avma
action against medical accidents

The charity for patient safety and justice

Lawyers Service Newsletter

Contents

Editorial

Lisa O'Dwyer
Director, Medico-Legal Services

The "Rising Star" award is a new competition aimed at recognising the work done by more junior, but nonetheless dedicated clinical negligence lawyers with less than five years post qualification experience. The idea has certainly been well received with over fifty practitioners submitting applications.

After a difficult first sift the candidates were whittled down to twelve strong contenders. The really tough work then began, the judges who included myself, Master Roberts, Daniel Lewis, Professor Dominic Regan and Reuben Glynn met to consider each of the twelve applications in detail. After several hours of deliberation we were able to arrive at this year's winner and two runners up – they will be announced at the AvMA annual conference after lunch on Friday.

However, all of the judges were unanimous that recognition should be given to the final twelve who in no particular order were: **Carys Davies** – Harding Evans Solicitors; **Lynda Reynolds** – Hugh James Solicitors; **Fiona Dabell** – Barcan + Kirby; **Emma Beeson** – Penningtons Manches LLP; A**nia Bean** – Irwin Mitchell; **Wallis Crockford** – Moore Blatch; **Stephen Clarkson** - Slater Gordon; **Rhian Smith** – JCP Solicitors; **Sarah Stocker** – Tees Law; **Isabel Foenander** – Tees Law; **Carly Saxon** – 2020 Legal; **Mark Cawley** – Irwin Mitchell.

Uncertainty around how clinical negligence claims may be dealt with in the future continues; AvMA is representing the patient's interest in patient safety and access to justice on the Civil Justice Council's core working party on fixed costs in clinical negligence claims.

Peter Walsh gave oral evidence to the Joint Select Committee on 18th June about the proposal to introduce a "safe space". He welcome's any practical examples from our readers of how prohibiting disclosure of investigation information will make it more difficult to take forward cases. Please forward any examples to Peter's PA, Vicki Norman whose email address is: pa_chiefexec@avma.org.uk Peter's update is included in the Newsletter.

This Newsletter again sees a selection of very topical articles for your consideration. The articles are geared towards the busy practitioner who wants a reliable analysis of recent cases and pertinent issues which they can readily apply to their own practice.

By sheer coincidence this edition of the Newsletter has a number of helpful articles on birth injuries starting with the all-important issue of funding. Louise Ford's (Legal Aid Agency (LAA) Clinical Negligence Team Leader) article: **"Legal Aid for Clinical Negligence – Speeding up the decision making process"** aims to address the most common reasons for the LAA refusing applications and looks at how to work towards a position where applications receive a decision first time round – clue: the secret is in the use of the Clinical Negligence Funding Checklist. There are other issues around LAA decisions and Louise has kindly agreed to write further articles for future additions of the Newsletter to help guide practitioners.

An ability to understand and interpret the cardiotocography (CTG) trace is central to any potential birth injury claim. Mamta Gupta is a barrister at No 5 Chambers and her article on **"Cardiotocography: An introduction"** is a good starting point in developing the skills necessary to interpret the CTG trace.

Our next two articles take a closer look at the approach to be taken when considering liability and causation issues. Dr Simon Fox QC of No 5 Chambers and Exchange Chambers argues that not only is the classic Bolam test no longer the starting point on liability in consent and advice cases but the courts are taking a different approach more generally in "pure diagnosis" cases. His article: **"Bolam is dead. Long live Bolam"** looks at which test should be used and when.

The LAA article makes clear that they are looking for counsel's opinion that offers a full medical legal analysis and does not shy away from problems. That provides the perfect link for our next author, John de Bono QC, of 1 Serjeants' Inn and his article on **"Material contribution in acute hypoxic ischaemia"** claims. John sets out his advice on a difficult area of law in a clear and concise way; this is an article which you will no doubt want to read and re-read.

In another stunning result for Christopher Hough of Doughty Street, his write up of the case of **Rajatheepan v Barking Havering & Redbridge NHS Foundation Trust 2018** illustrates the importance of the healthcare provider ensuring basic and effective communication with their patients especially when it is known that they have no or little command of English. The judge's decision makes clear that effectively ignoring a patient is not an acceptable way of dealing with these problems.

Justin Valentine, St John's Chambers, Bristol, article: **"G v NHS Commissioning Board.** Case note focusing on: **(1) Erb's Palsy ...(2) NHS Res Approach to settlement"** takes a closer look at difficulties encountered in bringing Erbs Palsy cases and the importance of holding your ground in settlement negotiations. Helen Hammond is a Senior Associate at Pennington Manches LLP, she considers the **"The link between Fetal Growth Restriction and Stillbirth"** helpfully drawing attention to the indicators for FGR and suboptimal care

Many of us await, with interest the Supreme Court' approach to the case of **Darnley v Croydon Health Services [2017]** – the case is expected to be heard this month. Tara O'Halloran of Old Square Chambers has taken this opportunity to remind us of the facts in Darnley and contrasts it with another similar case also heard in 2017 involving a patient acting on the advice of a receptionist at the same trust– the case of **Macaulay v Karim and Croydon Health Services NHS Trust**.

Paul Sankey's article **"A cautionary Tale for Experts: Understand your duties and stick to your expertise"** reminds us of the importance of the expert's duty to the court. Although the case of R v Pabon [2018] involved the Criminal Procedural Rules the expert's conduct in that case serves as a salutary reminder to all experts not to step outside of their area of expertise. Paul is a solicitor and Partner at Enable Law, Bristol.

AvMA ran another successful inquest conference in May and we are grateful to Aneurin Moloney of Hardwicke chambers for allowing us to reprint his **Update on inquest case law**. We are also pleased to refer you to Tom Semple's overview of the **Inquest touching the death of Miss Audrey Allen**. The inquest was held over three days and identified the disturbing fact that despite Miss Allen being recognised as a vulnerable, elderly lady with a history of falls she had never undergone a falls risk assessment; her diabetes and weight were not properly managed and there were insufficient senior staff to supervise. Tom is a barrister at Parklane Plowden Chambers.

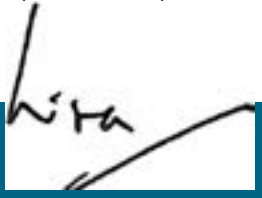
Caroline Wood of Park Square Chambers, has also written up an AvMA inquest; the **Inquest touching the death of James Sheffield**. In that case the coroner made a prevention future death report on the issue of ensuring that patient medical equipment brought into the hospital with them, stays with the patient especially when they transfer from one hospital department to another.

We are grateful to Tom, Caroline and all the barristers who assist us with the Inquest Service for their help and commitment to the service.

My final thanks in this edition of the Newsletter go to all of you who responded to AvMA's mediation questionnaire. I have now written up the findings from the survey and an article is included as a separate item in this Newsletter

We look forward to welcoming you to the AvMA annual conference which this year takes place Thursday 28th – 30th June in Brighton.

Best wishes



Update: Peter Walsh CEO

A joint select committee has started work on scrutinising the draft Health Service Safety Investigations Bill. The Bill contains controversial proposals for extending the so-called 'safe space' prohibition on sharing information collected by investigations with the patients/families concerned. AvMA believes that this would destroy public confidence in NHS investigations. Concern has also been expressed by families involved in the Learning from Deaths programme.

The proposals fly in the face of the recommendations of the Expert Advisory Group on the formation of the Healthcare Safety Investigations Branch (HSIB). It recommended that all relevant information must be shared with patients/families. Many other commentators have also warned against the 'safe space' arrangements being applied to local investigations – especially NHS bodies investigating their own incidents. The Chief Executive of HSIB himself has publicly stated that this would be a bad idea. The proposal appears to be driven by a desire to prevent patients/families being able to use information from investigations to help make a clinical negligence claim against the NHS. The committee is due to complete its scrutiny of the Bill in July.

AvMA CEO Peter Walsh gave oral evidence to the Joint Select Committee about safe space 18th June. He would welcome any practical examples from our members of how prohibiting disclosure of investigation information such as witness statements would make it more difficult to take forward cases. See **here**

All change at the NMC

The Chief Executive of the Nursing and Midwifery Council (NMC), Jackie Smith, announced in May she will be stepping down from the end of July. The move came in advance of the publication the same week of a damning report by the Professional Standards Authority about the NMC's handling of cases from the Morecambe Bay scandal.

It is a time of huge change for the NMC, with two important consultations about to finish. The NMC's consultation on proposed changes to its fitness to practice procedures closes on June 8th.

It proposes shifting most responsibility for investigating concerns about nurses and midwives to the employers, and drastically reducing the number of cases that proceed to a formal hearing by dealing with them through a process called 'consensual disposal'. AvMA has concerns that employers will not always be the best people to investigate concerns about nurses or midwives, and that 'consensual disposal' of cases might involve 'plea bargaining' behind closed doors.

Whilst not opposed to avoiding unnecessary hearings, AvMA is calling for guarantees about the transparency of the process, so that it can be seen that a nurse or midwife simply accept the allegations and appropriate sanction, or proceed to a hearing. The NMC is also consulting on how it will regulate Nursing Associates. This consultation closes on July 2nd.

Patient Safety Congress

You can still book a place to see AvMA Chief Executive Peter Walsh speaking at this year's HSJ Patient Safety Congress. His talk will focus on engaging patients and their families in patient safety investigations.

Taking place on 9-10 July in Manchester the Congress will be focusing on legal issues including:

- Building an effective and just complaints culture
- Learning from incidents and investigations to prevent harm
- Learning from deaths
- Identifying the underlying causes of systemic failure

See the full agenda **here**

Legal Aid for Clinical Negligence - speeding up the decision-making process

LOUISE FORD, SOLICITOR
LEGAL AID AGENCY CLINICAL NEGLIGENCE TEAM LEADER

Legal Aid Agency

LEGAL AID FOR CLINICAL NEGLIGENCE – SPEEDING UP THE DECISION-MAKING PROCESS

Those of us in the Clinical Negligence team of the Legal Aid Agency are highly aware that the cases you submit to us are always of overwhelming importance to your clients and their families and that success in a claim will be life-changing for them. I accept that every time we refuse an application it causes frustration and disappointment. Even a delay while we request further information from you may cause real anxiety for your client. I will try to address the most common reasons for refusal and how we can all work towards a position where almost all your applications receive a decision first-time.

The Clinical Negligence Team is very proud of its close working relationship with AVMA which goes back to 2000 when the Special Cases Unit of the Legal Aid Agency was set up to manage the public funding of very high cost and high-profile cases and multi-party actions. Over the past few years, with feedback from AVMA and its panel members, we have developed ways of simplifying the legal aid funding process, and the Funding Checklist remains unique to Clinical Negligence cases. When we introduced it in 2009 most providers were very pleased that they no longer had to produce detailed costs schedules which were often a huge source of time-consuming frustration and dispute. The principle that the costs of clinical negligence cases are expert driven has largely succeeded in producing a consistent and predictable level of indemnity for our providers and has enabled the LAA team to focus on risk and outcomes rather than on lengthy disputes about costs. We should all be very proud of the good success rates of publicly funded clinical negligence cases and, whilst the principle of good stewardship requires our team to protect the Fund, our aim is a non-interventionist approach which devolves as much of the budget and case management as possible to you, as trusted specialists. For us to achieve this we need the right information from you throughout the life of a claim.

A small team of 4 or 5 experienced LAA lawyers deal with the public funding of all clinical negligence cases and between us we have seen and funded almost all the brain injury at birth cases across England and Wales for the past 10 years. We do therefore recognise the features of a meritorious case or of a particularly difficult one but we aspire, as far as possible, to allow you to progress the claims as they develop without unnecessary bureaucracy or intervention.

Recently our team has had fewer opportunities to deliver presentations to specialist provider groups such as AVMA, or to attend feedback sessions where we can listen to your concerns or provide detailed guidance which can help resolve points of contention. Whilst there will always be a minority of cases where we disagree on the merits themselves, which need to go to an Independent Funding Adjudicator, I intend in this article to give a few pointers which I hope will increase the number of 'grant first time' applications for those cases that meet the LASPO criteria, and improve understanding of the information we in the LAA need to fulfil our role as independent merits assessors as required by the tests in LASPO 2012.

It is worth pointing out that although you, our specialist providers, and we the LAA, have the same objective - winning cases for the legally aided client - our focus is of necessity slightly different from yours. Your primary duty is to your client, ours is to the Fund. This inevitably creates a tension and sometimes you may feel that the LAA is just one more obstacle to be overcome. It may not feel like it to you at times but refusals are time-consuming and frustrating for us as well and we try to avoid them unless it is clear the criteria are not satisfied. Often you have the information necessary to demonstrate that your case is likely to win but perhaps are not always aware that we also need to understand why your case will win or why your evidence is likely to be preferred, because otherwise we cannot fulfil our role of independently assessing that the criteria are met. As always, open communication is key.

CRITERIA TO BE SATISFIED FOR A GRANT OF FUNDING AND THE INFORMATION IN SUPPORT

The guidance below follows discussions with providers who have asked specifically what information is required to obtain an initial grant of funding.

In Clinical Negligence it is possible to obtain £22,500 on the initial application to investigate a 5-6 expert case. The information you need to provide to the LAA to obtain this sum (rather than the CCMS default initial costs limitation of £2,250) is therefore more substantial than in all other areas of law.

It can appear from the LAA's CCMS system as though it is not necessary for you to submit documents online in support of applications for legal aid funding. However, you will still need to upload the same documents that you would for an old-style paper application.

The starting point is Paragraph 23(1) Part 1 Schedule 1 LASPO which states that public funding is available for a claim for damages relating to clinical negligence which has caused a neurological injury to an infant either when in its mother's womb or within a specified time around birth up to 8 weeks after the date of birth.

Therefore, although the percentage prospects will be unclear, the LAA needs to be satisfied at the outset that there is a prima facie case in negligence and that your client has suffered a neurological injury. It is not enough that a neurological injury may, or even is likely, to become apparent in the future.

Use the Clinical Negligence Funding Checklist for all applications and work your way through the various questions (in fact, this applies to any stage of a publicly funded Clinical Negligence case). The questions are designed to capture the information that is necessary to determine an application. If you do not provide a fully completed Stage One Checklist questionnaire the application is likely to be rejected/refused for further information.

The latest version of the Checklist can be found **here**:

1. You should provide the following key documentation with initial applications:

Essential:

• The Clinical Negligence Funding Checklist and statements from the mother/parent/family. The notes of the initial consultation with the family are an acceptable substitute if it is not possible to provide a statement. Do not rely on the CCMS Merits Report.

Recommended:

• Relevant medical records. If you have not obtained or considered these it is likely to be difficult in a brain injury at birth case to show that the criteria for Investigative Representation are met.

• The neonatal discharge summary.

• Complaints procedure documents and /or Serious Untoward Incident Report.

• Your comments on these documents drawing attention to how the evidence shows that the criteria for Investigative Representation are met are critical and should specify where your investigations will be focussed. These comments should be included in the answers to the Funding Checklist.

2. A formal diagnosis of cerebral palsy or other neurological injury as a result of which the baby is severely disabled.

The LAA will generally need to see a formal diagnosis of a neurological injury which can be scientifically linked to birth trauma. We still see a lot of applications where the only diagnosis is of autism or ASD or dyspraxia for example. The causes of these conditions are still insufficiently understood to form the basis of a LASPO compliant claim.

Applications made before the child is 18 – 24 months of age risk refusal on the grounds of prematurity. These applications can be resubmitted at a later date. A refusal may not mean *'no'*, it may just mean *'not yet'*. Where a future diagnosis of cerebral palsy looks probable, an application for a certificate will be considered if you can show that to delay investigations until a diagnosis is available will prejudice the case.

The following information is very helpful and is likely to lead to your application being dealt with quickly:

1) Apgar scores and blood cord gas results/acidosis.

2) Condition at birth.

3) Level of resuscitation required.

4) SCBU/NICU admission?

5) Lack of oxygen? How long?

6) Hypoxic Ischaemic Encephalopathy (HIE) – grade/ severity? seizures?

7) Organ failure?

8) Details of treatment provided.

9) Information about the neonatal period.

10) Is there an MRI? Please provide details.

11) Current condition – a letter or medical note is preferable to a parent statement alone.

As specialists you will understand the relevance of this information in showing what the likely allegations of negligence will be and that, depending on the expert evidence, how you can potentially show that negligence caused a neurological injury and severe disability.

3. Other conditions

ADHD/autism/ASD/dyspraxia cases are more or less excluded (unless there is also a diagnosis of cerebral palsy or other neurological injury), due to the current lack of a proven causal link. Studies showing an "association" between birth trauma or oxygen starvation and these types of conditions are unfortunately insufficient to satisfy causation and are likely to be refused on the grounds of "poor prospects of success".

4. Allegations of breach and causation. The case theory.

Always include:

a. Likely allegations of negligence based on early information. These may change as the case progresses.

b. How causation is likely to be shown.

In a very problematic case, the way to maximize your chance of obtaining funding is to identify to the LAA what might be the knock-out blow to a claim and specify the minimum steps or perhaps the one expert which will determine whether there is any prospect of success. This will have a far greater chance of achieving a grant of funding, albeit initially short of the full £22,500, than an application which glosses over the difficulties.

COUNSEL'S ADVICE

The same principle of engaging with difficulties and communicating them to us applies throughout the life of a case and leads onto another area of common contention. Why, when you have a positive opinion from an experienced QC, do we sometimes still query the merits? The answer goes back to our role as independent merits assessors. There are broadly 2 types of Counsel's Opinions that we see - firstly, the full medical/legal analysis which does not shy away from problems and which helpfully engages with how these will be addressed, or alternatively, the Opinion which confidently states that prospects are 'good' but whose conclusions do not appear to follow from the expert evidence which may not be completely supportive. We place real weight on Counsel's Opinion, but only to the extent that we can see that the conclusions clearly flow from the available evidence. It may be the case that the real analysis has taken place in conference to be followed by a rather bland positive Opinion perhaps produced out of concern that a 'warts and all' analysis might lead to the withdrawal of LAA funding. The reality is that we view a realistic advice with far more confidence than an inexplicably optimistic one. The latter may lead to protracted correspondence as we try to understand whether the merits really do meet the 50% or above merits requirement.

