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Lawyers Service Newsletter

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Contents

Editorial

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Welcome to our summer edition of the Lawyer Service Newsletter! Traditionally this Newsletter is timed to go out just before AvMA's annual clinical negligence conference (ACNC) sadly, due to coronavirus this is the second consecutive year we have been unable to hold our conference. However, we hope to see you at our welcome event in Leeds on 23rd March 2022, with the conference on 24th – 25th March.

Some of you may be aware that AvMA gave evidence to the Justice Committee's enquiry into the coroner's service last autumn, their report was published on 27th May https://publications.parliament.uk/pa/cm5802/cmselect/cmjust/68/6802.htm.The committee's recommendations are welcomed by AvMA especially the call for non means tested legal aid to be available in complex inquests and/or those against public bodies to be implemented by 1st October 2021. If this is introduced, it will certainly provide greater equality of arms for families attending healthcare inquests. The recommendation that a new body be introduced with the power to ensure that risks to public safety, identified by the coroner during their enquiry are followed up is potentially game changing for improving patient safety. If this recommendation is accepted it could mean that prevention of future death (PFD) reports and hopefully, representations made in Action Plans will have to be monitored and policed to ensure that lessons are learned, and change happens. We are pleased also that the committee recommended a National Coroners Service to ensure quality and consistency of service for the bereaved. Certainly, there is more work to do to ensure these recommendations are introduced in a timely way and with sufficient funding to make them effective.

Our thanks to David Knifton QC of Exchange Chambers for his article **"How to win your clinical negligence Trial"**. David draws on his considerable experience when setting out factors which are likely to increase the chances of a successful outcome, including a reminder to keep things simple, where possible.

Secondary victim claims are rarely simple. Currently there are two secondary victim claims waiting to be heard by the Court of Appeal (*Paul v Royal Wolverhampton Trust* [2020] and *Polmear & another v Royal Cornwall*

Hospitals NHS Trust [2021]). Anna Datta of Parklane Plowden's excellent article **"Secondary victim claims in clinical negligence cases – watch this space..."** considers the issues of proximity and relevant traumatic event and the need for greater clarity for claimant's bringing these types of claims.

Challenges around funding clinical negligence claims continue. Richard Mumford, barrister at 1 Crown Office Row looks at possible recourse for claimants where private medical treatment was paid for by credit card. In his article **"Medical treatment claims under section 75 of the Consumer Credit Act 1974"** Richard points to the fact that between 2013 – 18, one in four patients opted for self-funded private medical treatment across all medical specialities, not just cosmetic surgery.

I cannot mention challenges and funding in the same sentence without referring to the long overdue consultation on fixed costs in low value clinical negligence claims. If no news is good news, then I have good news for you – government remains eerily silent on the issue. In the meantime, the travesty of wasted costs is well illustrated in Sarah Stocker (solicitor at Tees) article **"Fixed recoverable costs: Change needs to start at the top"**. AvMA has long argued that a focus on improved patient safety is the only real route to reducing unnecessary pain, suffering and costs!

"Care home or home care?" Howard Elgot of Parklane Plowden Chambers reviews some of the arguments for and against each option and reminds us that it is about whether the treatment chosen and claimed for is reasonable.

The coronavirus pandemic has forced change on each one of us. For those of us fortunate enough to have remained in employment over the last 16 months or so most of us will have achieved this by embracing technology (some of us more willingly than others). The court system too has had to make changes by introducing increased use of remote hearings in one form or another, there are of course pros and cons with presenting evidence and hearing arguments remotely. We are pleased to include an article by Lee Speakman, barrister at Exchange Chambers **"Hybrid trials – Are we ready?"** where Lee candidly draws on and shares his own experience of representing a claimant in a complex clinical negligence case. Lee's experience may resonate with your own and we encourage you to share your views and experiences of remote hearings with us.

You may recall that our March edition of the LS Newsletter featured an article "A sting in the tail: The court of appeal and cauda equina syndrome" by Jonathan Godfrey of Parklane Plowden Chambers. This edition of the Newsletter includes a case report by Spencer Collier (Partner and head of clinical negligence) and Amy-Beth Probert (associate) both of Geldards LLP who ran the case of ***"Remigio v Cardiff and Vale University Local Health Board"***, the facts of which centred on an exceptionally rare condition, secondary cauda equina. The case illustrates how robust expert evidence, good witness evidence from the claimant and scrutiny of the timeline of events led to a successful mediation which itself was conducted remotely.

As many of you know, Laurence Vick retired from active clinical negligence practice in January 2020, since then he has focused his attentions on advocating for improved patient safety, he has been a welcome and valued contributor to the LS Newsletter. This edition sees Laurence examine findings from the HSIB report on nasogastric tube never events and the role of guidelines in his article **"Placement of nasogastric feeding tubes and the "too long to read" clinical guidelines"**.

Laurence's article is well timed as it complements work recently undertaken by AvMA's Inquest Team which investigated two cases where use of nasogastric tubes was a factor in each death. The Hussey family was represented by Catherine Meenan of Cloisters chambers, and the Oakes family by Tom Beamont of 1 Crown Office Row. The families were advised and supported by Fleur Hallett and Dr Caroline Graham of AvMA respectively and we are grateful to Tom for preparing the case report **"Inquest into the deaths of Peter Hussey and Stephen Oakes"**.

Fosters solicitors are based in Norwich and are currently looking to recruit a lawyer to work in their inquest team, for more information please see advert at the back of this Newsletter.

Whether you are planning a summer break at home or away we hope that the sun shines for you and that the next edition of the LS Newsletter sees a return to some sort of normality. Remember, if you would like to submit an article for the November edition of the LS Newsletter do contact Norika with your suggested title (norika@avma.org.uk).

Best wishes

How to win your clinical negligence Trial

EXCHANGE CHAMBERS

DAVID KNIFTON QC
EXCHANGE CHAMBERS

David Knifton QC draws on his long experience of both conducting clinical negligence claims as an advocate and trying them as a Recorder, to examine the factors most likely to lead to success.

Introduction

Clinical negligence claims are rarely straightforward. On the contrary, they are frequently time-consuming, require a review of extensive medical records, involve a good deal of technical scientific evidence, and sometimes raise challenging issues of law. The prospects of success are often difficult to assess, and depend heavily on the quality of your experts. Having recently conducted a clinical negligence trial (in which judgment is awaited), and heard a trial whilst sitting as a Recorder, I thought it might be helpful to draw on those and other experiences as a guide to the factors which, in my view, are likely to bring success.

Get the Law Right

This may seem obvious, but it is important to ensure that the correct legal test is applied to the circumstances of your case. Any allegation of negligence requires proof of a failure to take reasonable care. In cases of diagnosis and treatment, involving an exercise of professional skill and judgement, that involves application of the well-known *Bolam* test (*Bolam v Friern Hospital Management Committee* [1957] 1 WLR 583 at 587), as explained and analysed in *Bolitho v City & Hackney Health Authority* [1997] UKHL 46). A clinician is not negligent if he/she has acted in accordance with a practice accepted as proper by a reasonable, responsible or respectable body of medical opinion. Thus, to establish liability in such a case, it must be shown that no reasonably competent clinician would have acted as the defendant did.

Where, however, the criticism does not relate to a matter of clinical judgement, it is arguable that the *Bolam* test does not apply. If, for example, the criticism is of an allegedly negligent interpretation of a histology slide (*Muller v Kings College Hospital NHS Foundation Trust* [2017] EWHC 128 (QB); *Penney v East Kent Area Health Authority* [2000] Lloyd's Rep Med 41), the first question to be determined is one of fact: what could be seen on the slide? Whilst that requires expert evidence, it is for the judge to make his own finding of fact on the balance of probabilities. The *Bolam* test does not apply. Only thereafter does the judge have to address the question whether a reasonably competent cyto-screener could have failed to see what was on the slide, or could have treated it as negative. Similarly, where there has been a disastrous failure to interpret ultrasound scan images, which in fact show abnormalities, it will be difficult for a defendant to maintain that the scan was interpreted with reasonable care unless it can present a reasonable and plausible explanation for the failure (*Lillywhite v University College London Hospitals NHS Trust* [2005] EWCA Civ 1466; *XXX v King's College Hospital NHS Foundation Trust* [2018] EWHC 646 (QB)). In such *"pure diagnosis"* cases the court may be willing to infer a failure to exercise reasonable care and skill, without resort to the *Bolam* test.

