Healing Centres
CDP points: 1 hour Bar Council & 1 hour APIL

For details on sponsorship opportunities, please e-mail conferences@avma.org.uk, call +44 (0)20 3096 1140 or http://www.avma.org.uk/event

The Annual Clinical Negligence Conference 2014

27 – 28 June, Hilton Brighton Metropole

AvMA wishes to thank the following organisations for their support:

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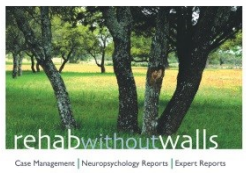

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Answers to Secondary Victim Espresso Quiz

A1. A primary victim is someone who is involved as a participant in an incident or accident and directly affected by it. A secondary victim is someone who witnesses an incident or accident to another or comes upon the immediate aftermath of it. The most well-known formulation of the distinction comes from Lord Oliver's speech in *Alcock v. Chief Constable of South Yorkshire* [1992] 1 AC 310, at 407D.

A2. False: the same principles apply to clinical negligence secondary victim claims as any other secondary victim claim. This was confirmed by Ward LJ at paragraph 43 of *North Glamorgan NHS Trust v. Walters* [2002] EWCA Civ 1792.

A3. False: the control mechanisms are used for determining whether someone can claim as a secondary victim in law; they are not relevant to a primary victim claim.

A4. Once there is reasonable foreseeability of psychiatric harm from the Defendant's negligence, a Claimant must establish: (i) Close ties of love and affection with the primary victim; (ii) Proximity to the incident in time and space; (iii) Direct perception of the event or its immediate aftermath (hearing about it from a third party is not enough); (iv) Injury from sudden shock. The wording used differs between the cases so provided you are describing the same concept, you get your point for naming two of the control mechanisms.

A5. It was 1989 when the Hillsborough Stadium disaster took place which gave rise to the Alcock case (the relatives' claims) heard by the House of Lords in 1992 and also White/Frost (the policemen's claims) in 1999.

A6. True: a primary victim claim does not always give rise to a secondary victim claim which can be established in law, e.g. there may be no secondary victim at all or it may not be possible for the loved one to establish the strict control mechanisms. But you cannot have a successful secondary victim claim, even if the control mechanisms are satisfied, without being able to establish that a Defendant is legally liable to the primary victim. The secondary victim claim is parasitic on the primary victim claim and depends upon there being underlying liability for (clinical or other) negligence.

A7. No, there is no easy to apply cut-off period of time, it will depend on the facts of the case and factors such as what the state of the primary victim was when the loved one arrived, to look at whether this was sufficiently proximate to the Defendant's negligence. The period of time was around 2 hours in the key original case of *McLoughlin v. O'Brian* [1983] AC 410, but the boundaries have been stretched in other cases since.

A8. Not necessarily. An event is not frozen in time and can be made up of a series of events beginning with the negligent infliction of damage and up until the conclusion of the immediate aftermath. It can be a sequence of events or made up of a number of components which as a whole led to the secondary victim's psychiatric injury. These observations come from two cases: *Walters* (cited at A2.) where the relevant event lasted 36 hours and *Galli-Atkinson v. Seghal* [2003] Lloyd's LR 285, where the period was shorter but it was a sequence of events leading up to a mortuary visit. The longest period I am aware of for an 'event' is around 48 hours in a first-instance reported case dealt with by an AvMA member, Grainne Barton of Hugh James. See the clinical negligence secondary victim case of: *Tredget & Tredget v. Bexley Health Authority* [1994] 5 Med LR 178.

Answers to Secondary Victim Espresso Quiz

A9. False: It is the negligent incident/ accident and not the death which is the relevant event for the purposes of determining whether the secondary victim is sufficiently proximate and can establish a secondary victim claim. The secondary victim must be close in time and space to the original negligent event or its immediate aftermath. Witnessing a later traumatic consequence (such as death) caused by that earlier event is not sufficient: *Taylor v. Novo (UK) Ltd.* [2013] EWCA Civ 194.