If you have a case where there is significant factual dispute for example, or where there are a number of hurdles which all need to be overcome, including persuasive expert reports produced by the Defendant, then we need the Opinion to specify how the challenges will be met so we can see how the percentage prospects are arrived at. If the experts have identified a problem with the case or are not in agreement with each other, then Counsel needs to suggest a solution, as otherwise we may not accept the Advice to proceed. We need to see that Counsel can identify a problem and how it can be dealt with as otherwise we fear that the case will fail.

There are several issues that I haven't touched on that could probably benefit from further discussion such as the VHCC contract terms; unforeseen developments in a case which increase costs; experts' fees; unrecoverable costs; and applications to cover trial where settlement negotiations have failed. The feedback I have received however, suggests that clearer guidance on how you can avoid refusals was the topic of most immediate concern.

Please continue to feedback either to AVMA or directly to me and let me know whether this helps you to understand how we can reduce refusal rates and speed up the decision-making process.

(The views in this article are the author's own)

Louise Ford – Solicitor

Legal Aid Agency Clinical Negligence Team Leader

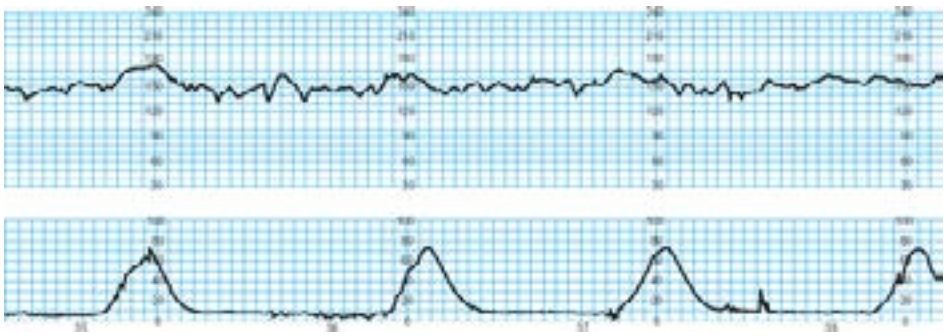
Cardiotocography: An Introduction

MAMTA GUPTA
NO 5 CHAMBERS

Cardiotocography traces form a central piece of documentary evidence in litigation related to adverse perinatal outcomes, which are alleged to have arisen due to events that took place during the labour and/or delivery of the baby. Cardiotocography is therefore an important element to get to grips with for any practitioner when working on birth injury cases. Errors in electronic fetal heart rate monitoring or cardiotocography are a common theme in such cases with injuries to the baby including cerebral palsy, stillbirth and scarring and injuries to the mother including damage to the mother's perineum or vagina resulting in disability which limits sexual intercourse, lack of control of bladder/bowel function and of course psychological or psychiatric sequelae. A recent review by NHS Resolution in September 2017 found that 32 out of the 50 cerebral palsy cases looked at, involved errors of cardiotocography interpretation. This article is a beginner's guide to cardiotocography for application in medical negligence cases.

What is cardiotocography?

Cardiotocography is a technical means of recording the fetal heartbeat and the uterine contractions during pregnancy and intrapartum. The cardiotocography recording is produced in the form of a graphical trace and is important to midwives and obstetricians when evaluating in real time whether there is fetal compromise or not. The upper channel [cardiograph] represents the fetal heart and the lower [tocograph] records the frequency of uterine contractions [not strength].



The cardiograph may be recorded by an ultrasound signal through the mother's abdominal wall or via an electrode attached to the baby's scalp, so called a fetal scalp electrode. The tocograph is produced by an external tocodynamometer placed at the fundus of the uterus to measure the frequency of the contractions.

Internal monitoring of the fetal heart rate by use of a fetal scalp electrode provides a more accurate and consistent transmission of the fetal heart rate than external monitoring because factors such as movement do not affect it. Internal monitoring may be used when external monitoring of the fetal heart rate is inadequate, or closer surveillance is needed.

The current relevant guidance on cardiotocography is detailed within NICE Clinical Guideline CG190 on Intrapartum Care[1] . The use of a standard format in the guidance to interpret and respond to fetal heart rate, serves to facilitate safety in clinical practice and provide more clarity in legal cases. Practitioners should refer to the relevant guidance in place at the time of the alleged negligence when considering matters of negligence. More about the guidance below.

Usage

Cardiotocography is most commonly used in the third trimester and during labour. Its purpose is to monitor fetal wellbeing and allow detection of fetal distress which usually means the fetus is hypoxic or anoxic. [deprivation of adequate oxygen supply]. All pregnancies, regardless of risk category, need effective monitoring: only 1 in 5 claims for cardiotocography interpretation involve a high-risk pregnancy[2]. An abnormal CTG trace indicates the need for more invasive investigations and potentially emergency Caesarean

1 Section 1.10, Clinical Guideline CG190. NICE CG190, Intrapartum Care: Care of healthy women and their babies during Childbirth. December 2014.

2 Powers & Barton on Clinical Negligence, Bloomsbury Professional, 5th edition.

section. Appropriate interpretation of CTG traces is therefore fundamental if there is to be a reduction in the number of baby deaths and/or serious injury. The relevance to medical negligence work will be patently clear.

Interpretation

Interpretation of CTG traces is a very complex subject of which experts frequently differ. As a consequence, even the most superficial review would be beyond the scope of this article.

Lawyers are advised to leave the interpretation of CTG traces to their instructed experts. Experts will be looking at the traces when considering the standard of care provided and whether there were signs of fetal compromise or not at a certain time which should have prompted earlier or later action in relation to delivery. Below is only a high-level summary of the main features.

Tables 10 and 11 of the current NICE guideline, CG190 provide guidance on the interpretation of CTG traces and the reader is referred to the whole of section 10 for further information. [3]

The four main features used to assess a CTG trace are:

1) Baseline fetal heart rate

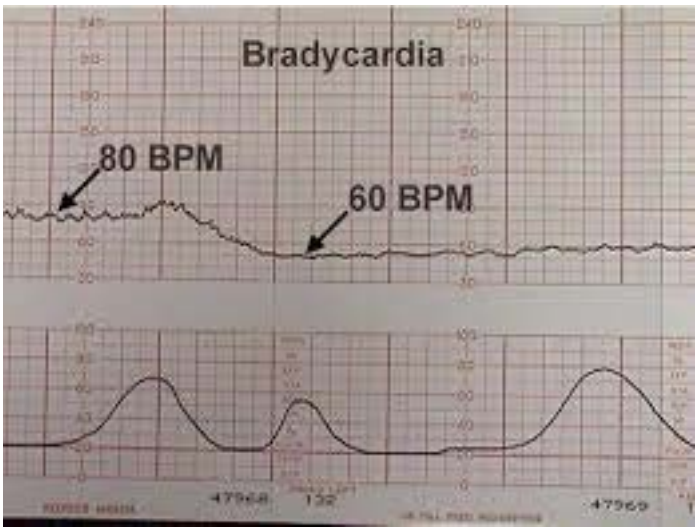
2) Baseline variability

3) Fetal heart rate accelerations

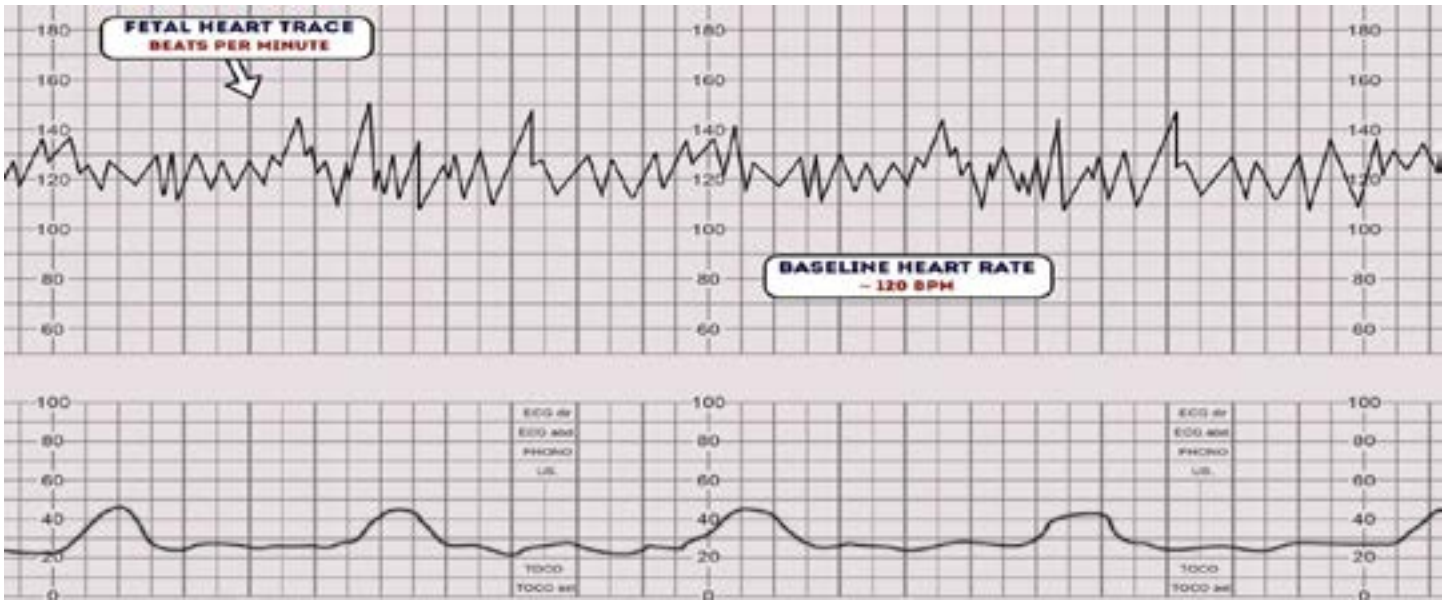
4) Fetal heart rate decelerations

Generally, accelerations are a sign the baby is healthy. The appropriate response to a uterine contraction is an increase in the fetal heart rate [acceleration]. The baseline rate is the average heart rate of the fetus in a 10-minute window. The normal fetal heart rate is between 110 – 150bpm. A baseline variation of less than 5 bpm is an abnormal sign! Variability greater than 5bpm is generally a sign that the baby is healthy.

Decelerations are an abrupt decrease in the baseline fetal heart rate by 15 bpm for 15 seconds or more. There are different kinds of decelerations, [early, variable, late and prolonged] each with varying significance. The baseline rate, variability and decelerations are categorised as



3 *https://www.nice.org.uk/guidance/cg190/chapter/Recommendations#monitoring-during-labour*



normal/reassuring, non-reassuring and abnormal as per Table 10. Table 11 provides the management approach subject to the interpretation and categorisation of the features of the CTG trace. When there is a single prolonged deceleration or bradycardia with a baseline below 100 bpm persisting for 3 minutes or more, the CTG is classed as abnormal and warrants the need for urgent intervention.

When instructing experts, practitioners should ensure that the full clinical picture is taken into account, as clinicians must do in practice. Such factors include the presence of meconium stained liquor in the amniotic fluid; delay during labour[4], abnormal fetal position and whether there is acidosis following blood gas analysis of a fetal blood sample. Furthermore, whether the pregnancy was high or low risk will also be relevant. Such factors will assist when trying to understand what the picture was at the time of the index events and what the clinicians knew at that time when providing treatment and care.

Medical negligence

Uncertainty is part and parcel of CTG traces and therefore the scope for error can make clinical negligence claims challenging. Traces have a high false positive rate and the transducer could be picking up the maternal heart rate instead of the fetal heart rate. Practitioners should try and draw out any potentially misleading features on the CTG traces with their experts in order to get a realistic snapshot of how a responsible body would have interpreted the CTG trace at the time. Intrauterine observation along with consideration of the full clinical picture is critical in determining whether or not breach of duty is established. The majority of birth injury cases incorporate similar allegations of negligence which broadly centre around the inability to interpret the CTG trace correctly, for example failure to identify bradycardia in time leading to delay in proceeding to caesarean section. In the ordinary case it is still necessary to show that the signs of foetal compromise could reasonably have been detected and that delivery could and should have been expedited. Casework will usually include analysis of the timings as to when fetal distress would have been identified by a reasonably competent midwife/obstetrician and at what time should certain steps/treatment have taken place. Conversely allegations relating to liability may be that the delivery was carried out too soon causing injury.

In the event breach of duty can be proved by a Claimant, it will still be necessary for the Claimant to prove on balance that the injury, be it cerebral palsy or otherwise would have been avoided if delivery was expedited at a certain time. Not only can breach of duty be a difficult hurdle to overcome in obstetric cases, but causation can also bring its challenges. The experts will need to consider what would have happened if the patient had been delivered at a certain time with appropriate management along with the likely cause of the injury actually suffered. In cerebral palsy cases, paediatric neurology expert evidence may be needed to identify the cause of brain damage which may have occurred in any event irrespective of any delay.

Practical guidance

The doctor's or midwife's clinical notes are not sufficient; practitioners must consider the CTG traces themselves. Claimant lawyers will need to ensure they have the whole trace relating to the labour and delivery of the baby in any given case and that it is clear enough to be read. Practitioners should instruct their experts [obstetricians or midwives] to explain the trace in detail in their reports with reference to the relevant guidance in place at the time of the index events. Similarly, the Defendant clinicians' witness statements in relation to the interpretation of the CTG trace must be cross referenced with the Claimant's expert's own interpretation of the trace. When preparing for trial, parties may wish to include a glossary of terms in the trial bundle to assist the Court with the technical medical concepts and practitioners should also consider enlarging the traces for trial in order to ensure they are as legible as possible reducing the scope for error.

Finally, cardiotocography despite its limitations and scope for error is here for the foreseeable future. There is not currently a more effective way of monitoring fetal wellbeing and therefore doctors, nurses and lawyers will need to continue to rely upon them and endeavour to interpret them.

4 *Sections 1.12 and 1.13. NICE CG190, Intrapartum Care: Care of healthy women and their babies during Childbirth. December 2014.*

Bolam is dead, long live Bolam!

DR SIMON FOX QC
NO5 CHAMBERS AND EXCHANGE CHAMBERS

As a doctor transferring from medicine to law 25 years ago, I was struck by the illogicality of the Bolam test, in that it seemed to me that it couldn't logically be applied to many circumstances of medical negligence.

The most obvious to me, then and now, is an allegation that a surgeon negligently injured the bowel during routine abdominal surgery. It always struck me that it was nonsensical to consider whether this would be a *"practice accepted as proper by a reasonable and responsible body of surgeons"* – the classic Bolam test. No surgeon would consider an accidental iatrogenic bowel injury to be an acceptable way in which to carry out the operation. The injury was accidental, and to me the proper test should be whether the surgeon exercised reasonable skill and care, as it would be in any case of an accident occurring through negligence.

But the Bolam test is the test for medical negligence and has been routinely rolled out for all types of case for decades. I liked John-Paul Swoboda's description of this process as *"the deep ossification of the Bolam test in the common law"* in his excellent recent article on Bolam (JPIL 2018 issue 1, p.14).

However, there is some recent judicial support for my long held view that we are often applying the wrong test if we simply apply Bolam each time.

Montgomery replaces Bolam, but is it limited to consent ?

Montgomery has toppled Bolam from its long held position as the test for breach in consent cases. But is its application limited to consent cases? It would be wrong in my view to think this is the case, as illustrated by the recent case of Webster v Burton Hospitals [2017] EWCA Civ 62.

In Webster the Court of Appeal considered the application of the Montgomery test. Webster was a cerebral palsy claim in which there was an admitted negligent failure to carry out further scanning in response to poor fetal growth, asymmetry and polyhydramnios at an antenatal scan. On the Bolitho causation issue of what the Defendant's staff would or should have done if they had repeated the scan, the Claimant alleged that the results of the further scan would or should have led to the obstetrician advising the Claimant's mother of the alternative of an earlier delivery. She would have opted for this and the Claimant would have been born intact before his brain injury occurred.

The Defendant asserted that their obstetrician would not have advised of the alternative of earlier delivery, but would have continued the pregnancy and this would not have been negligent. The Claimant's injury would still have occurred. At first instance – before Montgomery – the Judge found for the Defendant.

The appeal was heard after Montgomery and the Claimant won; using the Montgomery test his mother should have been advised of the alternative of an earlier delivery and the complications and risks and uncertainties of different treatments. She would have opted for early delivery if she had been so advised, avoiding his brain injury.

However, Webster was not what we normally think of as a consent case – ie it was not a consent for surgery case. In Webster the allegation was of a negligent failure to advise in antenatal clinic of the options for further management of pregnancy. The Court of Appeal still applied Montgomery as the test and found for the Claimant.

We should therefore in my view be considering Montgomery as the test for negligence in cases on advice, not just consent to surgery cases.

Is Bolam still the correct test for all other types of case, not involving consent or advice ?

In my view the short answer is no.

The recent case of Muller v Kings College [2017] EWHC 128 (QB) concerned an allegation of negligent interpretation of a histology slide. Defence counsel submitted that the classic Bolam test applied to such circumstances. Mr Justice Kerr rejected that submission and made the distinction between what he called a "pure diagnosis" case and a "pure treatment" case. He considered that the classic Bolam test of a reasonable and responsible body of doctors applied to "pure treatment" cases – such as a decision in the obstetric management of a labour in the case of C v North Cumbria [2014] EWHC 61 (QB) - but not to a "pure diagnosis" case such as misinterpretation of a histology slide in the case of Muller.