The same would also be true in the case of obvious medical errors, such as amputating the wrong leg or leaving surgical forceps inside a patient.

In cases concerning consent, *Montgomery* now establishes that the *Bolam* test no longer applies. A doctor is under a duty to take reasonable care that the patient is aware of any material risks involved in treatment and of any reasonable alternative treatments. That is because the question whether a risk of surgery, or the availability of an alternative form of treatment, ought to be discussed with the patient is not a matter of purely professional judgement (*Montgomery v Lanarkshire Health Board* [2015] UKSC 11). If, therefore, a claim can properly be characterised as one involving a failure to obtain the patient's informed consent (i.e. by discussing the risks and benefits of treatment and any reasonable alternatives) it

may be easier to establish liability than if you are alleging *Bolam* negligence.

In cases involving unusual types of loss, it is important to consider the scope of the duty. As Lord Hope stated in *Chester v Afshar* [2004] UKHL 41 at [51]: *"damages can only be awarded if the loss which the claimant has sustained was within the scope of the duty to take care."* For example, in wrongful birth cases, there is no claim for the costs of raising a healthy child (*McFarlane v Tayside Health Board* [2000] 2 AC 59), but the additional costs of bringing up a disabled child are recoverable, where the disability arose from genetic causes or foreseeable events during the pregnancy (*Parkinson v St James and Seacroft University Hospital NHS Trust* [2001] EWCA Civ 530). On the other hand, where the doctor's duty was to advise the claimant that she was a carrier of the haemophilia gene, the doctor was liable for the additional costs of raising a child with haemophilia, but not for any other risks of pregnancy, including the risk that the child might suffer from autism (*Khan v Meadows* [2019] EWCA Civ 152).

It is thus essential to determine at the outset the basis upon which you are alleging negligence, and to ensure that your expert is addressing the correct test in their report. Equally, do not assume that the judge will necessarily be familiar with the legal principles. In most cases, there is no better starting point than Green J's excellent summary in *C v North Cumbria University Hospitals NHS Trust* [2014] EWHC 61 (QB) at [20]-[24].

Limit the Number of Issues

Avoid a scattergun approach. Your client may have numerous complaints about his/her treatment, many of which may have made no difference to the outcome. It can, moreover, be tempting for experts to raise issues about which they are critical, sometimes as the case develops, which add little to the claim. Whilst the case plan needs to be sufficiently flexible to accommodate changes resulting from new information, it is important not to allow the experts to determine how the case is to be run. My preference is to obtain a draft expert's report, prepared on an advisory, rather than a Part 35, basis. This can be subjected to careful analysis and discussion in conference, taking into account issues raised in the letter of response, in order to formulate the claim. If the expert's views do not withstand rigorous testing, an alternative expert could be instructed at that stage, without the risk of having to disclose the initial report (cf *Edwards-Tubb v JD Wetherspoon PLC* [2011] EWCA Civ 136 at [31]). Otherwise, draft Particulars of Claim can then be prepared for approval by the expert, and used as a template for the Part 35 report. Everyone should then have a clear picture of how the case is put.

Consider also whether there is an alternative presentation which would make the case easier to prove. The more unusual the presenting condition, the harder it will be to show that it ought to have been recognised by a reasonably competent clinician. For example, I am currently dealing with a case involving a failure by a paediatrician to deal with a longstanding, but rare, vascular malformation, leading to tumour growth and compressive damage to the spinal cord. Rather than alleging a negligent failure to diagnose the condition (which would be outside the knowledge and experience of a reasonable paediatrician), we have alleged a failure to refer to a specialist multi-disciplinary team, on the basis that there were sufficient concerns regarding the patient's condition to merit tertiary referral.

Ensure Causation has been Considered and Pleaded

The claimant must prove that the defendant's breach of duty caused or materially contributed to the injury (*Bailey v Ministry of Defence* [2008] EWCA Civ 883; *Williams v The Bermuda Hospitals Board* [2016] UKPC 4). Merely adding a potential risk factor is insufficient (*Wilsher v Essex Area Health Authority* [1988] AC 1074), nor it would seem is the loss of a chance of a better outcome (*Gregg v Scott* [2005] UKHL 2). Obviously, if the outcome would have been the same but for the defendant's negligence, the claim fails on causation (*Barnett v Chelsea & Kensington Hospital Management Committee* [1969] 1 QB 428). If the claimant alleges that she was not properly informed about the risks of treatment and the availability of alternatives, it is necessary for her to plead and prove what she would otherwise have done. In particular, if the claimant relies upon a surgeon's failure to warn of the risks of surgery, it is normally necessary for the claimant to prove that, properly warned, she would never have undergone surgery. Where, however, there has been a negligent failure to warn of a particular risk, and the injury is intimately connected to the duty to warn, then the injury is to be regarded on policy grounds as being caused by the breach of the duty to warn (*Chester v Afshar* [2004] UKHL 41). If that extension to the established principle of causation is to be relied upon, it is necessary to plead the point and support it by evidence (*Correia v University Hospital of North Staffordshire NHS Trust* [2017] EWCA Civ 356).

I sometimes find that it is easier to consider issues of causation before breach of duty. In cases of obstetric

negligence resulting in cerebral palsy, for example, it is usually critical to determine the latest time by which the baby would need to have been delivered, in order to avoid hypoxic brain damage. Once that has been established, the enquiry may solely focus upon breaches of duty prior to that time.

What Facts Need to be Proved, and How?

Cases are invariably won or lost on the quality and strength of the evidence. Clinical negligence claims are no exception. In any such claim it is essential to obtain and carefully review the clinical records. Contemporaneous evidence in medical records, made pursuant to a professional duty to inform the care and treatment of a patient, is by its nature likely to be reliable, and will frequently be preferred where it conflicts with the recollection of witnesses. For example, in a case I recently tried concerning an allegedly negligent delay in diagnosing a Clostridium difficile infection, careful review of the nursing records and prescription charts confirmed the entries in the clinical records regarding the time of onset of the claimant's diarrhoea. Where, however, there is uncertainty concerning the circumstances in which a critical note was made, it will be less persuasive (*Synclair v East Lancashire Hospitals NHS Trust* [2015] EWCA Civ 1283).

Given the fallibility of human memory, it is essential to obtain detailed instructions from your client and any witnesses, and to incorporate their accounts into signed witness statements at an early stage, even though those statements may need to be refined and redrafted prior to trial. The reliability of those accounts should be assessed against the contemporaneous clinical records. If it is suggested that the records are inaccurate, how can they be successfully challenged? It may be that a witness has a particular reason for recollecting that an event occurred on a particular date or in a particular manner (for recent examples, see *Henderson v Hillingdon Hospital NHS Foundation Trust* [2018] EWHC 3281 (QB) and *Shaw v Stead* [2019] EWHC 520 (QB)). If so, that needs to be clearly explained in their witness statement. Are there any other sources of reliable evidence? I am currently involved in a cerebral palsy case involving a failure to expedite delivery when shoulder dystocia occurred, in which the timings recorded by the midwife in the notes were demonstrated to be wrong by producing metadata from footage of the labour and delivery filmed by the patient's mother on her mobile phone. Having been presented with such evidence, the hospital has admitted both breach of duty and causation.

Can Adverse or Benevolent Inferences be Drawn?

In *Wisniewski v Central Manchester Health Authority* [1998] PIQR P324, an obstetric negligence case where the doctor who should have attended the patient declined to return from Australia to give evidence at trial, the Court of Appeal indicated that a court may be entitled to draw adverse inferences from the absence or silence of a witness who might be expected to have material evidence to give on an issue, provided there was a case to answer. Such an inference might strengthen the evidence adduced on that issue by the other party, or weaken the evidence adduced by the party who failed to call the witness.