A10. False: the House of Lords (historically in cases such as White/Frost) and the Court of Appeal (in 2013 in the *Taylor v. Novo* case) have made clear that despite the current law being 'to some extent arbitrary and unsatisfactory' there should not be any further substantial extension of the law in this area. The Courts have been clear that this should only be done by Parliament. In the current political and economic climate, it is highly unlikely, in my view, that Parliament will legislate to widen the scope of secondary victim claims. But, depending on the outcome of the Hillsborough Inquests, pressure could build to look again at the principles established in the cases arising from that disaster, given that we now know that some of the facts of what happened that day were supressed and misrepresented.

What was your score out of 11?

0 to 3: You need another espresso!

4 to 7: Well done, impressive stuff, take a bow (provided you didn't take a sneaky peek at the answers before finishing).

8 to 11: You're a legal lexicon. Reward yourself by taking the rest of the day off. Your friends might have been saying you need to get out more!

Charles Bagot

Barrister

Hardwicke

June 2014

Charles Bagot acted for the successful Appellant in the first secondary victim appeal to reach the Court of Appeal for 10 years in *Taylor v. Novo (UK) Ltd.* [2013] EWCA Civ 194. He is a specialist personal injury and clinical negligence barrister at Hardwicke, London and recommended in the Legal 500 and Chambers UK Directories as a leading practitioner. He sits as a Deputy District Judge in the London County Courts and is on the Editorial Board of Kemp & Kemp: the Quantum of Damages. He tweets about PI/Clin Neg as @BagotBriefs

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Feedback from our member lawyers to invaluable informing and supporting AvMA's policy and campaigning. Please do let us have any suggestions you have, but we would particularly like feedback on the following issues:

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- Any examples of difficulties you are experiencing in securing medical expert reports at the rates allowed by the Legal Aid Agency.
- Any refusal of legal aid for a case which you think meets the criteria.
- Case studies where the client may be prepared to speak to AvMA and/or the media with regard to:

  - Negligent care at one of the 14 trusts currently under review due to high mortality rates.

- Comments or suggestions about any other relevant areas of policy or forthcoming consultations.

Please send your comments to ls@avma.org.uk

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The site will be totally free to access for AvMA clients and their relatives and thoss of our partner legal firms and panel members. The home page will enable them to set up a special remembrance page for their loved ones allowing family and friends to pay tribute and leave messages. The site will provide a very simple set up process and help if required for the initial pages. It will allow your clients to upload photographs and memontos and post special messages and tributes. They can also encourage other friends and relatives to add their tributes and the site is accessible anywhere on the planet. Their individual tribute page will remain active for at least 10 years.

In addition relatives and friends can light a candle for a loved one to remember them on their birthday or other occasion and there is a special garden of remembrance where people can upload photos and tributes. There are messaging boards and the opportunity to communicate with distant friends and relatives. Should they wish to make contact with other families who have also suffered the pain of sudden loss it is possible to do so via the site. This shared experience can provide much needed comfort and support in the most difficult times.

Finally if any families would wish to show their appreciation of the help given them by either your firm or AvMA they can when they set up a tribute fund encourage people to make a donation. This money can then go directly toward AvMA's Inquest project and Advice and Information project, thus enabling the charity to help more families in future years. You can be assured any gifts dedicated through such tribute funds are to be used only for direct help to families

MuchLoved has been a pioneer of memorial websites for more than 10 years, hosting over 20,000 memorial sites for leading UK bereavement charities.

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Please do visit the Tribute home page click on the image or follow this link here

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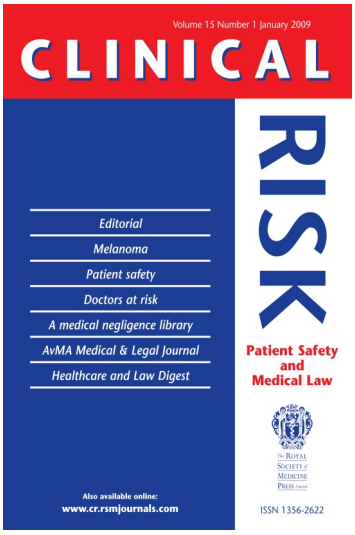

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