He considered that the correct test in a "pure diagnosis" case such as interpretation of histology was firstly to establish as a matter of fact what was present on the slide and secondly to decide whether in missing these features the doctor had exercised reasonable skill and care. The Judge found support for this approach in the earlier Court of Appeal decision in

Penney v East Kent [2000] Lloyd's Rep.Med.41 where the same test was applied in a similar histological interpretation case.

A further recent case of XXX v Kings [2018] EWHC 646 QB demonstrates that the Court will also adopt the same test of reasonable skill and care in cases of ultrasound scan interpretation. The Judge in that case also found support in an earlier Court of Appeal ultrasound scan case - Lillywhite v UCL [2005] EWCA Civ 1466. In both cases the Court addressed breach on the basis of what was present as a matter of fact and then considered whether this could have been missed with reasonable skill and care on the part of the doctor, not the classic Bolam test of a reasonable responsible body. The Court of Appeal in the ultrasound scan case of Lillywhite referred to the same test in the histology Court of Appeal case of Penney in their reasoning. It is clear therefore that the Courts are treating histology and ultrasound scan cases similarly in terms of the test used for breach – and it is not classic Bolam.

Mr Justice Kerr in Muller has therefore highlighted and detailed an important distinction in the test for breach, which is in fact to be found in in earlier cases at both first instance and the Court of Appeal.

In my view we should add to his "pure diagnosis" category, cases where doctors make errors during procedures - for example the surgeon who injures the bowel during routine abdominal surgery referred to at the start of this article. In my view in all of these situations the classic Bolam test is inappropriate and the appropriate test is to whether the doctor exercised reasonable skill and care.

By the same taken in my view we should add to his "pure treatment" category, cases where appropriate assessment and investigation are the issue, for example whether to carry out a particular diagnostic test, to be decided by the classic Bolam test.

<u>So which test for which case ?</u>

Broadly speaking my approach is –

"Pure diagnosis" cases and surgical/technical errors – reasonable skill and care.

"Pure treatment" cases and assessment/investigation cases – classic Bolam.

Consent and advice cases – Montgomery.

So it might be more accurate to say – Bolam is dead for some cases, but lives on in others, at least for now.

<u>What does this mean in practice ?</u>

Firstly, I think it means that we have to stop and consider right at the start of any case "What is this case about and which test for breach applies?" My summary above risks oversimplifying that process. In some cases this will be obvious. In others less so. It is also something to involve Counsel on. I appreciate that the solicitors amongst you will say "you would say that, wouldn't you" but if your case gets to trial and your expert is addressing the wrong test, it will be Counsel who has to explain why.

Secondly, I think we need to be much better at setting out the correct test that we ask our experts to address when we instruct them.

Thirdly, I think it is best practice to ask the expert to set out the test which they have been asked to address at the start of their report. This will mean that whenever the expert describes something as a failure in the narrative of their report, it is clear what they mean by that term. It also avoids that embarrassing moment in cross examination when an expert is asked to explain what they mean by a failure – and they stun the Court with some illogical and embarrassing mishmash of Bolam. My favourite example of an expert's take on Bolam is *"It is my opinion that the failure to manage the patient in this way could be considered negligent by a body of experts" !*

I have been criticised by an opponent at trial for asking an expert to include the correct wording of the Bolam test in their report, on the basis that this taints the independence of the expert's opinion and comes close to a breach on my part of the CPR 35 Guidance for the Instruction of Experts in. The trial Judge dismissed that criticism.

It helps no one in my view, especially the trial Judge, if what the experts mean by negligence is unclear. But for the experts to be clear as to what they mean by negligence, us lawyers need to be clear first.

Material contribution in acute hypoxic ischaemia

JOHN DE BONO QC
SERJEANTS' INN

1. There is no doubt that since the decision in Bailey v MoD the claimant's task in proving causation has become significantly easier because she no longer needs to prove that her condition is worse than it would have been 'but for' the defendant's breach of duty. There are cases where it is not possible to say whether or not she is worse off but causation is nevertheless established because the breach of duty has made a more than negligible (or material) contribution to the outcome. What though is the position in a conventional case of acute profound hypoxic ischaemia caused by breach of duty at the time of delivery?

The conventional 'but for' approach

2. The conventional approach is to take the end point as being when the baby is resuscitated following delivery and circulation restored so that the baby's heart rate is back to >100bpm. In 'acute profound' cases it is usually assumed that a baby can withstand 10 minutes of total (or near total) hypoxia without injury but that it will not survive more than about 30 minutes. Where a baby has cerebral palsy caused by acute profound hypoxia the usual legal approach will therefore:

a. firstly, identify the probable time of the onset of the terminal bradycardia (which will be not more than 30 minutes earlier than restoration of the circulation post-delivery);

b. secondly, see whether it is possible to argue that delivery should have been either before that point or within 10 minutes after it.

3. Such an approach enables the claimant to argue that all of the injury would have been avoided i.e. *'but for the breach there would have been no damage'*.

Is a 'material contribution' argument available?

4. There will be cases where either it is not possible to succeed on 'but for' causation or where different findings are possible as to how much earlier delivery should have been. The question then is whether the claimant can achieve a fall back position and succeed on the basis of material contribution to an indivisible injury?

Popple

5. The first case to consider material contribution in cerebral palsy was Popple v. Birmingham Women's NHS Foundation Trust [2012] EWCA Civ 1628. In that case the court (upheld on appeal) found that Nathan who was delivered at 1449 should have been delivered ten minutes earlier, by 1439. HHJ Oliver Jones QC found in the alternative that if he was wrong about that then Nathan should have been delivered by 1444.

6. He found that Nathan's brain damage was caused by a period of 15-20 minutes of acute profound hypoxia immediately prior to birth of which the first 10 minutes was non damaging. This enabled him to find 'but for' the delay Nathan would have been uninjured – because with delivery by 1439 he would have avoided any injury.

7. The judge then went on to consider the alternative case on breach and say that even if delivery should have been by 1444 i.e. only 5 minutes earlier, the Claimant would have established causation on the basis of material contribution.

8. The Court of Appeal, considering the scenario where delivery was at 1444 concluded that either causation would be established on the basis of 'but for' causation or 'material contribution'. See Ward LJ at 78:

"I agree with Mr Sweeting that all of the damage might have been done in the last five minutes before delivery i.e. after 1444 if the overall duration of the insult was 15 minutes. Some damage might have occurred during the five minute period prior to 1444 if the overall duration of the insult was 20 minutes, but there would still have been damage in the entire last five minutes from which Nathan would have been had he been delivered by 1444. It was not possible to say how much, if any, damage occurred prior to 1444, whereas all of the period thereafter must have been damaging. Thus on any view, a failure to deliver by 1444 either caused the damage in its entirety or made a material and probably preponderant contribution to it.

"The rule established by Bailey... is per Waller LJ at [46]

'In a case where medical science cannot establish the probability that 'but for' an act of negligence the injury would not have happened but can establish that the contribution of the negligent cause was more than negligible, the 'but for' test is modified and the claimant will succeed.'

"Here the negligent failure to deliver Nathan before 1444 caused all the damage if this was a 15 minute insult. Medical science cannot establish whether it was a 15 minute insult or a 20 minute insult. If it did take 20 minutes, the damage done in the last five minutes must have made a contribution to the overall harm which was more than minimal. I cannot see why the Bailey principle does not apply."

DS v. Northern Lincolnshire

9. The issue arose for a second time in DS v. Northern Lincolnshire and Goole NHS Trust [2016] EWCH1246 QB. In DS the claimant failed in his argument that there had been a 6 to 9 minute delay in delivery. Cheema-Grubb J found that at most there had been only a 3 minute negligent delay. The overall period of hypoxic ischaemia was 39 minutes. The judge's conclusion on material contribution was, in effect, that causation would have been established on the basis of a 9 minute delay but not with either a 6 minute or 3 minute delay.

10. The judge's conclusion is found from paragraph 196 onwards. See firstly, paragraph 196 vii):

"... on all the evidence I have read and heard, I am persuaded that if birth had been as much as 9 minutes earlier, a substantial proportion of the total hypoxic insult would have been avoided and although I cannot calculate it exactly I am satisfied on the balance of probabilities that it would have made a difference to DS's cognitive abilities so that although the care support he needed may have been the same his ability to manage himself, to make daily (not legal) decisions and the degree to which he would be able to join in his care would have been substantially improved."

11. This is in effect a finding that a 9 minute delay, had it been proved, would have led to a finding of material contribution in respect of the claimant's cognitive but not physical impairment.

12. Cheema-Grubb J then goes on to say at 196 viii in relation to six minutes of delay:

"... the Claimant has not persuaded me that it is likely he would have suffered materially less injury had he been delivered 6 minutes before 1529... DS was bound to suffer significant brain damage from the acute hypoxia following placental abruption until resuscitation and although a saving of 6 minutes before delivery and a consequential shorter period of necessary resuscitation may have made some proportionally minor difference to his cognitive functioning, it is impossible to say to what extent that saving of time would have improved his current condition."

13. I read that as a rejection of the material contribution argument. The judge though appears to have understood the test to be whether the claimant could prove that he would have been less injured. I would respectfully question that approach which is not what is normally understood by material contribution causation. In Bailey the whole point was that the Claimant could not prove that she would have avoided, or suffered less, brain damage had she been kept reasonably hydrated in hospital, the court could not say one way or another. All that could be said was that the failure of hydration had made a more than negligible contribution to the outcome. Similarly in Williams v. Bermuda, the court was not able to find that with earlier CT scanning and surgery the claimant would probably have had fewer cardiac and respiratory complications, only that the these had been contributed to by the delay.

14. The judge should have asked "would the outcome for DS probably have been the same in any event". If the answer was 'yes', then there could have been no material contribution. It was an error to suggest that the Claimant was required to prove how much less injured he would have been with earlier delivery.

15. In respect of three minutes she found at paragraph 197:

"On the basis of the negligent delay of 3 minutes I have found proved, my conclusion is that for all the reasons set out above, the Claimant has not proved on the balance of probabilities that but for the negligent delay in delivery of 3 minutes he would have not sustained brain damage or that the damage he has suffered would have been materially less severe in its impact on his ability and capacity."

16. Again, the question should have been *'would he probably have suffered the same injury in any event'* and it appears that the answer would have been 'yes'. Causation would therefore have failed anyway, but the test was wrong.

Discussion

17. In Popple the Defendant had the difficulty that the experts had agreed that the total period of hypoxia

was 15-20 minutes of which the first 10 minutes was probably non-damaging. This meant that the damage was done over a period of 5 to 10 minutes. The period of culpable delay was between 5 and 10 minutes. There was no option therefore for the defendant to argue that even with earlier delivery there would probably have been some damage in any event.

18. In DS the position was very different. Here the total period of hypoxia was 39 minutes, which was exceptionally long and difficult to explain. In that context the door was open to the defendant to identify a level of damage which would probably have occurred in any event because even taking the Claimant's case at its highest with a 9 minute period of culpable delay there would have been 30 minutes of non-negligent hypoxia. The judge made an attempt to divide the Claimant's injury based on the evidence of Dr Rosenbloom for the defendant and found that his physical function would have been similar but that he would have been less cognitively impaired. This would have been significant for the assessment of quantum because, relying on Reaney v. Staffordshire the defendant would have been able to argue that the same care would have been required in any event and, in all likelihood, most of the special damage claim would have disappeared. She, understandably, found that a 3 minute delay in the context of a total period of 39 minutes was not material.

19. It is important to understand that it is not enough for a defendant to prove that some damage would have occurred anyway unless it is possible to say 'how much'. See John v. Central Manchester [2016] EWHC 407 (QB). This was a case of a 44 year old man who suffered brain damage having fallen downstairs. He would undoubtedly have suffered some brain injury in any event but this was materially contributed to by a negligent delay in performing a CT scan and then surgery. In the period of delay he suffered damaging raised intracranial pressure. The judge, Picken J, refused to apportion damage as between the negligent and non-negligent causes, see paragraph 98:

"This brings me, then, to Mr Kennedy's submission that in a case such as the present the Court should engage in an apportionment exercise of the sort carried out in the Holtby case. I cannot accept that this can be right. First, I am in some doubt how this argument can work in circumstances where, as Mr Kennedy accepted during closing submissions, if the 'material contribution' test has been satisfied, then causation is made out. It seems to me that, if that is the position, then if the evidence is such that it is not possible to attribute particular damage to a specific cause, the claimant must be entitled to recover in respect of the entirety of his or her loss."

20. In particular CP cases the strength of the material contribution argument will depend on the facts – including the overall period of hypoxia, the length of the 'avoidable/ culpable delay' and nature of the injury. If (as in DS) there is a long period of hypoxia and a very short period of delay then it will be harder to argue for a material contribution than where (as in Popple) the period of delay and the period of damaging hypoxia are similar in length.

21. We know that some experts are attempting to divide hypoxic ischaemic injury and identify a level of injury that corresponds to the period of damage – as Dr Lewis Rosenbloom did in DS. Where this approach will work best for defendants is where it is possible to argue that there would have been profound damage in any event with little or no change in functional outcome or care needs. However for claimants, even in such cases material contribution may allow a claim to succeed in respect of some of the damage – for example a claim for plsa in respect of the degree of cognitive impairment.

22. Overall it would be wrong to generalise about the applicability of material contribution causation to cases of acute profound hypoxic ischaemia. Popple shows that the argument has a good foundation in law. Whether it applies to a particular case will depend on the expert evidence and the facts – in these cases as much as any other clinical negligence claim.

Rajatheepan v Barking Havering and Redbridge NHS Foundation Trust 2018 EWHC 716

CHRISTOPHER HOUGH
DOUGHTY STREET

This unusual case considered the duties owed by a Hospital to a young, non-English speaking mother whose child went on to develop catastrophic cerebral palsy as a consequence of poor feeding. This damaging process took just 12-15 hours after discharge from Hospital.

In February 2008, Mrs Rajatheepan joined her husband in the United Kingdom. Both were young Tamils from northern Sri Lanka, who had the misfortune to be caught up in the civil war. Her husband had been successful in his application for asylum in this country.

Mrs Rajatheepan grew up in a rural part of Sri Lanka. Although she attended school in a city, her journey was frequently disrupted by government forces, and her school was often not able to open. As a result, she had little formal education, and very little English.

Within a few months of her arrival in London, she became pregnant. The management of her pregnancy was shared between her GP (who was a Tamil speaker) and the staff at St George's Hospital in East London. This had a very busy maternity unit, but only one of the staff involved in her care was able to speak Tamil.

The Hospital's ante-natal records started with a "tick box" form that Mrs Rajatheepan needed an interpreter. This was later highlighted with a large handwritten endorsement that she could not speak English and needed an interpreter. At different stages in the ante-natal care, the midwives commented on communication difficulties.

In general, Mr Rajatheepan accompanied his wife to act as interpreter but this was not always possible. Unfortunately, the one ante-natal appointment where her husband was unable to attend was the occasion the midwife should have given advice on feeding (according to the NICE Guidance). An English speaking friend went with her, but was asked to wait outside. This missed opportunity was never remedied.

The pregnancy went beyond term and she was admitted for induction of labour in July 2009. The CTG trace was normal to begin with, but became pathological. It was agreed by the obstetricians that the CTG trace was consistent with the cord being around the neck (as was found when the young boy was, eventually, delivered). As the day went on, the CTG trace had prolonged decelerations of up to 3 minutes.

The staff failed to recognise these abnormalities, and failed to arrange an emergency CS. It was admitted that this was negligent – but not causative. The observations at birth (Apgar scores and acidosis levels) were normal. Amazingly, Nilujan was unscathed by the prolonged episodes of cord impairment affecting oxygen supply.

Nilujan was born at 11pm on the 16th July. For the first 12 hours of Nilujan's life, the midwives fed him with bottles. Once mother had a chance to get some sleep, at about 2pm on the 17th, she began to breast feed. Nobody ever sat down and showed her what to do. Any observation by the midwives was done from a distance, at the end of the bed, as the midwives walked past. They accepted that Mrs Rajatheepan would have been unaware of the observations.

By the following morning, the 18th July, Mrs Rajatheepan was becoming more and more concerned. Her son was restless and upset (crying a lot). Feeding did not seem to relieve him. She did not know what was wrong. At 6.50 am on the 18th July, the midwives noted that Nilujan was restless. There were no subsequent entries which commented on feeding, or any note indicating concern. During this post-natal period, the midwives should have monitored Mrs Rajatheepan's feeding and advised her on the consequences of poor feeding. As the trial judge held:

> *The sad reality is that Mrs Rajatheepan did not in fact ever get any instruction on how to feed properly still less did not receive any instruction on what to look out for and what to do if feeding was unsuccessful*

It was common ground that the notes suggested Nilujan was feeding satisfactorily and that there was nothing to record any concerns. However, Mrs Rajatheepan's case that the contemporaneous noted failed to reflect the true

position. Her recollection was that, through the course of the 18th July, she pressed the help button twice. She walked to the midwives station on 2 or 3 occasions to seek help. But, the language barrier meant nothing happened. Her young age, lack of experience, the short time she had been in the UK and the stress of the situation prevented her from asserting herself. She was, as the judge found, *effectively ignored*.

At about 8 pm, her husband arrived from work, along with a friend to drive mother and baby home. They were concerned at the distress and discomfort and asked for a review, but were told that babies cry, and that there was nothing of concern. At about 10pm, they were discharged. After sitting in the car with a crying baby for 20 minutes, father and friend went back to the ward to ask for a review, but were sent away.

The following lunchtime, the 19th July, the community midwife attended and found Nilujan pale and floppy. A note recorded that he had been fed at 9pm prior to discharge from the Hospital. He was rushed back to Hospital where he was found to be hypertonic, pale and unresponsive. The ambulance staff recorded fits. Shortly after admission, he was diagnosed with hypoglycaemic brain damage. He has suffered catastrophic injuries.

The expert evidence eventually agreed that what had happened was 12-15 hours of poor feeding (or fasting as they called it) had led to depletion of Niujan's reserves of glucose. This is as important for a baby as oxygen.