Similarly, where a defendant's breach of duty has made it difficult or impossible for a claimant to adduce relevant evidence, the court should judge a claimant's evidence benevolently and the defendant's evidence critically. In *Raggett v Kings College Hospital NHS Foundation Trust* [2016] EWHC 1604 (QB), where the Defendants' breach of duty had resulted in early amputation of the Claimant's leg, the judge took a benevolent approach to the evidence when determining for how long the leg would have remained viable, but for the negligence. Likewise, in *JAH v Burne* [2018] EWHC 3461 (QB), a doubt as to whether anticoagulation treatment would have been effective in avoiding amputation was resolved in the Claimant's favour, as it was the Defendants' admitted breach of duty which deprived her of this opportunity.

I recently relied on those cases in circumstances where a defendant failed to call evidence from the doctor who undertook the allegedly inadequate consent process, and where, owing to a failure to ask for how long a claimant had experienced a new symptom, there was no evidence as to its onset and duration, and accordingly as to the likelihood of a non-surgical cure.

Ensure your Experts are Prepared

Most clinical negligence claims are won or lost on the quality of the expert evidence. Choosing the right expert is essential, as is ensuring that they have complied with their duties under Part 35 of the CPR and *The Ikarian Reefer* [1993] 2 Lloyd's Rep 68. It is the responsibility of the legal team to ensure that the expert has the necessary expertise, is aware of their duties, and has seen all relevant factual material, whether supportive or not (*Kennedy v Cordia* [2016] UKSC 6 at [38] and [57]). Essential guidance as to the principles and considerations applying to the assessment of expert evidence are set out by Green J in

C v North Cumbria NHS Trust [2014] EWHC 61 at [25]. By far and away the most important consideration is the logic of the expert opinion tendered, whether it accords with the inferences properly to be drawn from the clinical notes and other evidence, and whether relevant clinical guidelines or literature have been considered and addressed.

Whilst experts will be assisted in their joint discussions by preparation of a well-drafted agenda, it is important that attempts to agree the agenda should not become a battleground. In the vast majority of cases, any disagreement ought to be capable of resolution through a bit of give and take, or the insertion of some additional questions (*Welsh v Walsall Healthcare NHS Trust* [2018] EWHC 1917 at [35]-[36]).

What carries weight is the expert's reasoning, not the conclusion. An expert's bald statement of opinion is of no real assistance, unless the process of reasoning which led to the conclusion is carefully set out. This was well illustrated in a case I recently tried, in which two eminently qualified and experienced surgical experts disagreed upon whether an entero-cutaneous fistula and bowel rupture had been caused by inadvertent but unrecognised injury to the small bowel during earlier surgery (as contended by the Claimant), or by subsequent herniation of the bowel through the abdominal wall (as contended by the Defendant). Each expert accepted that either theory was possible, but maintained that their version was more probable. In oral evidence, however, two important factors emerged, which led me to prefer the evidence of the defence expert:

1. Whilst both experts considered the CT scan findings to be important, the Claimant's expert had not viewed the images themselves, but had relied upon the radiologist's report, the wording of which was somewhat equivocal. In contrast, the Defendant's expert had viewed the images for himself.

2. The Defendant's expert justified many of the assertions made in his report by references to the medical literature, when the Claimant's expert did not. Such literature strongly supported the suggestion that, even if an undetected injury to the small bowel had occurred during surgery, this was a rare but recognised complication of this type of operation.

If Possible, Keep it Simple!

It goes without saying that, if you are able to provide the judge with a straightforward and logical route to a verdict in your favour, you are likely to win. The most skilful advocate will distil an apparently complex case into its essential elements, concentrating attention on the key points and filtering out the unimportant.

I can think of no better example than the well-known case of *Darnley v Croydon Health Services NHS Trust* [2018] UKSC 50. The Claimant attended at hospital with a head injury. Having been told by a receptionist that he would have to wait 4-5 hours to be seen, when he would in fact have been assessed by a triage nurse within 30 minutes, he went home and later suffered a deterioration in his condition resulting in permanent brain damage. At 1st instance and before the Court of Appeal, there were extensive arguments regarding the scope of the receptionist's duty, whether there had been an assumption of responsibility to give accurate information, whether this was a case of negligent misstatement, whether it would be fair, just and reasonable to impose a duty (*Caparo Industries v Dickman* [1990] 2 AC 605), whether the Claimant's decision to leave broke the chain of causation, and so on. Only when the case reached the Supreme Court (and in the light of the recent decision in *Robinson v Chief Constable of West Yorkshire Police* [2018] UKSC 4) was there a fundamental shift in the presentation of the Claimant's case. The duty of care was owed by the hospital, not the receptionist. Once the claimant attended hospital and was booked in, the hospital owed a duty to take reasonable care not to cause him foreseeable physical injury, a duty which extended to the provision of misleading information. The Claimant succeeded.

Secondary victim claims in clinical negligence cases – watch this space....

ANNA DATTA
PARKLANE PLOWDEN

Since *Alcock v Chief Constable of South Yorkshire Police* [1992] 1 AC 310, there have been strict control mechanisms on secondary victim claims, one of which is proximity. In clinical negligence cases, this is even more difficult to establish due to there typically being a delay between breach of duty and damage. Consequently, Defendants have often sought to strike out these claims.

Walters v North Glamorgan NHS Trust [2002]

This Court of Appeal case is considered a success for Claimant's bringing secondary victim claims. The Defendant hospital admitted liability for the negligent misdiagnosis of a 10-month-old baby. Whilst in hospital, his mother woke in the night to find him fitting. She was later told that her son had suffered irreparable brain damage and died 36 hours after the initial fit.

The question for the Court of Appeal to consider was whether the 36-hour period could be regarded as one horrifying *'event'* for the purposes of establishing proximity. The Court concluded that an *'event'* could occur over days. As Lord Justice Ward commented, there was an *'inexorable progression from the moment when the fit occurred ...and the dreadful climax when the child died in her arms. It is a seamless tale with an obvious beginning and an equally obvious end.'*

Taylor v A Novo [2013]

The Court of Appeal case of *Taylor v A Novo* however represented a shift in approach and appeared to dispose of secondary victim claims where proximity was in issue.

The Claimant's mother was injured at work. Three weeks later she unexpectedly collapsed at home and died due to a deep vein thrombosis and consequent pulmonary emboli caused by the injuries sustained in the original accident at work. The Claimant (who was not present for the initial accident), witnessed her mother's death and suffered significant post-traumatic stress disorder.

The Court of Appeal concluded that the accident at work had two consequences. The first was the initial injuries; and the second (three weeks later) was the death. The claim was dismissed on the basis that there was insufficient proximity in time – the three-week delay meant that the Claimant's mothers' death was not a *'relevant event'* for the purposes of deciding the proximity question.

Paul v The Royal Wolverhampton Trust [2020] and *Polmear and another v Royal Cornwall Hospitals NHS Trust* [2021]

There are however, now two appeals *Paul* and *Polmear* waiting to be heard by the Court of Appeal on the issue of proximity. Both appeals arise out Defendant applications to strike out the secondary victim claims.

In *Paul* there was a 14-month gap between the breach of duty (the failure to diagnose and treat the Claimant's father's heart condition) and the Claimant's father's death. Once again, the dispute between the parties was whether the Claimant's father's collapse and death could be viewed as one *'event'*.

At first instance, Master Cook struck out the secondary victim claim on the basis that viewing 14 months as an *'event'* was not supported by *Taylor*. On appeal, Mr Justice Chamberlain concluded that negligence and the traumatic event did not have to occur at the same time. He argued that shocking *'event'* concludes when the damage becomes evident. *Taylor* was therefore distinguished, as Mr Paul's heart attack was the first occasion on which the hospital's negligence manifested.