The physiological effect of depleted glucose reserves is that brain cells begin to have insufficient energy to function – to send nerve impulses to other cells and to activate muscles. The baby begins to demonstrate subtle signs – irritability, lethargy and poor feeding. Over time, the signs become more obvious: fits and reduced consciousness.

If still untreated, the brain cells gave insufficient energy to sustain vital function – particularly the cell membranes which, by pumping, keeps sodium and calcium out, and potassium in. If there is insufficient energy to maintain cell membranes, sodium, calcium and potassium changes lead to cell injury, cell death and brain damaging hypoglycaemia.

This process could have been prevented by a "simple" feed. Through the early hours of the 19tth, this could have been breast or bottle feeding. As the hours progressed, the management might have been IV administration of glucose.

The experts agreed that the injuries would have been avoided if mother and son had been kept in Hospital. The changes described above would have been observed, recognised and the baby fed. It was agreed by the midwives that she should have been kept in if her evidence was accepted about her son's deterioration on Day 2 after delivery. The window of opportunity to avoid the damage completely ended in the early morning – but even a feed at 8-9 am would have avoided much of the injury.

It was also agreed that there needed to be effective communication. If Mrs Rajatheepan only had a few words of English, the staff should have used the Language Line facility to ensure that she understood.

At the trial of the action, there were a number of issues:

1) Was there effective communication? The Trust called no less than 15 witnesses of fact, who recalled that they able to communicate with Mrs Rajatheepan. Doctors and midwives signed witness statements that they were used to dealing with non-English speakers and were able to communicate effectively. We found these statements surprising:

a) Mrs Rajatheepan had very little English in 2018, even after many years living in East London.

b) The contemporaneous notes were littered with records of problems communicating, including the Defendant's own paediatric staff recording that mother could not speak English. When Nilujan was transferred to other Hospitals (including Great Ormond Street), the Hospitals always provided an interpreter or used Language line (a 3 way telephone service offering simultaneous translation).

c) Of the 15 witnesses called, most accepted that they had been unable to communicate anything but simple requests, and referred to using sign language and play-acting to convey such things as encouraging mother to drink water.

d) One of the midwives recorded that she had been able to go through a 112 page Discharge booklet written in complicated English in 20 minutes. We took one 4 line entry:

Sudden or very heavy blood loss and signs of shock, including faintness, dizziness, palpitations or tachycardia (when you become aware of your heart beating very fast)

The note continued that this could mean haemorrhage and required emergency medical attention. Mrs Rajatheepan was asked to read this small section, and could not understand it. We asked the midwife to show the judge how she had conveyed the information. The demonstration was baffling. It was not a surprise that

the judge rejected the midwife's evidence that she had been able to explain this document effectively.

2) Did any midwife sit down and advise Mrs Rajatheepan on how to feed and what to do if feeding was unsuccessful? The Trust's case rather shifted – they ended up saying that it wasn't necessary to do so, and a distant observation was sufficient.

3) Did Mr and Mrs Rajatheepan try and communicate their concerns with the midwives? This was a question of fact. The Hospital relied upon the notes. Everybody agreed that such a request should have been noted. The Trust argued that the absence of any record could be taken as a reliable indication that no such request was made.

The Trust placed heavy weight on the contemporaneous notes, and referred to Lord Pearce's speech in Onassis v Vergottis 1968 2 Ll Rep 403

> *It is a truism, often used in accident cases, that with every day that passes the memory becomes fainter and the imagination becomes more active. For that reason a witness, however honest, rarely persuades a Judge that his present recollection is preferable to that which was taken down in writing immediately after the accident occurred. Therefore, contemporary documents are always of the utmost importance.*

The Trust seemed not to recognise that Lord Pearce observations applied to their staff as well as the Rajatheepans, and their collective memory of effective communication flew in the face of most of the contemporaneous records of poor English, and poor communication.

The trial judge, HHJ McKenna sitting as a High Court Judge, accepted the parents' evidence. He found them witnesses of truth. The overwhelming weight of the evidence was against effective communication. Nilujan should have been reviewed, which meant that he should have been kept in Hospital. Accordingly, he found for Nilujan, with damages to be assessed.

This decision led to a torrent of on-line abuse of both the judge and the parents. I do not spend my time reading the comments sections of Mail Online, and even Mumsnet. But, having been told about them, wasted too much time reading the comments. The judge was criticised. There was racist abuse of the parents for not knowing that they had to feed their child (a shockingly inaccurate understanding of the true position). Britain and the NHS were said to be doomed by this decision.

I take the opposite view. It is greatly to the credit of this country that we provided sanctuary to the Rajatheepans. And that, when they were thought to have received poor medical treatment, public funds were made available through legal aid to support them in the investigation and pursuance of their claim against the Hospital. And immensely satisfying that they won.

Christopher Hough was instructed by Julie Aldred of Wiseman Lee for the Claimant

Sebastian Naughton was instructed by David Froome of Kennedys for the Defendant.

G v NHS Commissioning Board. Case Note Focussing on: (1) Erb's Palsy with Potentially Posterior Shoulder Dystocia. (2) NHS Resolution Approach to Settlement.

JUSTIN VALENTINE
ST JOHN'S CHAMBERS

The Claimant's birth in 1994 was complicated by shoulder dystocia. According to the Royal College of Obstetricians & Gynaecologists:

Shoulder dystocia is when the baby's head has been born but one of the shoulders becomes stuck behind the mother's pubic bone, delaying the birth of the baby's body. If this happens, extra help is usually needed to release the baby's shoulder.

Shoulder dystocia occurs in about one in 150 vaginal births and is associated, inter alia, with a large baby, a high maternal BMI and a long or induced labour. Shoulder dystocia must be resolved swiftly so that the baby can be born and he or she can start breathing.

A recognised complication of resolving shoulder dystocia is Erb's palsy, or brachial plexus injury, which is a paralysis of the arm caused by stretching of the upper group of the arm's main nerves. It is caused by a widening of the angle between the head and affected shoulder (imagine tilting the head to the left or the right, the damage thereby being sustained to the opposite shoulder) as the midwife or obstetrician pulls too hard on the baby's head in a lateral direction trying to free the baby's shoulder.

The McRoberts' procedure is now recognised as the standard procedure to resolve shoulder dystocia. This involves, inter alia, hyperflexing the mother's legs to her abdomen and the application of pressure on the lower abdomen (suprapubic pressure) so that the shoulder is pushed under the symphysis pubis.

In G's case it was noted that there had been shoulder dystocia but otherwise record-keeping was poor. At the date of G's birth, the McRoberts' procedure was well-known but the midwifery experts agreed that they would not have expected all units or all midwives and obstetricians to have used it. However, the trust had its own protocol which was not dissimilar to the McRoberts' procedure. There was evidence to demonstrate prima facie breach of the trust's own protocol in that there was no evidence of the application of suprapubic pressure.

G's Erb's palsy was assessed on the Mallet score as grade IV out of V (V being normal, I indicating no function). She was not able to elevate her shoulder fully or use the arm properly. She had surgery as a child but the symptoms were permanent and she was deemed by her orthopaedic expert to be disabled.

The two primary competing theories for Erb's palsy are excessive traction or injury sustained spontaneously by maternal forces. The matter has been dealt with a number of times by the High Court in recent years. For example, in *Sardar v NHS Commissioning Board* [2014] EWHC 38 (QB) the claimant suffered a right-sided brachial plexus injury. The experts were agreed in that case that if the right shoulder was posterior at birth then the injury was either due to maternal propulsive forces or non-negligent traction the reason being, according to this theory, that brachial plexus injuries are caused by the anterior shoulder impacting the symphysis pubic. In that scenario, the injury is caused by downward traction stretching the nerves of the shoulder impacting upon the symphysis pubis.

In Sardar, the issue was which shoulder was posterior and which anterior. Haddon-Cave J found that at birth the baby's injured right shoulder would have been the posterior shoulder and, therefore, the injury was caused by strong cervical contractions and/or impact with the sacral promontory (which is far less prominent than the symphysis pubis) and/or the sheer size of the baby.

A similar conclusion was reached in *Watts v Secretary of State for Health* [2016] EWHC 2835(QB). In that case the claimant sought to argue that his right injured shoulder was in the anterior position and that the injury was caused by excessive traction. However, the judge found that the right injured shoulder was in the posterior position and as in *Sardar* the injury was therefore more likely caused by maternal propulsion rather than excessive traction.

The judges in both *Sardar* and in *Watts* cited a passage from a 2008 paper by Draycott, Sanders, Crofts and Lloyd "A template for revising the strength of evidence for obstetric brachial plexus injury in clinical negligence claims" (Clinical Risk, 2008; 14: 96-100) in which the authors conclude:

> *Causation of obstetric brachial plexus injury is multifactorial; evidence suggests that while some cases are traction mediated, others may not be. There is growing acceptance in both the medical literature and case law that the propulsive forces of uterine contraction may play a part.*
>
> *The assumption that the presence of an injury is evidence that traction must have been applied is no longer valid. Injury may occur regardless of best efforts of the accoucheur. Diagnostic traction is acceptable and Claimants now need to demonstrate factual evidence of the use of excessive force or other inappropriate management to succeed in arguing negligent management.*

As noted, in G's case record-keeping was poor. However, the obstetric experts agreed that on the balance of probabilities the left, injured shoulder was in the posterior position at the beginning of labour. G's obstetric expert opined that it could not be assumed that the shoulder would still be posterior as the delivery progressed especially in a pelvis with a degree of cephalo-pelvic disproportion whereas the Defendant's expert was of the view that at birth her injured left shoulder would have remained posterior.

G's orthopaedic expert, however, was firmly of the view that maternal propulsive forces could not explain permanent injury to the brachial plexus. He observed that maternal propulsive forces would help expel the shoulder being held up and could not do anything to the head and neck interface once the head is delivered. He cited an article to support that view; Mechanism of Neonatal Brachial Plexus Injuries: Leslie Iffy, Journal of Women's Health Care 2014 3:2.

Further, it appeared that insufficient attention had been given to more recent evidence of avoidance of brachial plexus injury: "Prevention of brachial plexus injury – 12 years of shoulder dystocia training: an interrupted time-series study" Crofts et al BJOG, 2016. 123(1): p. 111-8. None of the 17,039 babies in the last cohort studied suffered permanent brachial plexus which suggests that if shoulder dystocia is properly managed permanent injury is entirely avoidable. This throws into question the maternal forces theory in relation to permanent brachial plexus injuries such as that suffered by G.

G's mother's evidence as to the use of excessive traction was ambivalent. She recalled being told to push and the midwife saying "Right, let's go for it" but was unable to confirm excessive traction or whether G's injured shoulder was posterior or anterior at birth.

G's claim was presented in the region of £1 million, the bulk of which (over £700,000) being loss of earnings presented as a Ogden 7 style handicap on the labour market award; G achieved a 1st class degree and her earnings expectation was high. The Defendant's Counter Schedule totalled approximately £23,000. Nothing was allowed for loss of earnings on the basis that a professional woman would be unlikely to suffer the sort of losses associated with disability pursuant to the deduction for contingencies other than mortality approach.

A joint settlement meeting was held in November 2017. The Defendant sought to persuade G to drop her case citing the case law referred to above. Towards the end of the day an offer was made by the Defendant in the region of £40,000 plus costs and finally £120,000 costs and damages (costs were in the region of £200,000 to trial). No settlement was reached. The trial was listed for April 2018.

In the interim a schedule of issues was prepared for the orthopaedic experts to prepare their joint report. This included addressing the issue raised by G's orthopaedic expert that the maternal propulsive theory could not explain brachial plexus injuries which issue the Defendant's expert had not previously dealt with.

In the event, the joint orthopaedic report was put on hold pending a solicitor and client-only mediation in January 2018. Settlement was achieved in the sum of £135,000 plus costs.

Practice Points:

1. Cases where the evidence points to posterior brachial plexus injury are likely to be robustly defended. The obstetric literature appears to be in a state of flux. Orthopaedic evidence can be utilised to bolster the contention that the maternal propulsive theory is unsustainable.

2. It appears that the NHS were seeking to avoid setting a precedent where there was sufficient evidence for the trial judge to reject the maternal propulsive forces' theory on the basis of the orthopaedic evidence. In that context the robust stance taken at the JSM was, in retrospect, tactical.

Counsel for the Claimant: Justin Valentine

Solicitors for the Claimant: Lamb Brooks, Basingstoke

The Link Between Fetal Growth Restriction and Stillbirth

HELEN HAMMOND
SENIOR ASSOCIATE
PENNINGTON MANCHES LLP

Historically, most stillbirths were considered 'unexplained'. In recent years medical research has shown that most stillborn babies had no structural abnormalities and were small for gestational age (SGA).

A baby who is small is therefore at a much higher risk of being stillborn and, accordingly, measures have been put in place to try to identify these babies during pregnancy.

Babies who are experiencing growth restriction are referred to as FGR. Only around 30-50% of babies who are SGA are growth restricted, with the others presenting as appropriate for maternal size and ethnicity. The likelihood of FGR is higher in severe SGA infants. However, SGA babies are at an increased risk of compromise and stillbirth, but this risk is greatest in those who fall into the FGR group.

Identifying a baby with fetal growth restriction

The starting point for considering whether a stillbirth has resulted from growth restriction is the birth-weight, as a baby is classed as SGA when they present at less than the 10th centile. Severe SGA is considered where the estimated fetal weight is less than the 3rd centile. Historically the focus was on babies with a birthweight below 2.5 kilos and population based centiles were used. Customised centiles taking into account maternal characteristics such as maternal weight, height, parity and ethnic group, as well as gestational age at delivery and infant gender are more effective at identifying small babies at higher risk of compromise and/or stillbirth, and should now be used.

Typical presentations seen in a baby who has died as a result of growth restriction are:

- Low birth weight or birthweight low for gestational age (as above);
- Asymmetrical growth restriction;
- Oligohydramnios;
- Thick meconium on delivery (likely to be suggestive of oligohydramnios).

The asymmetrical growth restriction will present in a noticeably larger head than body, as the baby will redistribute circulation towards the head at the expense of the body when this is compromised.

Problems with care

In 2016, a Confidential Enquiry found that screening for small babies was one of the most frequent areas of suboptimal care associated with stillbirth before labour.

Most frequently the issues that arise with the delivery of care are:

- Failing to identify a woman as being at high risk of FGR at booking (for example, not noting a previous SGA baby);
- Failing to act on a blood test result at 12 weeks suggestive of the mother being at risk of developing problems with the placenta;
- Delays between identifying potential growth restriction and referring for or undertaking a growth scan to check baby's size;
- Failing to act on findings of fetal weight below the 10th centile at ultrasound scan;
- Incorrect plotting of the fetal weight on the growth chart, leading to false reassurance of the baby's growth.

The basic level of care and identifying errors

There is not yet a single test in existence to identify every baby at risk of developing FGR, therefore a mixture of consideration of risk factors and monitoring the clinical presentation are used to identify SGA babies.

The main reference document for considering the standard of care is the RCOG Guidelines on '*The Investigation and Management of the Small-for-Gestational-Age fetus*'. This clearly outlines that all women should be assessed at booking for risk factors for a SGA fetus/neonate to identify those who require increased surveillance. For example, women who have previously had a SGA baby

have at least double the risk of a subsequent SGA infant and this risk is increased further after two SGA births.

The known major risk factors for a SGA infant are:

Maternal age 40 or over	Maternal smoking of more than 11 cigarettes per day
Cocaine use	Daily vigorous exercise
A previous SGA baby;	Previous stillbirth
Maternal SGA	Chronic hypertension
Diabetes with vascular disease	Renal impairment
Antiphospholipid syndrome	Paternal SGA
Heavy bleeding	Echogenic bowel
Pre-eclampsia	Severe pregnancy induced hypertension
Unexplained antepartum haemorrhage	Low maternal weight gain
PAPP-A < 0.4 MoM at 12 weeks	

In these cases a prompt referral for serial ultrasound measurement of fetal size and assessment of wellbeing with umbilical artery Doppler is required.

When presented with an SGA baby, who was stillborn before delivery, it is important to look back at the early pregnancy care to ensure that none of these factors, which would have led to increased monitoring, have been overlooked.

The clinical management in place to identify a SGA baby during the pregnancy is:

- Use of customised growth charts (there is some controversy about whether Gestational Related Optimum Health (GROW) software should be used but if it is in use in the Trust then arguably it should be adhered to);
- The 20 week anomaly scan – the baby's weight will be estimated during this assessment and can be plotted on the customised growth charts to highlight if it falls below the 10th centile;
- Serial measurements of symphysis fundal height (SFH) at each antenatal appointment from 24 weeks of pregnancy;

Women with a single SFH, which plots below the 10th centile or serial measurements, which demonstrate static or slow growth by crossing centiles, should be referred for ultrasound measurement of fetal size.

It is also important, therefore, to examine maternity records to ensure that SFH has been plotted correctly and any static growth has been acted upon correctly.

Maternal complaints of reduced fetal movements should also be closely reviewed, as an FGR baby will gradually move less as it becomes increasingly compromised, but there may still be time to deliver the baby safely if this presentation is acted on correctly.

Management of the pregnancy and delivery

Once a baby is found to be presenting as SGA it needs vigilant monitoring and this will include the use of repeated ultrasound scans, monitoring of the amniotic fluid index and Doppler for surveillance.

In FGR fetuses there will be a gradual trend towards increasing resistance in the umbilical artery, reducing liquor volume and abnormalities on CTG. The decisions made as a result of these findings will vary depending on the gestation of the baby but it is reasonable to offer delivery in SGA infants at 37 weeks gestation, though this may be required at an earlier stage if clinically indicated.

Early admission is recommended in women in spontaneous labour with a SGA fetus in order to instigate continuous fetal heart monitoring.

Practical application

I have experience of a number of cases involving FGR, involving the following issues:

- Incorrect plotting of the growth on the chart;
- A failure to act when the baby was found to be below the 10th centile on ultrasound;
- a failure to act on a crossing of centiles on the growth chart, and
- a failure to act on abnormal CTG results.

These are largely avoidable human errors with devastating results.

Case example

C was classified as a low risk pregnancy and did not have any risk factors for SGA. At 28 weeks the SFH was plotted as 28cm, showing on the 90th centile. At 31 weeks the SFH was 31cm, which demonstrated that the SFH had dropped to the 49th centile, and this was plotted on the customised growth chart. Evidence obtained confirmed

that this change should have initiated a referral for an ultrasound scan.

In reality, such a referral was not made and C continued to 38 weeks pregnant when she went into spontaneous labour. On admission to hospital, the baby's heartbeat could not be located and intrauterine fetal death was confirmed.

The baby was found to have a body weight on the 3rd centile with its head significantly larger. The finding was of severe asymmetrical growth restriction with the baby likely to have died in the final week before delivery.

We are presenting a case that with referral for an ultrasound scan and obstetric review, the baby's SGA status would have been identified at around 32 weeks gestation and serial ultrasound scanning would have commenced, leading to safe delivery of the baby well before 38 weeks gestation.

Conclusion

FGR usually presents as a gradually deteriorating picture, requiring ongoing surveillance. If it can be demonstrated that a baby should have been monitored for SGA at any stage during the pregnancy, there is a reasonable chance that causation will be proven, given that the focus of the monitoring will have been on the optimum time to effect safe delivery.

A short commentary on Darnley v Croydon Health Services

TARA O'HALLORAN
OLD SQUARE CHAMBERS

OLD SQUARE CHAMBERS

Health authorities owe a non-delegable duty to establish an adequate system of care in much the same way as they owe a duty to provide competent staff and proper equipment. However, it is not always obvious whether a duty should be imposed in any given circumstance and, if so, what the scope of that duty should look like.

In *Darnley v Croydon Health Services*[1], the Court of Appeal held (McCombe LJ dissenting) that it was not fair, just or reasonable to impose a duty on receptionists in A&E departments not to provide inaccurate waiting times to patients. The case involved a receptionist who told a patient, presenting with a head injury, that he would have to wait up to 4 to 5 hours to be seen when he should have been told that a triage nurse would see him within 30 minutes. He decided to leave the hospital after 19 minutes, but was later rushed back to hospital where an extra-dural haematoma was discovered. The Claimant was left with hemiplegia.

Before reaching his conclusion, Jackson LJ stated that *'the question whether the law of tort imposes a duty of care in any given situation is not a binary question admitting a simple yes or no answer. It is necessary also to consider the scope of the suggested duty and the range of consequences for which the defendant is assuming responsibility or is to be held responsible'* [45]. Jackson LJ did not accept that, by giving an indication of waiting time, the receptionist was assuming responsibility for the catastrophic consequences the patient might suffer if he simply walked out. Providing this information was not part of her core function and to impose such a duty would add another layer of responsibility for clerical staff; lay fertile ground for litigation about who said what to whom in A&E waiting rooms; and potentially oblige receptionists to keep patients abreast of fluctuating waiting times. Sales LJ also observed that receptionists' pay did not suggest such an assumption of legal responsibility.

There is of course no principle of law that precludes administrative staff from owing a duty of care to patients.

In *Darnley*, the Claimant relied on *Kent v Griffiths*[2], which suggests that clerical staff who accept emergency calls on behalf of the ambulance service owe a duty to take reasonable care to pass on correct information and can be liable for injury if they fail to do so. But the majority in *Darnley* drew the following distinction: paramedics and patients rely on correct information from the ambulance service to tell them where to go - for example, what address the ambulance should attend or whether the patient should arrange alternative transport to the hospital. Inaccurate waiting times given by the ambulance service could negligently induce a patient to wait in the wrong place for medical assistance. The patient in A&E is in the right place for medical treatment and will receive it if he or she simply waits.

But conclusions may also differ depending on whether focus is placed on the individual or on the system. In *Darnley*, McCombe LJ (dissenting) could not accept that the functions of the hospital should be divided up into those of receptionists and hospital staff. He felt that the duty of the hospital has to be considered in the round and, if the hospital has a duty not to misinform patients, the duty is not removed by interposing non-medical staff. He considered that it would not have been beyond the hospital's reasonable resources to tell patients, by way of leaflets if nothing else, that head injuries would be normally assessed by a clinician within 30 minutes.

In *Macaulay v Karim and Croydon Health Services NHS Trust*[3], the Claimant was also given misinformation by a receptionist and decided to leave the hospital before clinical investigations had concluded. The Claimant, who had been seen by the triage nurse and two junior doctors earlier in the day, asked the receptionist what was happening and was told there was no record of any referral of him to another doctor, suggesting he was not due to be seen by anyone else. The Claimant decided to leave the hospital when important blood tests were outstanding, and no attempts were made to call him back.

1 *[2017] EWCA Civ 151 – on appeal and due to be heard by the Supreme Court in June 2018.*

2 *[2000] 2 W.L.R. 1158*

3 *[2017] EWCH 1795 (QB)*

Foskett J held that, but for the negligent system, blood tests would have been performed earlier and the Claimant would have stayed for further investigation. The hospital should have made attempts to call him back once he left and failure to do so amounted to breach of duty. Foskett J's general impression was that the Claimant had "slipped through the net" and classified what had occurred as a "system failure" rather than any breach that could fairly be attributed to an individual [166]. Notably, the Claimant's decision to leave the hospital did not frustrate his claim and it was not an unreasonable burden on the hospital to impose a duty to make contact with him once he had left.

The facts of *Macaulay* are self-evidently different to *Darnley*. The Claimant in *Macaulay* had been in the system for the best part of the day: he had been seen by a number of clinicians and there had been considerable opportunity to chase up his blood tests and to ensure that he was fully aware of the need to stay in hospital until they had been obtained. The Claimant left the hospital under the impression that no further action was due to be taken in respect of his care and/or treatment. In Darnley, the Claimant had not engaged with the system in the same way: he knew that clinicians had not assessed or treated his injury, but decided to leave after 19 minutes without informing a member of staff.

It will be interesting to see how the Supreme Court approach *Darnley*; in particular, how they balance encouraging better practice in A&E departments without imposing an unreasonably high burden on hospitals that are already struggling to cope. It may be that hospitals can hand out a leaflet (or put up signs) which inform patients that there is a triage system; that head injuries will normally be assessed within 30 minutes; and that waiting times may fluctuate but patients (who do not feel well) should not leave the department without informing a member of staff. This could improve the system without encouraging any form of clinical assessment from the receptionist; avoid the need to go in search of patients to correct fluctuating waiting times; and educate the patient about what they can expect from the system and what is expected of them. If hospitals can show that leaflets or signs were available, this may also control Jackson LJ's concern about any rise in litigation about who said what to whom in A&E departments. By the same token, patients will need to take responsibility for their own care and for engaging with a system that is free and available to them – a system that may well have capacity to be improved without creating new heads of liability for NHS trusts.

It will be interesting to see how the Supreme Court address these issues but, for now, patients will need to properly engage with the system of care whilst those who do their best to participate but slip through the net, will find some comfort and redress in litigation.

A Cautionary Tale for Experts: Understand your Duties and Stick to your Expertise

PAUL SANKEY
PARTNER
ENABLE LAW

A recent Court of Appeal case[1] is a cautionary tale on how not to give evidence. The expert failed to comply with his duties and gave evidence on matters outside his expertise. The court was highly critical of his conduct.

The case concerned an expert in banking. His evidence was governed by the Criminal Procedure Rules. However, the same duties apply to experts reporting on civil claims under the Civil Procedure Rules and there are valuable lessons for medical experts.

Mr Rowe was called as an expert in a prosecution brought by the Serious Fraud Office (SFO). A number of Barclays Bank PLC employees were accused of conspiracy to defraud by dishonestly rigging the LIBOR (London Inter-Bank Offered Rate – which is the interest rate at which banks borrow from each other). One of those accused was Mr Pabon.

Mr Rowe had previously been called as an expert in LIBOR trials twice before. He then gave evidence first at the trial of Mr Pabon and then at a retrial. He was instructed to explain various matters of banking practice. These matters were within his expertise. He also ended up giving evidence about short term interest rates (STIR), a matter which was not.

During the retrial what the Court described as 'dramatic developments' took place in relation to his evidence.

1. The Defence produced some emails from Mr Rowe. These showed that parts of his report had been prepared by a colleague, Mr O'Kane. Mr O'Kane was a partner at Mr Rowe's firm and a Professor of Pricing and Risk Financial Derivatives. Mr Rowe had not acknowledged Mr O'Kane's role in his report or that he had been assisted by anyone else.

2. The Defence also produced emails showing that Mr Rowe had consulted 3 other experts and sent them extracts from the case papers. Over the month prior to trial, he had exchanged about 60 text messages with one of them.

3. At the end of the first day of his evidence during the retrial, the judge gave him a standard warning not to discuss his evidence with anyone overnight. Within an hour, Mr Rowe had nevertheless approached another expert to assist him, asking for 30 minutes of paid work. He exchanged 26 texts or emails. In one of them he confessed, 'I don't know the usual trades STIR people put on but I am learning'. In a subsequent message he added, 'It doesn't help when I have to explain a few emails and look knowledgeable'.

4. He was cross-examined as to whether he had read the Criminal Procedure Rules when he signed his report. He responded, 'I don't think I could have read them fully'. In response to a supplementary question he answered in rather vague and somewhat unimpressive terms, 'I'm pretty sure I glanced at something'.

5. Confronted with having approached other experts to explain issues, he asked, 'So what else am I supposed to do as an expert?' This may have been intended as a rhetorical question but as counsel for the Defendant pointed out, the right answer would have been to say that it was not his field and advise the SFO to approach another expert.

6. He claimed to have indicated to the SFO that he was not an expert in STIR in contradiction of what the SFO's principal investigator had said in court earlier.

When summing up at the retrial the judge scathing in his comments to the jury,

> *'...you may have formed a judgment that he knew very little about the duties of an expert...he seems to have been perfectly content to sign a standard declaration in which he declared that he had read the Criminal Procedure Rules which govern his conduct as an expert, both before trial and in giving evidence, and*

1 *R v Pabon [2018] EWCA Crim 420*

the booklet on his duties of disclosure without doing anything really to familiarise himself with either of these documents'

Mr Pabon appealed against his conviction. The Court of Appeal heard his appeal in November 2017 and the judgment was reported in March 2018.

The appeal focussed on Mr Rowe and his evidence. It was in fact unsuccessful because The Court of Appeal concluded that the obvious shortcomings in his evidence nevertheless did not render the conviction unsafe. However, it was highly critical of Mr Rowe as an expert. Experts giving evidence outside their area of expertise was not just of no use but 'corrosive of the trust placed in such witnesses'. Mr Rowe had 'signally failed to comply with his basic duties as an expert'. He had signed declarations of truth in his report and claimed to have understood his duties despite knowing that he had failed to comply with those duties. At best this disregard of his duties was reckless. He failed to disclose Mr O'Kane's role and failed to inform either the SFO or the court of the limits of his expertise. He gave evidence on matters (in particular STIR) which were beyond those limits. He flouted the judge's instruction not to discuss his evidence whilst in the witness box. 'We take a grave view of Rowe's conduct; questions of sanction are not for us, so we say no more of sanction but highlight his failings for the consideration of others'.

The judgment concluded with this comment:

'...there is no room for complacency and this case stands as a stark reminder of the need for those instructing expert witnesses to satisfy themselves as to the witness' expertise and to engage (difficult though it sometimes may be) an expert of a suitable calibre'.

The lesson from this story is: understand your duties as an expert as set out in the court rules; comply with them; and do not give evidence on matters outside your expertise.

Paul Sankey is a solicitor and partner at Enable Law, specializing in clinical negligence claims for patients.

Inquest Update on Case Law May 2018

ANEURIN MOLONEY
HARDWICKE

SCOPE OF INQUESTS

R (on the application of Julie Hambleton and others) v The Coroner for the Birmingham Inquests (1974), Reilly, West Midlands Police, and Davis [2018] EWHC 56 Admin

Facts: The senior Coroner in Birmingham ruled that the inquests into the 1974 Birmingham pub bombings should be resumed. Preliminary hearings determined that these would be Article 2 inquests, however, the investigation into the identity of the suspected perpetrators would not be within scope. This decision was judicially reviewed by the families.

Issues: Scope, Article 2, criminal/civil liability

Held: The Coroner did not ask himself the right question. There was no discretion on whether or not to investigate the circumstances of death. The correct formulation was therefore 'whether the factual issue of the identity of the bombers (and those that assisted them) was sufficiently closely connected to the deaths to form part of the circumstances of death.'

More general guidance on determining the scope of inquests was given – see paragraph 35.

The engagement of Article 2 did not of itself require the identity of the perpetrators to be within scope.

Note: The Coroner has no discretion on whether to investigate matters that form part of the circumstances of death.

R (on the application of Donald Maguire and others) v Assistant Coroner for West Yorkshire, Cornick and other Interested Parties [2018] EWCA Civ 6

Facts: A teacher was murdered by a 15 year old pupil. Police interviewed 9 other pupils who all had contact with the murderer on the morning of the killing. Some were seemingly aware that he had a knife with him that day. The murderer told some of the pupils that he was going to kill the teacher, but all thought it was bravado. This was an Article 2 inquest. The Coroner decided not to call or further question the other pupils, and had weighed the usefulness of their evidence against the potential adverse harm that they might suffer in revisiting events. This decision was judicially reviewed.

Issues: Witnesses, scope, Article 2

Held: The evidence of the pupils fell within the scope of the inquest, but only to a small extent. However, their evidence would be of very limited value. There were no school policies on which to question the pupils. The Coroner's approach was correct.

R (on the application of LF) v HM Senior Coroner for Inner South London and Kings College Hospital NHS Foundation Trust [2017] EWCA Civ 31

Facts: A woman with a severe mental impairment died in ICU. The Coroner determined that an inquest would be held without a jury, on the basis that the death did not occur whilst the deceased was in state detention.

Issues: Scope, deprivation of liberty, deaths in state detention, Article 2

Held: There was no deprivation of liberty or state detention. Applying ECHR law, the patient was being treated for a physical illness, and the treatment was the same as it would have been for a person without the patient's mental condition. The root cause of any loss of liberty was the physical condition, not restrictions imposed by the hospital.

The patient was free to leave within the meaning of the acid test' of *Cheshire West.*

There was no Strasbourg authority on point, and this was not an ECHR case in any event.

Note: The position is likely to be different in the case where a MHA 1983 Order or Best Interests Order under MCA 2005 is made.

STILLBIRTHS / ANONYMITY ORDERS

R (on the application of T) v HM Senior Coroner for the County of West Yorkshire [2017] EWCA Civ 318

Facts: A woman had given birth at home. It was not known whether the baby was born alive. A week after the birth, the woman brought the body into hospital in a shoe box. Police investigated the matter and eventually decided not to charge the woman, citing evidential difficulties in proving whether the baby was born alive.

An inquest was opened. Following the first hearing, press reported the identities of those involved, and the apparent facts. The family applied for an anonymity order but this was refused. The family judicially reviewed the Coroner's decision to hold an inquest, and to refuse to grant an anonymity order.

Issues: Stillbirths, jurisdiction, scope, anonymity orders

Held: So long as a Coroner suspected that the s1(2) matters were in play, they were permitted to investigate the death of a baby who may or may not have been born alive.

There was no requirement for a Coroner to determine the question of status on birth as a preliminary issue; this was one of the essential purposes of this inquest.

It was appropriate to refuse the anonymity order. There were no threats to the family, and their embarrassment was not a sufficient exception to open justice.

Note: The Civil Partnerships, Marriages and Deaths (Registration etc) Bill, if enacted, is likely to bring stillbirths under the jurisdiction of Coroners.

COSTS OF INQUEST

Douglas v Ministry of Justice and Care UK [2018] EWHC B2 (Costs)

Facts: An 18 year old prisoner committed suicide. The Prisons and Probation Ombudsman investigated and found that the prisoner should have been returned to the Young Offenders Institute he had been held at before sentencing. A number of other failings were identified.

A claim form was issued before the expiry of the Human Rights Act limitation date. The claim was stayed pending the outcome of the inquest.

3 pre-inquest review hearings were held. After the third PIR, but before the inquest was heard, a 'full admission' of liability was made by both defendants.

The inquest hearing lasted 3 weeks, and findings were made beyond than those identified by the Ombudsman's report. The claim settled for £13,500 following the inquest, and without Particulars of Claim having been served.

The Defendants disputed the Claimant's costs for representation at the Inquest.

Issues: Costs, Article 2, admissions, detailed assessment

Held: The admission of liability was full and unqualified, including all ECHR breaches. Quantum and 'vindication' were the only outstanding matters, but there was little distinction between the two. Any further failings that the inquest may have exposed would make little difference to quantum. There was no basis for expecting that anything would emerge from the inquest that would change what was likely to be a modest award of damages. It was possible to have settled the claim prior to the inquest.

Notwithstanding those findings, some time for attendance and representation was held to be recoverable. Whilst the new failings did not add significantly to quantum, they were 'not irrelevant'.

Work relating to (i) disclosure and witness evidence of the defendants (but not other parties), (ii) making submissions to inform or persuade the Coroner to reach a particular conclusion, and (iii) receiving the jury's conclusion – was recoverable.

Work relating to (i) apportionment of liability, (ii) general procedural and housekeeping matters of the inquest, (iii) the Coroner's summing up, and (iv) waiting for the jury's conclusion – was not recoverable

The judgment only deals with recoverability of attendance in principle, and not the reasonableness and proportionality of the costs claimed.

Note: Unlike (most) negligence claims, the seriousness of the breach(es) influences the Article 2 award of damages. Therefore quantum had not been entirely settled by the pre-action admissions. The outcome may well have been different if this was not an Article 2 inquest and/or the claim proceeded only in negligence.