In *Polmear* the Claimants' secondary victim claims arose out of the Defendant's negligent failure to diagnose their daughter (Esmee) with a life-threatening condition. The parents had sought medical advice due to Esmee suffering from frequent episodes of breathing difficulties and vomiting. In the period between her second referral and being seen at the hospital, Esmee suffered from a more

serious event and sadly died. During the final episode, her parents were present and attempted to resuscitate her.

The key issue, was again, whether there was a relevant *'event'*. Unlike in Paul, Esmee had suffered several incidents of breathing difficulties before the episode that led to her death. Master Cook accepted, relying on the medical records, that the incidents of breathing difficulties were *'very regular and clearly very worrying'* for the Claimants. The Defendant therefore argued that this wasn't the first manifestation of the negligence. Considering the decision in *Paul*, Master Cook found there was at least an arguable case that Esmee's previous episodes of breathing difficulties were not a bar to the Claimants recovery as secondary victims.

Comment

The difficulty for secondary victim claims in clinical negligence cases is that the negligence typically involves an omission which leads to an injury that only becomes apparent at a later date. Consequently, there is rarely an *'event'* (as envisaged by the *Alcock* test) that gives rise to an immediate injury.

Although the cases of *Paul* and *Polmear* are successes for Claimants and suggest a shift away from *Taylor*, they are subject to appeal. It should also be considered that these cases involved strike out applications and that the test the Court was applying was whether there was *'no reasonable grounds for bringing the claim'*. Success defending a strike out application does not therefore equate to succeeding on the point at trial. As a consequence, Claimant solicitors should treat the judgments of *Paul* and *Polmear* with a degree of caution.

The *Alcock* test, and in particular the requirement for proximity, is intended to narrow the potential number of secondary victim claims. In the current era of cost-conscious litigation and escalating clinical negligence claims, it would be a surprise if the Court of Appeal broadened the proximity requirement. Guidance from the Court of Appeal would however be welcomed in order to be able to offer clients some clarity and avoid the gamble of defending strike out applications on the issue.

As with all secondary victim claims, each case must turn on a detailed examination of its own facts. When considering proceeding with a secondary victim claim, the advice would be to prepare early. Firstly, review the medical records for any prior *'damage'* arising from the negligence as this will certainly increase the litigation risk of the claim. Secondly, ensure that the medical evidence supports that the psychological injury is attributable to witnessing the shocking event. And thirdly, to ensure that it is clear and consistent throughout (letter of claim, medical evidence, and witness statement) as to the nature of the *'event'* and the impact it had on the Claimant, because this a claim that the Defendant is likely to challenge.

Medical treatment claims under section 75 of the Consumer Credit Act 1974

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Introduction

Where medical treatment has been paid for on a credit card, a dissatisfied patient may have recourse against the credit card provider under section 75 of the Consumer Credit Act 1974 ("CCA").[1] This provision gives consumers who have been the victim of a misrepresentation or breach of contract by the supplier of goods or services paid for on a credit card the option of seeking redress against the supplier, the credit card company or both.

Where healthcare is increasingly being sought on a private basis, in particular by those who *'self-fund'*, claims arising from such treatment are likely to increase in frequency. A LaingBusson report in November 2019[2] noted a doubling in the sum spent on self-funded private healthcare in the UK in the 5 years between 2013 and 2018, from £527 million to £1.1 billion p.a.; one in four private patients was self-funded. The growth in patients choosing to self-fund private hospital treatment was said to be present across all specialties, particularly orthopaedics, ophthalmology, gastroenterology, gynaecology and urology with growth in demand for diagnostic services such as MRI scans, CT scans and endoscopy. It seems likely that this trend towards self-funded private healthcare will have been accelerated by the Covid-19 crisis and the increasing pressures on NHS waiting lists. In addition, self-funding is the norm in elective cosmetic procedures, which seem likely to increase in number once pandemic restrictions are eased.

What then are the options for the self-funded patient who receives treatment that was not what he or she bargained for? A patient may of course pursue a claim against the clinician or organisation providing the treatment, usually both under common law negligence and breach of contract and less commonly under the tort of misrepresentation. There may however be challenges to that approach; the defendant may be insolvent, inadequately insured or difficult to trace (particularly if abroad). If however the treatment was paid for using a UK credit card, an additional route to compensation may exist. Section 75(1) CCA provides:

> *"If the debtor under a debtor-creditor-supplier agreement falling within section 12(b) or (c) has, in relation to a transaction financed by the agreement, any claim against the supplier in respect of a misrepresentation or breach of contract, he shall have a like claim against the creditor, who, with the supplier, shall accordingly be jointly and severally liable to the debtor."*

For these purposes, a *"debtor under a debtor-creditor-supplier agreement falling within section 12(b) or (c)"* means someone who has paid for goods or services on his or her credit card. The *"supplier"* is the person or company who sold the goods or services and the *"creditor"* is the credit card company. It is important to remember that the debtor's claim against the creditor is no different in substance from that against the supplier – it is *"a like claim"*. It is no wider, in that it still requires a misrepresentation or breach of contract by the supplier to be shown, but on the other hand no narrower in that it replicates in scope and remedy the claim against the *"supplier"* (in our example, the provider of private medical treatment).

How then could s75 CCA be of application to claims relating to medical treatment? I have attempted below to identify and where possible answer the key questions that clients and practitioners in this field are likely to have:

1. Does s75 CCA apply to medical procedures?

Yes. The section applies to *"a transaction financed by"* a credit agreement, without any restriction as to the subject matter of the transaction. The provision (though surprisingly rarely litigated for something which has been on the statute books for approaching half a century) has been held in a reported case to apply to a privately-

1 *The same may also apply where the medical treatment has been paid for under a specific loan agreement or finance scheme. For simplicity this article will focus on the credit card situation.*

2 *Private Healthcare: Self-Pay UK Market Report (2019, LaingBusson)*

funded medical procedure in the form of a *"treatment for baldness which went disastrously wrong"*.[3] Significantly, the section was relied on by around 600 claimants in the widely-reported PIP breast implant litigation to secure a settlement against their credit card provider Lloyds TSB[4] (albeit that this did not require the court to consider the scope of the section). Other reported claims under the section have been as varied as for purchase of land[5], a conservatory[6], a DVD recorder[7] and a personalised number plate.[8] The Financial Services Ombudsman (discussed further below) has determined a number of complaints under s75 in relation to medical treatment paid for with a credit card or finance scheme.

2. What is a *"misrepresentation"*?

A *'misrepresentation'* is an untrue statement of fact (which can be made by words or conduct) that causes someone to enter into a contract. Misrepresentations can be categorised as fraudulent, negligent or innocent. In the medical context, a fraudulent misrepresentation might include a surgeon stating that a proposed procedure had a 100% success rate when in fact the surgeon knew the success rate was much lower; the same statement might be negligent if the surgeon, though believing it to be true, ought with proper care to have been aware of literature which contradicted it; the statement might be an *"innocent misrepresentation"* if the literature disproving it had not yet been published. A claimant who has been induced to enter into a contract by means of a fraudulent or negligent misrepresentation is entitled to be put in the position which he or she would have occupied if the misrepresentation had not been made.[9] This can include not only the return of the money paid under the contract but also compensation for consequential losses arising from having entered into the contract, including damages for personal injury (though the cases on this are limited).[10] It should be noted that an action in negligent misrepresentation can be founded on common law as well as section 2(1) of the Misrepresentation Act 1967 and that there is an interface between the statute and Pt 4A of the Consumer Protection from Unfair Trading Regulations 2008 which prohibit certain aggressive or unfair trading practices. In respect of innocent misrepresentation, the primary remedy is rescission i.e. unwinding the contract to return the parties to the position they occupied before it was entered into (which, in the medical context, seems unlikely to be possible in the majority of cases); where rescission is impossible, the court has a discretion to award damages in lieu but those damages are not likely to include compensation for consequential losses including personal injury. In reality therefore claims in this area are likely to be limited to fraudulent or negligent misrepresentations.