PROFESSIONAL NEGLIGENCE

Shaw v Leigh Day [2017] EWHC 825 (QB)

Facts: A clinical negligence claimant instructed solicitors to represent her at an Article 2 jury inquest into her father's death. No adverse findings were made against the Trust or the surgeon. Judicial review of the inquest findings was sought and eventually dismissed. The clinical negligence

claim was stayed throughout the process of the judicial review. The client/solicitor relationship broke down before the judicial review proceedings were concluded.

The claimant instructed new solicitors and the stay was lifted.

A professional negligence/breach of contract claim was issued against the former solicitors shortly after the lifting of the stay. The claim included an allegation that certain matters should have been raised at the inquest. That claim was stayed pending the outcome of the clinical negligence claim.

Following further disclosure, the defendants in the clinical negligence claim consented to judgment being entered against them. Damages were awarded in the clinical negligence claim (see *Shaw v Kovac and University Hospitals of Leicester NHS Trust [2017]* EWCA Civ 1028 – no damages for loss of patient autonomy).

A district judge struck out the professional negligence claim on the basis that, if the claimant established the pleaded facts, she would recover only nominal damages. It was also held that there were not a real prospect of proving that the contract was within the category of exceptional cases in which damages for distress could be recovered. Mrs Shaw appealed against the decision to strike out her claim.

Issues: Solicitor/client duties, retainer, negligence, breach of contract, damages

Held: It is possible for damages for distress to be awarded for breaches of contract. This includes contracts for legal services. The solicitor/client contract for representation at inquest was concerned with ensuring that the circumstances relating to the father's death were investigated so far as possible.

There were real prospects of persuading a trial judge that an important object of the contract was to obtain peace of mind/closure, that the contract had been breached, and of recovering damages for distress.

It was also held that even if the claim was only for nominal damages – and the distress element would be worth more than nominal damages if proved – that this was not a valid reason to strike out the claim. A claim for nominal damages may still be brought on reasonable grounds, and it would not be an abuse of process.

QUASHING, RESUMING, AND RE-OPENING INQUESTS

R (on the application of Muhammad Silvera) v HM Senior Coroner for Oxfordshire, The Chief Constable of the Thames Valley Police, and Oxford Health Hospital NHS Foundation Trust [2017] EWHC 2499 (Admin)

Facts: The deceased and her daughter both had mental health issues, and both were under the care of the Trust. There had been a number of threats and actual violence from the daughter to the mother, carers and police officers. This resulted in the daughter being admitted to the Trust's hospital under Section 2 of the Mental Health Act 1983. After 2 days, she escaped and went back to the family home. The responsibility to return the patient is that of the Trust, but police said they would assist. After 10 days, police and the Trust staff returned the daughter to hospital, where she was violent.

5 days after a violent outburst, a consultant decided that she did not meet the Section 3 criteria and discharged her to an open ward as an informal patient. She stopped taking her medication and absconded the following day. Ward staff called the police and informed them that she was unwell and psychotic and *"might do something..... maybe she is holding mum hostage....."*

Police attended the address, only for the daughter to assure them she was okay. Police advised the Trust that they would assist if she threatened their staff. 5 days later, the grandmother called police to say that she had not heard from the Mother. Police went back and found the mother dead, with the daughter in the house.

The inquest was adjourned pending the outcome of the criminal investigation. A root cause analysis report and domestic homicide review were undertaken in private. In 2013, the daughter pleaded guilty to manslaughter on the grounds of diminished responsibility. She was made the subject of a hospital order and was detained in a secure mental health hospital. She died in 2014 from a DVT.

The son applied to the Coroner to resume the inquest. The Coroner refused, stating that the facts of the death had been *"adequately aired in public"* by the criminal proceedings, and the 2 inquiries.

Issues: Article 2 investigative duties, irrational act of Coroner, duty to hold or reopen inquest

Held: Where criminal proceedings and/or other inquiries have been held, the Coroner may decide that the matter has been fully investigated. The test is whether the Senior Coroner considers that there is sufficient reason for resuming the inquest. The early guilty plea and private inquiries did not satisfy the Article 2 or common law requirements for investigating the death.

Note: It will be unusual for an inquest to be held or resumed after completed criminal proceedings, but where Article 2 is engaged (as was the case in the instant

case), a full inquest is likely to be required unless there has been a criminal trial with cross examination of witnesses.

Re HM Senior Coroner for the Eastern Area of Greater London v Whitworth and Kovari [2017] EWHC 3201 (Admin)

Facts: 2 bodies were found in a churchyard. Inquests were held 1 year after the deaths, with open conclusions. Following the inquests, a man was convicted of murdering the 2 victims.

The Coroner applied under Section 13 of the Coroners Act 1988, to quash the original inquests and hold fresh inquests in light of the evidence gathered in the criminal proceedings. The test is whether a further inquest is necessary or desirable in the interests of justice.

Issues: Ordering fresh inquests, criminal proceedings, new evidence, interests of justice

Held: There was no criticism of the Coroner for not being aware of the evidence obtained by the criminal investigation. It was plainly necessary, desirable, and in the public inquest to order fresh inquests. The original inquests and conclusions were quashed.

Mueller v Area Coroner for Manchester West [2017] EWHC 3000 (Admin)

Facts: An order was sought quashing the inquest, and ordering a fresh investigation into the death of the applicant's wife. The deceased, who had long term mental health issues, committed suicide. Mental health professionals had been alerted to concerns shortly before her death.

An inquest was opened. The parties consented to a conclusion of suicide, to read a summary of the evidence, and that an inquest could be held without calling witnesses to give oral evidence. The summary of the evidence, included a summary of the lengthy suicide note which referred to not trusting the husband with other women.

After the inquest, articles were published suggesting that the deceased committed suicide as she believed that the husband was having an affair. The husband sought to quash the original inquest on the basis that he wasn't told of his right to challenge the summary of the evidence.

Issues: Ordering fresh inquests, interests of justice, evidence to be read

Held: The conclusion was not challenged, and whilst the applicant had cause to be aggrieved, it was not in the interests of justice to quash the conclusion and order a fresh inquest.

Wider guidance was given:

In clear cases, Coroners engaging with families to attempt to deal with an inquest without family or witnesses needing to attend, was to be welcomed. Care should be taken in what is to be read into the record of the inquest, and to explain the effect of this to all concerned.

R (on the application of Heinonen and Sawko) v Coroner for Inner South District of Greater London [2017] EWHC 1803 (Admin)

Facts: A post-mortem examination was undertaken after a person died of a rare brain tumour. The pathologist identified the deceased by name bands on the body, as well as a physical description. The family were concerned that some physical attributes recorded in the report did not match the deceased. The Coroner obtained information from the hospital as to how the wristbands came to be placed on the body, and accepted the identification by the pathologist. The Coroner refused the family's request to investigate.

Issues: Coroners' powers, identification

Held: The application for permission to bring judicial review proceedings was refused. Whilst there were legitimate concerns about the post-mortem findings, it was not within the Coroner's statutory powers to investigate. There was no reason to suspect that the deceased died an unnatural death. It was not arguable that the Coroner's refusal to order further investigation was *Wednesbury* unreasonable. The decision would have been the same even if full information had been available.

ARTICLE 2

Lopes de Sousa Fernandes v Portugal (Application no. 56080/13) (ECtHR Grand Chamber, 19 December 2017)

Facts: In 1998, a man died from meningitis following a polypectomy. There were concerns as to whether there was medical negligence in meningitis being contracted, diagnosed, and treated. In the diagnosis and treatment, there was a concern as to a lack of co-ordination between ENT and A&E.

In 2015, the ECHR gave a judgment indicating that merely negligent errors of judgment and communication could engage Article 2.

Issues: Article 2, substantive obligations, procedural obligation

Held:

Substantive obligations**:**

Mere medical negligence did not engage Article 2; only system errors would breach the general duty imposed by the substantive aspect. The lack of co-ordination between ENT and A&E did not amount to a system error. There was no denial of treatment within the meaning of the operational duty.

Procedural obligations:

Whilst the fact that the regulatory/disciplinary proceedings took over 4 years did not in itself render the proceedings an inadequate investigation, this, coupled with the fact that the proceedings were only on the papers, meant that this was not effective redress for Article 2 purposes.

The limited scope of the criminal proceedings in this case did not provide adequate Article 2 redress. The fact that the criminal proceedings lasted almost 7 years would also render it ineffective.

Civil proceedings for damages lasted 9 years, and considered only the time and direct cause of death. This was also ineffective for Article 2 purposes.

Note: There is a greater duty for a wider ranging investigation to be held where there is reason to suspect negligence.

REGULATION 28 'PFD' REPORTS

R (on the application of Siddiqui and Paeprer-Rohricht) v Assistant Coroner for the Eastern Area of Greater London Administrative Division CO/2892/2017

Facts: An inquest was held, following which the Coroner made a Regulation 28 report addressing concerns as to perceived shortcomings in the GPs' systems for following up discharge summaries. The shortcomings were not causative of the death, but the Coroner was concerned that they may put other lives at risk.

Following the report, the GPs provided information demonstrating that the issue was isolated only to the deceased's case. However, the Coroner did not withdraw the report. The GPs sought to challenge the decision to issue a PFD report by judicial review.

Issue: Challenging Regulation 28 reports

Held: Permission was not given to bring judicial review proceedings. The appropriate mechanism for correcting any mistake of fact was to respond to the report, not to launch a judicial review. The Coroner had no power to withdraw the report once it had been made.

Note: Judicial review is not the appropriate mechanism by which to challenge a PFD report.

FATAL ACCIDENTS ACT

Smith v Lancashire Teaching Hospitals NHS Foundation Trust and Lancashire Care NHS Foundation Trust and The Secretary of State for Justice [2017] EWCA Civ 1916

Facts: Fatal Accident Act Claims were brought by a surviving partner against NHS Trusts. The deceased and the partner had lived together for 11 years as man and wife, but they did not marry. The claims against the Trusts settled, and the Secretary of State for Justice was brought in as a third defendant for the bereavement award to be pursued. It was argued that Section 1A of the Fatal Accidents Act should be interpreted as extending to a cohabitee of at least 2 years, or otherwise to be declared incompatible with ECHR Articles 14 and 8.

Issues: Bereavement award, ECHR

Held: Section 1A of the Fatal Accidents Act 1976 was incompatible with Article 14 in conjunction with Article 8.

Note: The declaration of incompatibility does not affect the validity of the provisions of the Fatal Accidents Act 1976. Parliament must legislate for the law to change.

Dyson v Heart of England NHS Foundation Trust [2017] EWHC 1910 (QB)

Facts: A clinical negligence Fatal Accidents Act 1976 case was decided in favour of the Defendant on liability. Nevertheless, Sir Robert Francis QC dealt with quantum, and was asked to consider whether the Regan v Williamson award was a valid head of loss.

Issues: Fatal Accidents Act, bereavement award, damages

Held: An award of £3,000 was made. It was doubted that the reasoning in *Mosson v Spousal* was correct.

Inquest touching the death of Miss Audrey Allen

TOM SEMPLE
PARKLANE PLOWDEN

AvMA Medico-Legal Advisor: Dr Charlotte Connor

Counsel: Tom Semple of Parklane Plowden Chambers

Audrey Allen was born on 26 June 1935 and had previously enjoyed an independent life, with the support of her family, in Chesterfield. When she starting displaying symptoms of dementia, she moved to a care home operated by Derbyshire County Council in December 2015. She sadly passed away on 16 April 2016 after sustaining a fall at the care home. The investigations that followed Miss Allen's death revealed a series of failures in the management of her care. In the Coroner's view, Miss Allen would not have died when she did had the care home carried out the necessary risk assessments.

Background

Miss Allen had a history of diabetes, hypertension and osteoporosis, but was previously able to manage these conditions in the community. Between 2014 and 2015, it became apparent to Miss Allen's family that she was finding independent living more difficult and had developed symptoms of dementia. She was admitted to hospital in November 2015 after accidentally taking the wrong medication.

Miss Allen was then taken to the Staveley Centre, a care home managed by Derbyshire County Council ('the council') that specialised in caring for residents with dementia. However, due to a lack of beds, this was not a permanent placement. Following a fall at the Staveley Centre, Miss Allen was admitted to hospital but fortunately there were no serious injuries. The family then needed to find a permanent placement for Miss Allen. They were introduced to the Grange care home, also managed by the council, and on 3 December 2015 Miss Allen was admitted as a resident. The Grange was not specialised in caring for residents with dementia at the time and did not have nursing support.

During her short time at the Grange, the family noticed that Miss Allen's weight was not being properly managed. They were also informed that she had had a few falls, but nothing serious. Miss Allen also seemed to be more anxious around the care home staff, in stark contrast to her behaviour at the Staveley Centre. The family thought that the care home staff were struggling to cope, but the management advised that Miss Allen simply needed time to settle.

On 25 March 2016, Miss Allen had been left alone in her wheelchair in a dining room to eat her evening meal. The care home staff reported that they next found Miss Allen on the floor beside her wheelchair. Believing that there was no serious injury, Miss Allen was taken to her room. The next morning, on trying to get Miss Allen out of bed, she became pale and unresponsive. An ambulance was called, but the paramedics were never advised that Miss Allen had sustained a fall the night before.

Miss Allen was admitted to hospital on 26 March 2016 and, following a routine chest x-ray, she was found to have sustained multiple rib fractures on her left side. The hospital then queried whether there had been any trauma with the care home and notified the family. This was the first time the family were informed that there had been a fall on 25 March 2016.

Miss Allen developed a traumatic haemothorax but, as a result of her advanced dementia, a chest drain was not appropriate. Her chest was aspirated, but thereafter Miss Allen's condition deteriorated. She sadly passed away in hospital on 16 April 2016.

Due to the failure to disclose the previous fall to the hospital, the hospital staff raised a safeguarding warning against the Grange. This prompted a series of investigations, driven by the concerns of Miss Allen's family. It became apparent that, despite a history of falls, Miss Allen never underwent a falls risk assessment upon admission at the Grange. Furthermore, there were many other falls (25 in less than 4 months) that never prompted a review into what falls prevention measures should be adopted. There were also unexplained bruises that

were never investigated, a number of falls that were not reported to the family or Miss Allen's GP, a complaint of abuse that was never investigated, and a clear history of her diabetes and nutrition generally not being properly managed.

The family engaged the services of AvMA's pro bono inquest team to ensure that these concerns were fully explored at the inquest.

The Inquest

The inquest was heard in Chesterfield Coroner's Court before Assistant Coroner Peter Nieto over 3 days. Evidence was heard from the family, the care home staff and management, and the clinicians involved in Miss Allen's care.

It transpired in the course of the inquest that most of the care home staff considered Miss Allen not to be well suited to the Grange. Most of the carers felt that they lacked sufficient training to look after residents with dementia at the time. Furthermore, there was a lack of senior staff as a result of a poorly orchestrated restructure of the Grange's management. From January 2016, the Grange lacked sufficient senior staff to ensure that care was supervised and paperwork completed. This was a problem that affected many care homes operated by the council, although the Grange struggled in particular. This was the reason given as to why Miss Allen never underwent a falls risk assessment on her admission or after each subsequent fall. Similarly, it explained why Miss Allen's diabetes and weight were not appropriately managed as there was a lack of co-ordination and understanding of Miss Allen's needs. However, despite these shortcomings, the council was adamant that Miss Allen's care was not compromised.

It was accepted by the care home staff that the main method of reducing Miss Allen's falls risk was through observation. Despite this, she would normally be left to eat her meals alone. It was also acknowledged that it was not safe to leave Miss Allen alone in her wheelchair, as there was a risk that she would try to get out of it. Had a falls risk assessment been carried out, the staff felt that this risk would have been identified. Furthermore, it was felt that Miss Allen would probably have been supervised during her meals.

The Verdict

The Coroner was highly critical of the council. It was a requirement for the Grange to have carried out risk assessments for its residents upon admission and to ensure such assessments were reviewed. Had one been done, there would have been a clear management plan, a common understanding between the staff, and a proper consideration of what measures should have been adopted to minimise the risk of Miss Allen suffering a fall.

The reason for the lack of assessments being done was due to staffing shortages at the senior end. The lack of senior staff and failure to adequately complete paperwork clearly must have had an effect on Miss Allen's care, in the Coroner's view.

Had a risk assessment been carried out, the Coroner considered that Miss Allen's death would likely have been avoided. It was known to the staff that Miss Allen was not to be left alone in a wheelchair, as she might try to get out of the chair and possibly trip or fall. One of the measures that would have been in place had the assessment been carried out was to ensure that Miss Allen was supervised during her meals. Had those measures been in place, Miss Allen's fall on 25 March 2016, and her subsequent death on 16 April 2016, would likely have been avoided.

The Coroner was also critical of the evidence given by the carer who found Miss Allen after the fall. She had given inconsistent evidence that confused even her own colleagues, leading the Coroner to doubt her credibility.

Comment

This inquest demonstrated the utility of such proceedings in allowing the family to explore their concerns and for evaluating the prospects of civil claims. Although the Coroner did not find that there had been gross failure to provide basic medical care or a breach of Article 2, he was nonetheless critical of the council's management of Miss Allen's care. By law he could not make a finding that established civil liability, but the Coroner nonetheless drew a clear causal link between the care home's failure to carry out risk assessments and Miss Allen's death. The Coroner's findings will be useful indications to the interested parties if civil proceedings are contemplated. The same evidence can be adduced in a civil trial and the Coroner's verdict, whilst not binding, will undoubtedly be persuasive to a civil judge.

In addition, the Coroner was critical of one of the council's main witnesses. The inquest process can, in appropriate cases, be utilised to test the credibility of potential witnesses. Few civil claims are afforded such an opportunity before trial.

Inquest touching the death of James Sheffield

CAROLINE WOOD
PARK SQUARE CHAMBERS

The inquest touching on the death of James Sheffield was heard in Bolton Coroner's Court over two days on 30th and 31st January 2018 by a Judge alone.