3. What is a *"breach of contract"*?

At its most straightforward, a supplier of goods or services (in our contemplated example, a medical professional providing treatment) will be liable for any loss (including consequential losses) caused by a failure to comply with the terms of the agreement reached with the customer. The common law has long held that in most circumstances a contract for the performance of a service will include an *'implied term'* that the service will be carried out using reasonable care and skill. Section 49 of the Consumer Rights Act 2015 replicates the implied term of reasonable care and skill; section 50 goes further in providing that *"anything that is said or written to the consumer"* by the trader *"about the trader or about the service"* may become a term of the contract if (a) it is taken into account by the consumer when deciding to enter into the contract, or (b) it is taken into account by the consumer when making any decision about the service after entering into the contract. This formulation widens the scope of statements or representations which, though not forming part of the written agreement, may nonetheless be actionable as contract terms.

4. Are there financial limits on the cost of the treatment?

To qualify for protection, the cash price of the goods or services must be more than £100 and not more than £30,000 – s75(2). In certain circumstances where the cash price is over £30,000, a credit provider under a *"linked credit agreement"* might still be liable under s75A; an important feature of s75A is that (unlike s75) it requires at least *"reasonable steps"* to be taken to pursue the claim against the supplier first, before seeking redress from the creditor.

3 *Bond v Livingstone & Co [2001] 3 WLUK 739; [2001] PNLR 30*
4 **https://www.bbc.co.uk/news/health-20935107**
5 *Mal'ouf v MBNA Europe Bank Ltd (t/a Abbey Cards) [2014] 1 WLUK*
6 *MBNA v Ankers [2013] 8 WLUK 294*
7 *Grant v Electro Centre Ltd [2006] 6 WLUK*
8 *Lampon v Midland Registration Ltd [2000] 5 WLUK 821*
9 *I.e. the tortious measure of damages – see* **McGregor on Damages**, *20th Ed, Chapter 49.*
10 *McGregor cites the* "strange case" *of Burrow v Rhodes [1899] 1 QB 816 where the claimant was induced to join an invasion of the South African Republic by various fraudulent misrepresentations; he successfully claimed damages arising from the loss of his leg, his kit and his pay.*

5. Does the whole cost of the treatment/ procedure have to be paid for on a credit card?

No. Under section 189 CCA *"finance"* means to finance wholly or partly, and *"financed"* in s75 is construed accordingly. In essence, this means that only part payment (such as a deposit) is required to be made by credit card in order for the section to apply. Importantly, whilst a £100 threshold exists for the item which is the subject of the transaction, if any part of that single item (even less than £100) is paid for on a credit card, s75 is engaged.

6. Is the debtor/patient limited to a refund of the price paid or can he/she get damages for consequential loss?

Although reported cases interpreting the section are surprisingly sparse, there appears to be a consensus[11] that damages for consequential losses are recoverable pursuant to s75, an important consideration in medical treatment cases where the injury, loss and damage inflicted by inadequate treatment may outstrip the treatment cost many times over. This is consistent with the structure of s75, which replicates as against the creditor the debtor's causes of action in misrepresentation and breach of contract against the supplier. As discussed above, damages for consequential loss may be claimed under misrepresentation (fraudulent or negligent) or breach of contract against the supplier[12] and there is no express wording in the statute to limit the scope of the remedies available to the debtor in the parallel action against the creditor.

7. What if the treatment took place outside the UK?

Section 75 will still apply, so long as the credit agreement is with a creditor carrying on business in the UK. An argument that s75 should be limited to transactions in the UK was roundly rejected by the House of Lords in *Office of Fair Trading v Lloyds TSB Bank plc and others*.[13] This wider approach is clearly beneficial to patients who seek treatment abroad, paid for on a UK credit card, who may otherwise face an uphill struggle in obtaining compensation for deficiencies in that treatment.

8. Who is the creditor?

Section 189 CCA defines *"creditor"* as *"the person providing credit under a consumer credit agreement or the person to whom his rights and duties under the agreement have passed by assignment or operation of law"*. Essentially, this means the company (usually a bank or building society) that has provided the credit card under an agreement with the debtor rather than the payment processing network (such as Visa and Mastercard). American Express is both a credit card provider and a payment processing network.

9. What if the debtor was in breach of his or her credit agreement?

Section 75(4) CCA provides that *"This section applies notwithstanding that the debtor, in entering into the transaction, exceeded the credit limit or otherwise contravened any term of the agreement."*

10. What is the limitation period for bringing a claim?

Where the transaction concerned is one involving medical treatment, any claim for damages arising from inadequate treatment is likely to include a claim for damages *"in respect of personal injuries"*[14] within the meaning of section 11(4) of the Limitation Act 1980. In those circumstances a 3 year limitation period will apply, measured from the date the cause of action arose or the claimant's date of knowledge within section 14 of the 1980 Act. In *Bond* (see above), the claimant's representatives erroneously believed that a claim against two credit card companies could be brought as of right up to 6 years from the date of the alleged breach; the court found otherwise, declined to extend time pursuant to section 33 of the Act and dismissed the claimant's claim; the claimant then obtained summary judgment against his

11 *See Bond (supra) where no point is raised as to the legitimacy of a claim in general damages against the credit card company for the failed treatment.*

12 *Though the approach to the measure of loss differs between the tort of misrepresentation (where the Claimant's* "reliance interest" *is protected i.e. the claimant is to be put in the position he or she would have occupied had the misrepresentation never been made) and breach of contract where the* "expectation interest" *is protected i.e. the claimant is to be put in the position he or she would have occupied had the contract term been fulfilled.*

13 *[2007] UKHL 48*

14 *One might however have a claim for e.g. last minute cancellation of an elective procedure where the patient/debtor is seeking refund of the sum paid and consequential losses such as travel or accommodation expenses, which might not involve a claim for* "personal injuries".

solicitors for negligently failing to bring the claim against the credit card companies in time.

11. Does the debtor have to sue the supplier first / at all?

No. There is no requirement that the supplier (such as the operating surgeon or treatment clinic) be sued in preference to the credit card provider. Indeed, the Financial Ombudsman Service (which has jurisdiction in relation to complaints against consumer credit providers) has awarded compensation to a customer for inconvenience caused by a credit card company *"repeatedly, and incorrectly, telling him that it was only required to meet his claim if he first obtained a court judgment against the supplier."* That having been said, it would seem prudent to heed the words of Master Ungley in *Bond*, remarking on *"the desirability of joining all Defendants potentially at risk in the original action. It would not have greatly increased costs. There would have been three defences rather than one and they may well have served contribution notices against each other. Since proceedings were commenced it is difficult to see why it was not done in 1994. Had this been done, Mr Bond would have recovered the damages to which he seems undoubtedly entitled and there is some doubt whether the costs of the second proceedings being brought out of time would ever have been incurred."*

12. Does QOCS apply to a s75 claim against a credit card company in relation to medical treatment?

CPR 44.13(1) provides that section II of Part 44 which deals with Qualified One-Way Costs Shifting *"applies to proceedings which include a claim for damages – (a) for personal injuries..."*. Provided that the s75 claim does indeed include a claim for personal injuries, whether for general damages or losses arising (or more likely both), the QOCS provisions would seem to apply. This would also be consistent with the reasoning in relation to the application of the 3 year limitation period discussed in *Bond* (see point 10 above).

13. Can a claim be brought under s75 by the estate or dependents of a patient who has died following / as a consequence of medical treatment paid for on a credit card?

Subject to certain exceptions, all causes of action vested in (i.e. maintainable by) a person who dies will survive for the benefit of his or her estate (section 1 Law Reform (Miscellaneous Provisions) Act 1934). This would appear to include a s75 claim against the credit card company. However, the position is different in respect of a (usually more valuable) dependants' claim where the deceased's death is alleged to have been caused by the deficient medical treatment. The claim for the benefit of the dependants under the Fatal Accidents Act 1976 is purely statutory and the cause of action does not arise until the death of the deceased. In so far as a s75 claim requires the person bringing the claim to be both (in our scenario) the injured patient (who contracted with the supplier) and the credit card holder, this appears to preclude its being deployed by the surviving dependant(s).