On 12th July 2016 Mr Sheffield had suffered a respiratory arrest whilst an in - patient at Salford Royal Hospital from which he never regained consciousness.

Mr Sheffield had been admitted to Salford Royal Hospital following a fall at the Trafford Centre which resulted in hip pain. When investigated this indicated a pathological fracture to the hip. The hip fracture was caused by cancer of unknown primary but suspected to be renal. Mr Sheffield was admitted for a hip replacement.

Mr Sheffield had numerous co - morbidities including severe obstructive sleep apnoea (OSA) which meant that when he was asleep the muscles in his neck relaxed and obstructed his airway which would stop him breathing. OSA is rarely, if ever, life threatening as once breathing is obstructed the brain is alerted to wake up. Mr Sheffield had been prescribed a Continuous Positive Airway Pressure (CPAP) machine which is a mask he would wear when asleep and which exerts positive end expiratory pressure (PEEP) to keep the airway open. Mr Sheffield used the CPAP machine while in hospital.

He also suffered from obesity hypoventilation syndrome (OHS) which is defined as the combination of obesity, hypoxemia (falling oxygen levels in blood during sleep) and hypercapnia (increased blood carbon dioxide levels during the day) resulting from hypoventilation (excessively slow or shallow breathing)

After several weeks' delay, much of which was spent on Ward B6, the hip operation took place. Aside from a difficult extubation the operation was uneventful and Mr Sheffield was stepped down from HDU to Ward B6, where he had spent several weeks prior to the operation. Shortly after arriving on Ward B6 Mr Sheffield had lunch, was heard snoring and seen to be without his CPAP machine and then suffered a respiratory arrest from which he never regained consciousness. His CPAP machine has never been located.

Approximately 45 minutes to 1 hour prior to the respiratory arrest, the notes recorded that Mr Sheffield had asked if he could remove his nasal cannula, which was delivering 5 or 6L of oxygen. It was not clear from the notes if the cannula was removed or not but a statement provided shortly prior to the inquest confirmed that it had been removed.

The family's key concerns were: -

a. Loss of the CPAP machine.

b. Why, when Ward B6 were familiar with Mr Sheffield's use of a CPAP machine, had it had not been realised that he had been asleep without his CPAP machine?

c. Conflicting information being given following the respiratory arrest about Mr Sheffield's treatment and prospects of recovery

d. An apology was never given as opposed to offers of condolences for the loss.

The medical notes provided flagged potential concerns with:-

a. Use of Morphine, which can be a respiratory depressant, against a backdrop of OSA/OHV.

b. Removal of the nasal cannula.

The trust had undertaken a serious untoward incident report identifying that a bedside handover should have taken place. The nurse who has transferred Mr Sheffield said that she provided a telephone handover but none of the nurses in Ward B6 recalled it.

A statement had been provided for the purpose of the inquest giving hearsay evidence that Mr Sheffield had fragments of food in his mouth at the time of his arrest as if he had been eating. One of the questions asked of the pathologist by the representatives of the NHS prior to disclosure of the SUI report concerned whether Mr Sheffield could have choked on food as staff "may say that immediately prior to his arrest Mr Sheffield was sitting

up in bed eating his lunch and in fact during resuscitation efforts food debris was found in his mouth."

This question raised two inferential points, the first that Mr Sheffield was not asleep at the time of his arrest, and therefore would not have been wearing his CPAP machine even if it had not been lost.

The second inference, drawn by the pathologist when answering the question, was that Mr Sheffield may have choked in some way on food. The pathologist said that that there was no food debris within the airway and histological examination of the lungs did not suggest aspiration.

Consistent with the conclusion of the pathologist, disclosure of the witness statement provided for the preparation of the SUI report by the nurse who carried out the resuscitation included an observation that the particles of chewed up food were not obstructing the airway.

The pathologist also noted in answers to questions the possibility that the immediate collapse was due to cardiac dysrhythmia but there was no direct supporting evidence.

The bundle of documents produced by the trust for the inquest, unusually, placed the ECG records at the start, with Christopher Charlesworth from AvMA correctly predicting that the prime positioning of those records at the front of the bundle was an indication that the trust were going to implicate cardiac dysrhythmia as a potential factor.

The evidence was heard over two days from two consultants in intensive care medicine, the ward matron, two nurses present at the time of the arrest, a consultant anaesthetist, a consultant in general medicine, a family acquaintance who was with her son in an adjacent bed at the time of Mr Sheffield's arrest, the pathologist and Mr Sheffield's sister.

There was no getting around the fact that the CPAP machine should never have been lost, irrespective of whether it caused or contributed to the respiratory arrest. The trust had taken steps to prevent loss of equipment/ belongings on transfer of a patient by requiring a recording by not only the person giving the handover but also an acknowledgement by the ward receiving the patient. However, this was not sufficient as what it did not provide for was setting up of any handed over medical equipment on arrival at the new location. Therefore the Coroner made a Preventing Future Deaths report in relation to ensuring that whenever there is a transfer from one department to another, not just HDU or intensive care, the equipment must be put in place and in the possession of the person using it and made available to them as a matter of priority, even over lunch.

The evidence of the two nurses present at the time of the arrest and the family acquaintance visiting her son in the adjacent bed could not have been clearer that Mr Sheffield was snoring immediately prior to the arrest as it was his loud snoring, consistent with OSA, which resulted in the nurse looking in his direction and observing the moment he stopped breathing.

Most of the witnesses from the trust expressed their sorrow, either when giving evidence or outside the court room, which was important to the family. There was also an acknowledgement by one of the witnesses for the trust that he would have weaned Mr Sheffield off oxygen more slowly than in fact occurred although it was noted that there was no evidence that Mr Sheffield was seeming clinically hypoxic.

The coroner gave a narrative conclusion that Mr Sheffield died as a recognised complication of post operative recovery to treat injuries sustained in an accidental fall and naturally occurring disease, giving risk to a susceptibility to respiratory failure on a ground of pre - existing co - morbidities.

The Coroner said that he could not making a finding to the required standard in relation to the effect of the morphine, the propensity for hypercapnia and the possibility of susceptibility to hypoxia.

He also said, "On the Public Record; I convey to the family the dignity they brought to the inquest; the thoroughness of preparation of medico-legal issues; and the spirit in which they raised those issues deployed through their advocate and AvMA. No one could have asked for more than the assistance provided by Ms Wood [Counsel] and that Ms Wood had from AvMA."

From my own perspective it was a privilege to represent the family.

Conclusion

Consider in advance all the possible avenues for alternative causes of death where a person has multiple co - morbidities.

Disclosure of documents: In this case the SUI report, containing statements made closer in time to the happening of the event, was sought and provided.

The actual witnesses to the event need to be called to give evidence, in this case the nurses present at the time of the arrest, in addition to the ward matron who was not present but who provided a statement comprising hearsay evidence, for the purpose of the inquest.

The AvMA Mediation Survey

LISA O'DWYER
DIRECTOR MEDICO-LEGAL SERVICES

General background

The AvMA Mediation survey is believed to be the first of its kind, not only is it aimed at claimant lawyers and their client's experiences but it attempts to explore in more detail the strengths and weaknesses of the process and importantly the changes indicated to encourage greater take up of the process. It has been really important to us to have the views of those of you who have mediated as well as those of you who haven't. Thank you for responding to the survey.

We received a total of ninety five responses to the survey. Sixty five of the respondents had ten or more years post qualification experience (PQE) and eighteen had between five and ten years PQE. This is significant as it tells us that the majority of people responding had considerable litigation experience with seventy eight respondents holding the position of partner or senior solicitor and fifty respondents holding a specialist accreditation in clinical negligence.

The survey: invited practitioners to respond regardless of whether they had mediated or not. We took this approach in order to try and identify whether there were any particular reasons why practitioners had not or had refused to engage in the mediation process.

Back in October 2017, the Law Society Gazette reported that NHS Resolution believed that mediation had been slow to get off the ground due to ***"resistance from claimant lawyers whose preference is for the more formal route"***. However, our survey shows that in the period December 2016 – April 18 (this period coincides with NHS Resolution's appointment of two mediation providers – CEDR and Trust Mediation), over half of respondents (54) had never received an invitation from NHS Resolution to mediate. Three respondents routinely received invitations from NHS Resolution, the remainder had only ever received one or two invitations to mediate.

By contrast, the survey shows that forty seven claimant lawyers (no apologies for the emphasis!) had invited NHS Resolution to mediation. The offer was accepted in sixteen of those cases, refused in nine and in twenty-five cases NHS Resolution had not replied. Eighty five of the respondents said they had never refused an offer to mediate.

Of the ninety-five responses to the questionnaire, fifty people had first-hand experience of mediating in clinical negligence claims; the experiences were as a result of both NHS Resolution'S mediation initiative and other providers. Their experiences related to a range of clinical negligence claims, not just low value claims (that is claims under £25,000) and include cases involving vulnerable clients.

A significant number of respondents reported that typically, mediation is offered after proceedings are issued, quite frequently after without prejudice meeting of experts has taken place, when Round Table Meetings (RTM) are being considered or once the trial date has been fixed.

What does the survey tells us about the mediation process?

Question thirteen of the survey asks *"If you have mediation experience, how many cases have you mediated?"* Twenty four of our respondents had tried the process at least once, but twenty had tried the process more than once with at least seven respondents having gone to mediation three times and four having gone more than three times – one respondent had mediated eleven cases. This suggests that where claimant practitioners try the process once, thet are likely to return to it.

AvMA was particularly interested in the response to question fourteen which asked for feedback on what the client thought of the process. When considering the responses to this question we were mindful that although fifty of our respondents had undertaken mediations, several respondents had experienced mediation on more than one occasion, collectively they had experience of eighty-seven mediations or, put another way, eighty-seven clients had experienced the mediation process.

Nineteen clients were reported to have considered the process a "very positive, cathartic experience". This figure is lower than might have been expected particularly given that one of the strengths of the mediation process is often considered to be the opportunity for clients to vent their emotions. However, some caution does need to be attached to this figure as only forty three respondents answered this question on behalf of their clients.

Nonetheless, the figure cannot be ignored completely. A further seventeen clients reportedly found the process "okay" although they weren't particularly impressed. Some of the additional feedback received commented that although the process achieved settlement, the answers and explanations the client was hoping for were not forthcoming.

However, others reported that the mediation process provided an opportunity for the client to raise issues of importance that would not otherwise have been aired during the course of litigation. There was also recognition of the fact that mediation, unlike other forms of ADR, does give the client the opportunity to have their say,

and this can be important to the client. It may be that because the client has a forum where they can use their own voice (as opposed to being represented) they feel as though they are being heard; in some cases this fact alone could be key to allowing legal matters to progress. In such cases, even if the mediation does not conclude in settlement, it may well be instrumental in removing the difficult emotional barriers that impede settlement.

What are the key factors preventing mediation?

AvMA was keen to gain more of an insight into some of the factors that might be preventing an increase in the use of mediation. It would appear that there are a number of potential barriers which I have outlined below:

1. **Cost**: Concerns have been raised about a range of issues relating to the costs of mediation, not only in relation to how cost effective the process is but how the costs of mediation might be recovered. The primary concerns relate to:

   (i) **Cost effectiveness:** Many respondents felt that other forms of ADR such as telephone discussions and even RTMs were more cost effective and achieved the same results as mediation.

   (ii) **Recovering the cost of mediation:** Mediation falls outside of the cost budget and recovering the costs of the process is not automatic. It is not always obvious at cost budgeting stage that mediation might be appropriate. In some low value claims there is a real risk that the costs of mediation would be disproportionate to the sums in issue.

   (iii) **Global offers:** Claimant lawyers are generally unhappy about the use of global offers being made as part of the mediation process.

   Generally lawyers feel that these offers, whether made within the mediation process or outside of it, can put them in a position of potential conflict with their client and are therefore to be avoided.

   The use of global offers during mediation tends to be a bar to the process concluding in settlement.

   (iv) **ATE Policies:** There are a number of ATE policies on the market but there is no clear indication from insurers that the mediator's fee will be recoverable in the event the case is unsuccessful. It would appear that some insurers will consider extending cover but will only do this on a case by case basis.

   ATE providers vary in their approach to this and uncertainties could be avoided if ATE policies were clearer about their position on mediation at the outset.

2. **Parity between the parties:** There were a number of concerns expressed about the mediation process not only being fair but appearing to be fair. One example of this is ensuring that the same number of claimant representatives attend the process as defendant representatives. At least one respondent had attended the mediation on their own with their client only to realise the defendant had arrived with three legal representatives.

   Other examples illustrated the importance of parties being clear about who they should expect to be in attendance from the other side. Failing to comply with what has been agreed is potentially very damaging to the process and the client. In one very sensitive case involving the death of a baby, no one from the trust or NHS Resolution attended even though the client had been told they would be there.

3. **Time efficiency of the process:** This overlaps with the cost effectiveness of the process. The responses strongly indicate that there are times when other forms of ADR are more effective and avoid the need for the client to travel. The point was well illustrated by a case where all expert evidence had been exchanged pre mediation yet it still took eight hours to achieve a £20,000 settlement.

4. **Conduct:** There were concerns that invitations by the defendant to mediate were hollow and the process was being offered as a "box ticking" exercise so that panel firms could report to NHS Resolution that they had offered mediation.

   Some of the responses referred to the fact that defendants are agreeing to mediation but on the understanding that they are not going to admit liability or offer financial settlement. Those provisos defeat the object of the mediation exercise and only serve to confirm that the defendant's mind is closed to settlement. In those cases the mediation process is doomed and pointless

General concerns about mediation:

When should mediation take place?

The question of when to mediate can cause some consternation among practitioners. The survey indicates that most claimant practitioners would not consider mediation to be appropriate until after exchange of expert evidence. There are reports of NHS Resolution insisting on every bit of evidence being obtained prior to any mediation taking place.

The survey also indicates that the question of when the mediation should take place is essentially down to the judgement of the solicitor with conduct and his or her client. There were a range of responses to this question. Certainly, the survey suggests that many practitioners will go into mediation post exchange of expert witness evidence. Others take the view that the best time to mediate is at the point it becomes possible to value the claim properly. Some practitioners will routinely explore the possibility of mediation when the Letter of Claim is served.

Overwhelmingly, the view is that you cannot be prescriptive about when mediation takes place, it will depend on the case.

Is mediation the right process for the client?

It is clear that many patients/claimants feel there are considerable benefits to the mediation process: a sense of empowerment from having the right to speak directly to the defendants; a greater sense of accountability derived from the trust being in attendance; being more a part of the process as mediation avoids the formality of the court room; that the process is cathartic. The list of benefits goes on.

However, there are some claimants who find the mediation process very difficult. They report feeling exhausted and emotional; they may leave the process with concerns that they have said too much and where settlement hasn't been achieved on the day, that the process has lured them into saying something that may be detrimental to their case.

When it comes to mediation, one size does not fit everyone. It is important to remember that mediation may benefit some clients but not others; it is not a panacea for all ills. However, some of this may come down to putting the mediation experience in perspective and this means educating the client on what the alternative experience, giving evidence at trial, might be like.

The use of confidentiality clauses in mediation agreements

AvMA has previously expressed particular concern about confidentiality clauses being included as a standard term of mediation contracts.

AvMA fully recognises and understands the need for a confidentiality clause to cover the mediation process itself. Mediation does not guarantee settlement and it is important that the process offers the parties a "safe space" where they can talk openly and freely in the hope of reaching settlement. However, where settlement is achieved and where the claimant is happy to have the terms of settlement made public, they should not be prevented from doing so because of a confidentiality clause that has been included as a standard term of the mediation contract. Not only should the claimant be free to disclose the terms of settlement (should they so choose) but it is also important that this is encouraged so settlement outcomes achieved through mediation can be properly and independently evaluated.

Question fifteen of the survey invited further comment on the use of confidentiality clauses in mediation. Seventeen of the fifty respondents confirmed that their client had been subject to a confidentiality clause that related not to the process but to the terms of settlement. However, the survey also found that in ten out of those seventeen cases respondents were successful in removing the clause before the process commenced.

As an aside, AvMA having raised this issue with NHS Resolution and others understands that the use of confidentiality clauses preventing disclosure of the terms of settlement has now been removed. Confidentiality clauses should no longer be included as standard in the mediation contracts of CEDR or Trust Mediation, both of whom are NHS Resolution's preferred mediation providers. However, confidentiality clauses will be included where the parties expressly agree to such a term following settlement.

The mediator

The choice of mediator is often considered key to the chances of the process succeeding or not. Thirty one out of the ninety five respondents felt it was important that they were able to choose their own mediator and not be restricted by lists.

Some expressed concern over the appointed mediator's behaviour which appeared biased at the outset of the process. Other responses suggested that generally the mediator did not appear to add anything to experience although one respondent acknowledged that the mediator came into his/her own when the parties got stuck; it was the mediator who was able to facilitate further discussions between the parties.

Equally, it should be noted that were many reports of good experiences with the appointed mediator and in particular we received recommendations for NHS Resolution's two appointed mediation firms.

What factors would increase the take up of mediation in clinical negligence?

The fact that this question was answered by practitioners who had mediation experience and those who have none is important. The answers provided shed light on some

of the issues that keep practitioners away from mediation or cautious of it. Some of the concerns raised are around the pure economics of using mediation but other issues raised could be addressed through increased education of the benefits of mediating.

There are some areas where healthcare providers could and should do more. An example of this is the need for a specific and consistent pathway for learning and acting on mistakes identified during the mediation process.