14. What if the treatment was paid for on someone else's credit card?

Section 75 applies if the *"debtor"* has a claim against the supplier. In the context of credit cards, the question arises whether the term *"debtor"* only covers the person who enters into the agreement with the card issuer or whether it extends to any *"additional card-holders"* which the account-holder nominates to receive additional cards for use on the account. The definition of *"debtor"* in s.189(1) (as *"the individual receiving credit under a consumer credit agreement"*) suggests that only the account-holder is the *"debtor"*. The additional holders have been given authority by the account-holder to obtain goods or services to be paid for, in the first instance, by the card issuer, with reimbursement to be made by the card-holder. This arrangement does not render them *"debtors"* to whom the card issuer has provided *"credit"* in the sense of enabling them to defer payment. On the other hand, it may be arguable (at least in some fact situations) that when they use the card, the additional holders act as agents for the account-holder and therefore any claims arising against the supplier are the claims of their principal: the debtor. Moreover, the Financial Ombudsman Service has upheld a claim made by an additional cardholder where that person purchased goods for the benefit also

of the principal cardholder.[15] By contrast however, the ombudsman has rejected a number of claims where cosmetic surgery was paid for by the patient's spouse on credit, on the basis that the patient and the debtor were two different people.[16] Absent a successful argument that the patient in undergoing the procedure was acting as agent for the account holder and/or that the medical procedure was to the benefit of the patient and account holder jointly, a s75 claim in this situation appears unlikely to succeed.

15. Do I have to go to court?

Part XVI of the Financial Services and Markets Act 2000 created an ombudsman scheme *"under which certain disputes may be resolved quickly and with minimum formality by an independent person"*. The Financial Services Ombudsman has jurisdiction to determine complaints in relation to the provision of credit to consumers as a regulated activity under FSMA 2000. The outcome of complaints *"is to be determined by reference to what is, in the opinion of the ombudsman, fair and reasonable in all the circumstances of the case."* The overall approach of the FSO of providing a swift, free resolution of disputes without a hearing may on its face appear attractive. However, the absence of a hearing and of cross-examination to test evidence may limit the appropriateness of the scheme to only the most straightforward and modest of medical claims. The FSO rules allow for the referral of a complaint to another complaints scheme or the court, which may occur where the Ombudsman considers the matter too complex for the informal scheme to be appropriate or if the limit in the sum which he has jurisdiction to award may be insufficient.[17] The level of compensation which the FOS can award is subject to limits depending on the date of the acts complained of and the date on which a complaint is referred. The current cap is £355,000 (excluding interest) for complaints referred on or after 1 April 2020 about acts or omissions by firms on or after 1 April 2019.

15 *See* https://www.financial-ombudsman.org.uk/files/105848/DRN4115539.pdf

16 *See* https://www.financial-ombudsman.org.uk/files/64133/DRN2215933.pdf; https://www.financial-ombudsman.org.uk/files/106003/DRN4121740.pdf *and* https://www.financial-ombudsman.org.uk/files/240966/DRN7944294.pdf

17 *See for example* https://www.financial-ombudsman.org.uk/files/43870/DRN1246765.pdf

Fixed Recoverable Costs: Change needs to start at the top

SARAH STOCKER
TEES

Medical Defence Organisations (MDO) are currently calling on the government to speed up the introduction of Fixed Recoverable Costs (FRC) to address the *'unsustainable'* costs posed by clinical negligence litigation.

The Department of Health is continuing to consult on the implementation of FRCs for cases worth less than £25,000, with MDOs putting forward the argument that for claims worth under £25,000, the costs are disproportionate to the damages awarded.

The Chief Executive of the MDU was recently quoted as saying: *"The NHS went into the pandemic burdened by an outdated legal system for clinical negligence litigation... This situation has arisen not because care is somehow less safe – quite the contrary – it is because we have a medical negligence system that is unfair and unsustainable and results in millions of pounds leaving the NHS – money that could otherwise be spent on more and better services for patients. A balance needs to be found that is fair and affordable."*

I wholeheartedly agree that things need to change within the NHS with a view to reducing the costs incurred in resolving clinical negligence claims. However, reducing the costs incurred by claimant clinical negligence solicitors needs to be the final link in the chain. The government consultation on FRCs and the MDOs need to start from the top down, not the bottom up. Furthermore, any changes need to be incremental, assessing what steps do work to improve patient safety and reduce claims, before seeking to move to the next step.

Being a Claimant Clinical Negligence Solicitor is somewhat of a paradox, I enjoy my work and take great pride in helping those that have been harmed, through no fault of their own, get their lives back on track, but it is also a job that I wish didn't exist. I wish our NHS and private healthcare sector did not, on occasion, fail people: the delays in diagnosis; the administration of incorrect medication; the harm caused during surgery; and the avoidable deaths. The change needs to come from the top to stop these failures and the associated claims happening in the first place. This shouldn't be an argument about costs, this should an argument about how best to improve patient safety.

The government consultations and the MDOs fail to realise the work that claimant clinical negligence solicitors do in reducing the number of claims being put to the NHS and/or MDOs in the first place. It is accepted across our profession that for every 20 or so potential clients that come forward concerned about their treatment, only 1 will have a viable claim. We listen to the other 19 patients and take the time to help them understand what went wrong and why – often that is all they want. This can involve reviewing thousands of pages of medical records and sometimes getting expert input. We do not get paid for this, but we believe it is important work - patients have a right to understand what happened and the current system is still not as open, honest, transparent and thorough as it should be.

Specialist clinical negligence lawyers are, therefore, important gatekeepers for the NHS and MDOs – they screen vast numbers of claims without merits. The introduction of FRCs will however, make this unsustainable, resulting in an access to justice problem for potential claimants, an associated rise in litigants in person and non-specialist entrants to the market. This will increase costs to the NHS/MDOs who will have to investigate and respond to patients who are not legally represented or are represented by lawyers with no expertise in this area.

One change that has already happened and is starting to have a positive effect on costs incurred is the move to the Clinical Negligence Scheme for General Practice (CNSGP). From 1 April 2019, NHS Resolution began the state indemnity scheme for general practice which covers all GPs and others working for general practice who are carrying out activities in connection with the delivery of primary medical services – including salaried GPs, locums, students and trainees, nurses, clinical pharmacists, agency workers and other practice staff.

Historically, any claim brought against a GP would involve the claimant solicitor having to trace the GP in question to send Pre-Action Protocol documentation in order to ascertain the identity of their MDO. In cases concerning the actions of multiple GPs and the actions of those working within the GP surgery, this involved working with multiple MDOs and in some circumstances, the Partners of the GP practice for the actions of other members of staff.

I want to highlight a case from my own caseload, where a claim against multiple GPs and the GP Surgery itself resulted in increased costs. These issues would not have occurred under the new CNSGP and an example of how implementing change from the Defendant side would have resulted in a massive reduction in costs.

Case Example: (Case and Costs settled)

YY developed bilateral cataracts requiring surgery after the over prescription of a steroid ointment during the course of a 3 year period. This ointment was only supposed to be prescribed under the direction of an ophthalmologist on a short-term basis but was instead issued to YY on a repeat prescription.

A Letter of Claim had been sent by YY's previous solicitors to the GP surgery, setting out the allegations against three GPs and the GP Surgery itself as there was no documentation to demonstrate the identity of those who had re-authorised the repeat prescription at the end of each 6-12 month period.

The First and Third Defendant GPs were represented by one MDO and the claim was duly investigated. The Second Defendant GP did not pass the Pre-Action Protocol Correspondence to their MDO and no investigations were undertaken.

I took over the claim 10 months after the Letter of Claim was sent and despite the First and Third Defendants being represented by an MDO, no Letter of Response had been forthcoming. I subsequently located the Second Defendant and sent out separate Letters of Claim, particularising the allegations against each Defendant GP and the GP Surgery itself, including a request for disclosure of the audit trails to determine the identity of the unknown GPs who had also reauthorised prescriptions during the material period.

A Letter of Response was received from the MDO for the First and Third Defendant, 13 months after the initial Letter of Claim was sent, denying liability in full.

The Second GP finally passed the Letter of Claim to a different MDO, who advised that they would be investigating the claim. Four months passed and no Letter of Response was forthcoming. We were subsequently advised that the original fee earner had gone on maternity leave and in fact no investigations had been undertaken.

Quantum had been investigated and a Part 36 offer of £5,000 was sent to all parties. The MDO for the First and Third Defendants did not respond the offer. The Second Defendant refused to consider the offer as they had not yet investigated the claim and the GP Surgery did not respond to the offer.

Limitation was approaching and an extension was sought from the MDOs and the GP Surgery, as they had failed to provide disclosure or acknowledge receipt of the Letter of Claim. The First and Third Defendants were also Partners of the GP Surgery and their MDO sought to facilitate the passage of communication and information, whilst also making it clear to all parties that they did not represent the GP Surgery itself. The GP Surgery failed to agree a limitation extension.

A conference with Counsel and the experts took place and it was decided to issue proceedings against the First and Second Defendants and the GP Surgery, as they had failed to identify who was responsible for the reauthorisation of the steroid ointment within the relevant period.

Significant investigations still had to be undertaken to ascertain who had authorised the prescriptions and which GP Partners of the practice needed to be served with proceedings, as there was a change in partnership structure within the relevant time period. Proceedings were subsequently served on the First and Second Defendants and the GP Surgery.

Acknowledgements of Service were received from the First and Second Defendants. The GP Surgery failed to file one and an Application was made for Judgment in Default.

The First Defendant then advanced an offer of £3,900. After negotiations, the claim settled for £4,500. £500 less than our initial Part 36 offer, prior to the issue of proceedings.

A Tomlin Order was subsequently agreed between the First, Second and GP Surgery Defendants in which the First Defendant agreed to pay the Claimant's costs incurred against all Defendants.

A word does have to be said for the First Defendant's Solicitor at the MDO who did work with me on a number of occasions to try and facilitate the procurement of information from the GP Surgery. Such assistance was

also sought from the Second Defendant MDO and refused.

The bill of costs was served, detailing the difficulties throughout the litigation. No points of dispute were received from the Defendant and costs in this case were resolved at £60,000, including the previous solicitors' costs, ATE premium, costs draftsman's fees, interest and VAT.

The number of Defendants, different MDOs, delays and/or failures in responding to Pre-Action Protocol Correspondence, failure to respond to Pre-Action offers of settlement, failure to respond to offers of ADR and the actions of the unrepresented GP Surgery resulted in significantly increased costs.

The NHS Resolution CNSGP will avoid the difficulties encountered by multi-defendant and multi-MDO cases, which themselves will result in a vast reduction in costs.

This demonstrates that Defendant structures have been identified to change to reduce costs, not the actions of Claimant Solicitors. I am confident that I managed this case as quickly and as cost effectively as I could. I do not believe those acting for the Defendant MDOs could confidently say the same.

Care Home or Home Care?

HOWARD ELGOT
PARKLANE PLOWDEN CHAMBERS

The Problem

Usually it will be cheaper for a severely injured claimant to be cared for in a residential care home than in his/her own home. A house large enough for the claimant and his/her carers will have to be bought and a bespoke annual care package will have to be paid for, together with the costs of appropriate therapists. Defendants therefore tend to argue that it would be in the claimant's *"best interests"* for him/her to be cared for in a care home, or that the *"most practicable solution"* would be for him/her to be cared for in a care home.

The Law

See Pill LJ in *Sowden v Lodge* [2005] 1 WLR 2129, 2137:-

> *"11. The relevance of the Rialas[1] case is that the issue was whether the tortfeasor was required to pay for a 12-year-old boy to be cared for at home or whether he should live in an institution. That is a question similar to those in the present cases. On the facts of that case, the cost of caring for him in an institution was lower. Stephenson LJ stated that "what has to be first considered by the court is not whether other treatment is reasonable but whether the treatment chosen and claimed for is reasonable".*

.....38 The test to be applied is in my judgment that expressed by O'Connor and Stephenson LJJ in *Rialas v Mitchell* 128 SJ 704. That is different from the test applied by the judge who repeatedly used the expression *"best interests"* though he equated that with a position which *"most nearly restores her to the position in which she would be but for the accident"*. The judge's good intentions with respect to the claimant's welfare are not of course in question... but there is a difference between what a claimant can establish as reasonable in the circumstances and what a judge objectively concludes is in the best interests of the claimant. In this context paternalism does not replace the right of a claimant, or **those with responsibility for the claimant**, making a reasonable choice.

These principles were applied in favour of the claimant in *Harman (A Child) v East Kent Hospitals NHS Foundation Trust* 2015 PIQR Q4, a helpful case which considers arguments for and against institutional or domiciliary care on the facts of that particular case.

The Evidence

Kemp and Kemp 16-017.3 states that:-

> *"on the issue of whether a brain damaged claimant reasonably needs private accommodation, the court can expect to hear from a range of witnesses: the claimant's own family, the claimant's case manager, staff at the residential home, therapists and expert witnesses (not least neuropsychologist and neuropsychiatrist)."*

A defendant will often argue that:

- there will be great difficulty finding and retaining sufficient qualified staff to meet the claimant's needs in his/her own home;

- the claimant will derive benefit from the social stimulation of other residents of the care home that he/she cannot get elsewhere;

- it will be difficult for the claimant to adjust to a move from his/her care home.

It is trite law that in these cases a defendant will fail if its evidence in support of an alternative care regime is only put forward in general terms. As Edwards-Stuart J noted in *Sklair v Haycock*, [2009] EWHC 3328 (QB), para. 58:-

> *"The court needs to be guided by specific evidence rather than aspiration or speculation: in this situation it is for the Defendant to put forward cogent evidence in support of the alternative regime for which she*

1 *Rialas v Mitchell 128 SJ 704*

contends (see Sowden v Lodge [2005] 1 WLR 2129, at paragraphs 85 and 86, per Pill LJ)."

A court is highly unlikely to override the wishes of a claimant who has appropriate health and welfare capacity.

A Practical Example

The following passages in italics are taken from my Opening/ Skeleton Argument in *MB v NHS Trust* – an Anonymity Order was granted.

The Claimant had no useful limb movement, was fed through a tube and there was a dispute as to her level of consciousness. She responded very positively to her family and to music, and this was demonstrated on a video, to counter the more extreme expert's opinions.

The Suitability of the Present Care Home

Care at *"Care Home"* costs £122,720.00 per annum. Care there however is sub-optimal for the Claimant's needs. The cost should be contrasted with the opinion of Dr C that in order to provide an adequate care package for the Claimant he would expect a residential home to be charging close to £200,000 per annum (1, p.257, para.10).

It was always the aim of those at Care Home to discharge the Claimant into her own home, rather than to another nursing home (see e.g. MW, Joint Speech and Language Therapist, at 2, p.671, para.1.18/19 and p.682, para.7.8). A discharge planning meeting took place at Care Home on 22nd May 2018 and a prospective discharge date was set for 21st August 2018, although it was noted that the date might need to be extended. Since that date Care Home has allowed the Claimant to reside there pending the outcome of the quantum trial.

At Care Home the Claimant receives little mental stimulation or opportunity to partake in enjoyable activities unless visited by her family, as may be seen from the updated Care Home records, recently obtained.

Dr K believes that she is *"chronically under stimulated"* at Care Home (1, p.235, para.27). Dr C recommends 2 to 4 hours of meaningful/enjoyable activity per day once or twice a day (2, p.255, para.4 and 5). Without this the Claimant will deteriorate cognitively (2, p.255, para.3).

When seen at Care Home by AW, jointly-instructed neurophysiotherapist, the Claimant was tilted back in an armchair with the footrest up. *"She was not in a good position and was leaning to the left. She needed full assistance to correct this position to central within her trunk, which she then maintained."* (2, p.712, para. 5.5).