The survey indicates that if the following factors were addressed there would most likely be an increase is the use of the mediation process:

1. **An established pathway for demonstrating lessons had been learned from the mediation about the poor care provided and that there was a clear commitment to making identifiable improvements to address the defects:** 59 respondents supported this
2. **If there was greater confidence that the process would achieve the right outcome for the client:** 49 respondents
3. **If it was quicker:** 48 respondents
4. **If it fell outside of the rules on proportionality and payment for attending the mediation was guaranteed:** 44 respondents
5. **If it was cheaper:** 40 respondents
6. **If I could choose my own mediator as opposed to the two NHS Res providers:** 31 respondents
7. **If the treating clinicians were in attendance:** 12 respondents
8. **If I could persuade my client to enter into the process:** 5 respondents
9. **If I understood the process better:** 4 respondents

It is accepted that the responses to this part of the survey may be subject to debate, given that question seventeen arguably poses the answers by setting them out as possible options to choose from. Nonetheless, the fact remains that practitioners did respond to the list of factors identified and the relevant boxes were ticked. The fact that some boxes were ticked and others weren't does suggest that the respondents were discerning in making their choices and the results should be given proper consideration.

What conclusions might be drawn from the survey?

There is power in the mediation process and when it works, it appears to work well for both the practitioner and the client. Whilst there have been concerns expressed about the choice of mediator and or the mediator's conduct there is support for the two mediation firms currently appointed by NHS Resolution.

The survey does reflect the overall view that mediation can deliver much more than identifying a sum of money to compensate for the injuries sustained and/or loss. However, it would be a mistake to be prescriptive about mediation. Some clients did not benefit from the process and found it stressful and tiring. Some clients want to see the treating healthcare provider, others do not.

It is AvMA's view that the power of the process comes from the parties being open minded enough to come to the table willingly and freely. With that approach the parties are open to exploring the possibility of settlement in all its possible forms, not just financial. The process is least likely to work in circumstances where a party or parties, prior to the process commencing, seek to put restrictions on the discussion to be had during the course of mediation. A defendant who starts the process by saying "we are not going to admit liability" or similar has missed an opportunity and effectively rendered the process redundant before it has started. The survey appears to bear this out.

Similarly, the mediation process appears to be doomed where one of the parties does not have a genuine intention to use the process properly. Mediation should not be used as a box ticking exercise and offers to use the process should be made in good faith and with the genuine intent of exploring the issues with a view to trying to achieve a resolution which is considered fair and favourable to the parties involved.

For NHS Resolution to say that mediation had been slow to get off the ground due to ***"resistance from claimant lawyers whose preference is for the more formal route"*** is not born out by the findings from the survey. For fifty five of our respondents to have never received an invitation to mediate and only twenty eight to have received one invitation suggests that both NHS Resolution caseworkers and panel solicitors need to be better educated in the benefits of the process. However, it may also suggest that those parties recognise that mediation needs to be considered carefully.

Mediation is an effective tool and should be included in the litigator's arsenal of techniques to achieve the quickest and most cost effective way of concluding matters for the client. It is not appropriate in every case, it does not suit every client and it would be detrimental to the process to be prescriptive about the right time to mediate. This will depend on the issues in hand and whether the client is

ready to enter into the process. In our view, it would be a mistake to make mediation compulsory.

However, from the client's point of view, the power of the process can only really be fully appreciated if they have a good understanding of the alternatives. Litigation is not an easy alternative and the thought of giving evidence can strike fear into the heart of the most confident of claimants.

There are no guarantees with mediation and the cost of the process does need to be weighed up carefully. If the process were to become cheaper, then it would almost certainly become more attractive. However, the NHS Resolution mediation initiative, whilst not perfect, has almost certainly put the use of mediation in clinical negligence claims in the spotlight.

The use of the mediation process is evolving. It is AvMA's view that there are things that need to be done to improve it, for example, a mandatory mediator's Code of Conduct that parties and mediators involved in a clinical negligence mediation have to sign up to. That code should ensure that any unrepresented claimant is aware of where they can go to seek independent information on the process and other options that may be open to them.

Unrepresented claimants should have independent advice on the likely value of their claim as well as advice on and access to relevant documents prior to the mediation. For example their own medical records, any serious incident report and any independent expert reports that the defendant may have. There also needs be more transparency about the terms of settlement so that the fairness and effectiveness of the process as well as the client experience can be properly evaluated by claimant and defendant representatives alike. Last but by no means least, the process must build in a consistent way of ensuring that the cause/s of the harm has been fully and properly identified and set out what and how changes are to be introduced to address those failings.

PIC

PARTNERS IN COSTS

03458 72 76 78
info@pic.legal
@PIC_Legal
pic.legal

For 21 years, PIC has been the primary claimant-only costs specialist in the civil litigation market.

Our dedicated national team of costs lawyers and advocates can help to release your lock up in the shortest possible time.

we promise...

- COSTS BUDGETING EXPERTS
- HIGHEST PROFIT COSTS RECOVERY
- QUICK FILE TURNAROUND
- YOUR FEES RECOVERED, FAST

PIC
Robson House
4 Regent Terrace
Doncaster
South Yorkshire
DN1 2EE

www.pic.legal

PIC AT 21

Celebrating 21 Years of Cutting Edge Claimant Costs Advice

Look out for #PIC21 on Twitter for our latest 21st Anniversary updates!

Forthcoming conferences and events from AvMA

For full programme and registration details, go to www.avma.org.uk/events or email conferences@avma.org.uk

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

AvMA Annual Golf Day

28 June 2018, Singing Hills Golf Course, West Sussex

The fourteenth AvMA Golf Day will take place on Thursday 28 June 2018 at a new course – the beautiful Singing Hills Golf Course in Albourne, West Sussex (www.singinghillsgolfcourse.co.uk), set in an area of outstanding natural beauty with the South Downs as the backdrop. The Welcome Event for the Annual Clinical Negligence Conference will take place later that evening at the Hilton Brighton Metropole (25 minutes' drive away), so the Golf Day offers the perfect start to the essential event for clinical negligence specialists.

We will be playing Stableford Rules in teams of four and you are invited to either enter your own team or we will be happy to form a team for you with other individuals. The cost is only £98 + VAT per golfer, which includes breakfast rolls and coffee, 18 holes of golf and a buffet and prize-giving at the end of the day.

30th Annual Clinical Negligence Conference

29-30 June 2018, Hilton Brighton Metropole

Join us in Brighton for the 30th ACNC! This is the annual event that brings the clinical negligence community together to learn and discuss the latest developments, policies and strategies in clinical negligence and medical law. The programme this year explores the perils and pitfalls of diagnosis in a clinical negligence context with a focus on surgery, as well as covering many other key medico-legal topics at such an important time for clinical negligence practitioners.

The excellent programme of speakers includes the following plenary addresses:

- Lessons Learned Post-Paterson:

  A Legal and Clinical Perspective Professor Gordon Wishart, Consultant Breast Surgeon & Professor of Cancer Surgery, Anglia Ruskin School of Medicine; & Lizanne Gumbel QC, Barrister, 1 Crown Office Row
- Cardiothoracic Surgery

  Professor Stephen Clark, Consultant Cardiothoracic & Cardiopulmonary Transplant Surgeon, Newcastle upon Tyne Hospitals NHS Foundation Trust
- Urogynaelcology – Vaginal Mesh Implants

  Dr Wael Agur, Subspecialist and Lead Urogynaecologist, NHS Ayrshire & Arran; Career Fellow, NHS Research Scotland; & Honorary Senior Clinical Lecturer, University of Glasgow; & Hugh Preston QC, Barrister, 7 BR
- Wrongful Birth Claims

  Mr Myles Taylor, Consultant Obstetrician & Gynaecologist, Subspecialist in Fetal Medicine, Royal Devon & Exeter NHS Foundation Trust; & Eliot Woolf QC, Barrister, Outer Temple Chambers
- Biliary Surgery

  Professor Colin D Johnson, Honorary Consultant Surgeon, University of Southampton
- Intensive Care - Spotting the sick patient and what to do about it

  Dr Barbara Philips, Reader in Intensive Care Medicine, Brighton and Sussex Universities Medical School
- PROMPT (PRactical Obstetric Multi-Professional Training) – reducing preventable harm

  Professor Tim Draycott, Consultant Obstetrician, Southmead Hospital, Bristol
- The 2018 Legal Update

  Charles Bagot QC, Barrister, Hardwicke Chambers

We very much hope to welcome you to the 30th Annual Clinical Negligence Conference in Brighton.

Experts and Lawyers - Effective Team Working

Evening events in London (September 2018), Bristol (October 2018), Leeds (January 2019) – final dates and venues to be confirmed soon

Lawyers and experts are on the same team – lawyers need to learn to instruct properly; experts need to

report in a focused and timely manner. The importance of working together is key. By training lawyers and experts together we can provide both essential learning and an important opportunity to network together and discuss issues and concerns. These seminars are intended to be interactive sessions where the views of lawyers and experts are encouraged and welcomed. Full programme details available soon.

AvMA Specialist Clinical Negligence Panel Meeting & Christmas Drinks Reception

30 November 2018, America Square Conference Centre, 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 Friday 30th November - registration and a networking lunch will commence at 12.30, with the meeting starting at 13.30 and closing at approximately 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 America Square Conference Centre. The event provides an excellent opportunity to catch up with friends, contacts and colleagues for some festive cheer!

Clinical Negligence: Law Practice & Procedure

31 January - 1 February 2019, 3 Paper Buildings, 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. The programme will be available and booking will open in October.

Details of further events for Autumn and Winter 2018 and early 2019 available soon.

www.avma.org.uk/events Tel 020 3096 1140
e-mail conferences@avma.org.uk

Webinars

Medico-legal information at your fingers tips

Working on a client file and looking for more information to assist you with your case? AvMA's medico-legal webinars give you immediate access to leading specialists speaking on subjects ranging from interpreting blood test results to medico-legal issues in surgery and many more besides!

Over 40 key subjects from UK's leading authorities on medico-legal issues

Featuring some of the UK's leading authorities on medico-legal issues, AvMA's webinars bring you all the benefits of a specialist targeted seminar.

When and where you need

The webinars can be watched at a time convenient to you, all without having to leave your office. You can watch the video as many times as you want, download the slides and extras materials to aid your learning.

From £49 + VAT per individual webinar

Best value:

Take advantage of the special 20% discount for newsletter readers and get an annual webinar subscription for £960.00 + VAT

Annual subscription, over medico-legal 40 titles, from ~~£1200 + VAT~~ now **£960 + VAT**

Discount code – ACNC18

discount code valid until 01/08/2018

Book your webinar subscription now – **www.avma.org.uk/learning**

Please email **paulas@avma.org.uk** or call 020 3096 1140 for further details.

#ACNC18 Sponsors

AvMA wishes to thank the following organisations for their support

1 COR
1 CROWN OFFICE ROW

Contact Details:
Olivia Mackay, Marketing Manager
Tel: 020 7797 7500
Email: olivia.kaplan@1cor.com
STAND NO: 36

42 BEDFORD ROW

Contact Details:
Tony Charlick, Commercial Manager
Tel: 020 7831 0222
Email: TonyC@42br.com
STAND NO: 21

ARAG

Contact Details:
Mike Knight, ATE Sales Manager
Tel: 0117 917 1694
Email: Mike.Knight@arag.co.uk
STAND NO: 35

ASCENT
MEDICO-LEGAL CONSULTANCY

Contact Details:
Beverley Theato
Tel: 01924 457171
Email: Beverley.Theato@jordanssolicitors.co.uk
STAND NO: 17

premex

Contact Details:
Mike Dunleavy, Sales Director
Tel: 0844 811 8546
Email: mike.dunleavy@premex.com
STAND NO: 19

SERJEANTS' INN

Contact Details:
Isabel Biggs, Client Care Executive
Tel: 020 7427 5000
Email: IBiggs@serjeantsinn.com
STAND NO: 1

temple
legal protection

Contact Details:
David Pipkin, Director Underwriting Division
Tel: 01483 577877
Email: david.pipkin@temple-legal.co.uk
STAND NO: 37

#ACNC18 Exhibitors & Promotional Sponsors

Contact Details:
Paul Eeles, Senior Clerk
Tel: 020 7400 7305
Email: peeles@7br.co.uk
STAND NO: 7

Contact Details:
Oliver Parkhouse, Director of Clerking
Tel: 020 7583 081
Email: parkhouse@12kbw.co.uk
STAND NO: 13

Contact Details:
Kaushal Sampat, Account Manager
Tel: 0870 607 8999
Email: K.Sampat@abbeylegal.com
STAND NO: 3

Contact Details:
David Vine, Business Development Manager
Tel: 07710 017812
Email: david.vine@allianz.co.uk
STAND NO: 12

Contact Details:
Ros King
Tel: 01359 271 900
Email: ros.king@angliacasemanagement.co.uk
STAND NO: 22

Contact Details:
Adrian Mundell, Director
Tel: 01842 768 725
Email: adrian.mundell@ashtonslegal.co.uk
STAND NO: 5

Contact Details:
Sarah Preston, Director of Operations
Tel: 01327 876210 email: spreston@bushco.co.uk
STAND NO: 15

Contact Details:
Mark Farrell, Director of Client Services
Tel: 07506 222 002 email: mark.farrell@calculusholdings.co.uk
STAND NO: 38

Contact Details:
Anil Virji, Head of Costs
Tel: 020 7 842 5971
Email: anil.virji@civilandcommercial.com
STAND NO: 14

Contact Details:
Martin Kettle, Chartered Financial Planner
Tel: 0161 819 3636
Email: Martin.Kettle@concerva.co.uk
STAND NO: 24

Contact Details:
Phil Mumford, Managing Director
Tel: 01342 410 242 email: info@cowan-architects.co.uk
STAND NO: 30

Contact Details:
Karl Blockwell, Marketing & Communications Manager
Tel: 01903 883811
Email: Karl.Blockwell@das.co.uk
STAND NO: 16

Contact Details:
Sheila Rush, Operations Manager
Tel: 01799 588056
Email: sheila.rush@designforindependence.co.uk
STAND NO: 2

Contact Details:
Matthew Casson, Director
Tel: 0151 242 0960
Email: matthewcasson@evolutioncosts.com
STAND NO: 23

Contact Details:
Natasha Devlin-Clingham, Practice Manager
Tel: 020 7242 2523
Email: Natasha.Devlin@hardwicke.co.uk
STAND NO: 32

Contact Details:
Paul Talbot, Business Manager
Tel: 020 8998 2992
Email: Paul.Talbot@harrisonassociates.org
STAND NO: 29

Contact Details:
Kate Maclean, Director/Chief Executive
Tel: 01722 746 635
Email: Kate.Maclean@indliv.co.uk
STAND NO: 11

Contact Details:
Matthew Kain, Managing Director
Tel: 01279 755552
Email: michael.kain@kain-knight.co.uk
STAND NO: 28

Contact Details:
Colin Carr, Director of Business Development
Tel: 0151 728 3218
Email: colin.carr@kevinedward-costs.co.uk
STAND NO: 10

Contact Details:
Angela Fitzpatrick
Tel: 01608 682500
Email: office@maggiesargent.co.uk
STAND NO: 40

Contact Details:
Mark O'Conor, Business Development Manager
Tel: 0203 947 8888 email: mark.oconor@medbrief.co.uk
STAND NO: 41

Contact Details:
Cheryl Luscombe
Tel: 01752 568990
Email: cheryl.luscombe@medicalclericalbureau.com
STAND NO: 25

Contact Details:
Nicola Blair, Office Manager
Tel: 0161 928 1636
Email: nicola.blair@medicalrecordcollation.com
STAND NO: 6

Contact Details:
Ian Jenkins, Associate
Tel: 01483 453 453 email: Ian.Jenkins@mitchellevans.co.uk
STAND NO: 34

Contact Details:
Angela Lindley, Marketing and Business Development Assistant
Tel: 0161 830 8474
Email: al@costexperts.co.uk
STAND NO: 4

Contact Details:
Ryan Lewis, Director
Tel: 0161 763 4800
Email: ryan.lewis@nestorpartnership.co.uk
STAND NO: 8

Contact Details:
Mike Stubbs, Senior Clerk
Tel: 0844 499 5678
Email: michael.stubbs@parklaneplowden.co.uk
STAND NO: 31

Contact Details:
Geraldine Gardner, Business Development Manager
Tel: 020 7457 3000
Email: Geraldine.Gardner@Penningtons.co.uk
STAND NO: 27

Contact Details:
Adrian Hawley, Head of Court of Protection
Tel: 0345 872 7678
Email: Adrian.Hawley@pic.legal
STAND NO: 20

Contact Details:
Glenn Hotchin , Director
Tel: 0333 577 0809
Email: glenn@plg.uk
STAND NO: 33

Contact Details:
Emma Case, Senior Sales & Marketing Executive
Tel: 0151 481 4469
Email: emma.case@purelegalcosts.co.uk
STAND NO: 26

Contact Details:
Mark Hewitt, Managing Director
Tel: 0114 266 3300
Email: mark@picalculator.co.uk
STAND NO: 39

Contact Details:
Claire Baxter, Marketing & Public Relations Manager
Tel: 0190 856 0041
Email: claire@rehabwithoutwalls.co.uk
STAND NO: 18

Contact Details:
Jonathan Collins, Accommodation Expert & Project Manager
Tel: 01477 544499 email: jonathan@stevendocker.co.uk
STAND NO: 9

Contact Details:
Joely Hodgson, Marketing Executive
Tel: 01444 416 119
Email: joely.hodgson@bloomsbury.com

Contact Details:
Lesley Leek, 01270 759 786
Email: lesley@pfp-planahead.co.uk

Contact Details:
Dez Derry, CEO
Tel: 0161 452 0311
Email: dez@mmadigital.co.uk

THE EASIEST AND MOST RELIABLE WAY TO FIND SERVICE PROVIDERS SUPPORTING CLINICAL NEGLIGENCE SOLICITORS

The AvMA Lawyers' Service Directory provides listings of key service providers geared to the clinical negligence solicitor, including:

- Costs consultants
- Disability property specialists
- Rehabilitation consultants
- Nursing experts
- Counselling
- Mediators
- Court of Protection deputyship and personal injury trusts
- Medical records pagination, collation and review
- Investment managers

AvMA Lawyers' Service members can access the listings for free at

www.avma.org.uk/directory

avma
action *against* medical accidents