Even the hand splinting and palm protection necessary for the Claimant is not being dealt with in a reliable fashion at Care Home – see the annexed Care Home Hand Table compiled from the Care Home records which sets out the problem starkly.

At Care Home, the Claimant's access to physiotherapy, hydrotherapy, music and other therapies is sub-optimal or non-existent. Indeed Dr K believes that her spasticity is sub-optimally managed at Care Home (2, p.236, para.30).

The Benefits of a Home Care Regime

There is no nursing home with appropriately qualified staff and staffing levels within reasonable reach of the Claimant's family and friends.

The court will note the response of the Claimant to her family and to music in the recent video recording.

In order for the Claimant to have an optimum quality of life she also needs to have regular contact with her family and friends, all of whom live near the proposed site for the Claimant's new house. The Claimant's father and mother are both elderly and infirm. The Claimant's father has not been able to travel to see his daughter at all while she has been in Care Home. Currently the Claimant's mother and sister are able to visit her only sporadically because of the over 4 hour round trip to Care Home. As the Claimant's mother ages further she will be less able to travel long distances to see her daughter.

The problems that have arisen at *"Previous Care Home"* and even at Care Home would be far less likely to arise if the Claimant was being cared for in her own home with a dedicated staff with only a single person to care for. A careful eye could be kept by the case manager and the family on the quality of care given by the carers in a domestic setting close to where the family live. Dr K, the Claimant's Neurorehabilitation Consultant, reinforces the argument that having family in close proximity will carry the benefit of having support and advocacy for the Claimant and to keep an overview of her level of care, and whether she is thriving physically and emotionally (3, p.744-745, Q.16, Joint Neurorehabilitation Report).

The therapies that have not even been trialled at Care Home, that are recommended by AW, are:-

(1) A 24 hour postural management programme (2, p.710, para.5.2);

(2) Aquatic therapy sessions (2, p.714, para.6.1);

(3) Active-passive bike (2, p.714, para.6.1);

(4) Assessments regarding standing aids (2, p.714, para.6.1);

(5) Neurologic Music Therapy (2, p.710, para.5.1).

Dr K, Consultant in Neurorehabilitation, supports these recommendations as having a *"significant impact on communication ability [and] quality of life"* (K/C Joint Statement at 3, p.741, Q.10). See also Q13 at p.742.

Currently the Defendant's care expert agrees that *"either residential or home environment could meet her needs"*.

'Hybrid' Trials – Are We Ready?

EXCHANGE CHAMBERS

LEE SPEAKMAN
EXCHANGE CHAMBERS

I've recently had the privilege to represent at trial a man who sadly became completely blind as a result of complications arising from his treatment for a giant and invasive pituitary adenoma. Whilst we wait for our judgment to be handed down, it is worth reflecting on the particular case and lessons to be learned, both from the trial itself and from the way that the case evolved.

The first that the Claimant was aware of any problem was, as is typical with pituitary tumours, when he noticed changes to his eyesight. As the tumour grows, it presses upwards against the optic nerve. In time, the pressure can result in permanent and irreversible damage. The Claimant consulted his optician who in turn referred him to a neurosurgeon for scans.

The Claimant's neurosurgeon advised him to undergo an endoscopic procedure to remove the tumour by approaching transsphenoidally; that is, by cutting through the back of the nose and removing the tumour through the sphenoid sinus. The tumour was only partially removed and post-surgically the Claimant's sight deteriorated dramatically. Whilst surgery via the transcranial route (i.e., removing part of the skull) was scheduled for the following morning, it was too late to save any of the Claimant's sight. The exact mechanism of the deterioration is disputed, but is argued by the Claimant to have been swelling of the residual tumour.

The parties obtained expert advice from consultants in neurosurgery, radiology and ophthalmology. My involvement came rather late in the day, just before the PTR, as a result of the Claimant's previous counsel withdrawing from the case.

The Claimant's case, pleaded by counsel, was that the neurosurgeon had been wrong to elect for a transsphenoidal approach initially, and that in view of the scans available to him, he should have chosen the transcranial approach. Had he done so, it was likely that the tumour would have been entirely removed on the first attempt, and the Claimant's sight would have been preserved. In the alternative, a return to surgery should have been prioritised as an emergency when the dramatic and progressive loss of the Claimant's sight was noted in the hours that followed surgery.

The first problem for the Claimant was contained in his own neurosurgical evidence. The height of the neurosurgeon's evidence in his own report was that *he personally would not have chosen the transsphenoidal route*, and it was notable that although he had criticised parts of the care as being *'negligent'* and *'not within a range of reasonable opinion'*, he had avoided doing so in respect of the initial choice of surgery. A conference clarified that the expert not only knew the *Bolam* test, but did not think it was met. Quite why the decision was made to plead the case in the way it was is still something of a mystery. A decision was made to concede that part of the case and to concentrate on the delay in returning the Claimant to surgery.

The second notable feature of this case was that it was run as a hybrid trial; a novelty to counsel, solicitors, expert witnesses and judge. It was agreed in advance that the legal representatives, the expert neurosurgeons and all but one of the lay witnesses would attend in person. The allegedly negligent neurosurgeon and the ophthalmologists would give evidence remotely. By trial, it was agreed that there was no need for the radiologists to attend.

The court had arranged a CVP link which meant that those at court could watch on screens the evidence of remote witnesses. It quickly became apparent that the technology was not up to the job. Audio feedback resulted in ear-piercing screeching. The witness was asked to wear headphones, which meant that the feedback issue was resolved for those in court, but the witness had to listen to his own voice echoing back at him a second after he had started to speak. At times, the audio quality in court was extremely poor, which meant questions and answers had to be repeated, resulting, to my mind, in different answers on the second attempt. Although we had breaks to allow for technical staff to try to fix the problem, it remained a constant feature of the remote evidence. Many hours were spent preparing a composite note of the key witness' evidence by counsel and solicitors as a

result of dips in the audio. By Day 3 of 5, all of the other *'remote'* witnesses had elected to come to court.

Amongst the many interesting questions requiring answers in this case are;

1. Was too much reliance placed by the operating surgeon on radiology which had suggested no overall increase in the size of the tumour post-operatively rather than the clinical signs and symptoms demonstrated by the patient in recovery?

2. Was the patient's presentation post-operatively unique, and if it was, did it require a tailor-made approach? Was the Defendant's expert wrong to draw a parallel with a different condition?

3. Should dramatic and progressive loss of sight over a few hours be considered an *'emergency'*?

4. If so, how quickly should an emergency case return to theatre in a major teaching hospital with a dedicated neurosurgery unit in the middle of the night?

We expect judgment to be handed down soon. As social-distancing measures are reduced, many of us anticipate a return to attended hearings but there may remain good reasons for trials, or parts of trials, to be conducted remotely. Witnesses may need to shield and there may be practical benefits and costs savings in expert witnesses giving evidence by video link. The experience of this writer is that, sadly, hybrid hearings are an inferior alternative to either entirely attended or entirely remote hearings. It seems to require a leap in technology that currently looks like wishful thinking to be able to run a complex trial of this kind as a hybrid hearing. Our friends in the Crown Court may have much to teach us.

Remigio v Cardiff and Vale University Local Health Board

SPENCER COLLIER & AMY-BETH PROBERT
GELDARDS LLP

Geldards law firm

Geldards LLP recently concluded a rare secondary cauda equina syndrome case in a claim for clinical negligence against Cardiff and Vale University Local Health Board. The case was extremely challenging with significant difficulties legally and medically. The incidence of a single cauda equina is quite rare but a secondary cauda equina is exceptionally rare with very little published literature (if any) on its incidence and how it should be treated.

By way of background, Mrs Remigio had suffered back problems since 2002. By 2007 a lumbar disc prolapse at L4/L5 was diagnosed and a discectomy procedure was carried out in February 2008. The procedure was complicated by an early recurrent disc prolapse. A re-exploration of the lumbar spine followed and thereafter she underwent conservative pain management.

In February 2009, Mrs Remigio presented as an emergency with cauda equina syndrome. She underwent an L5 laminectomy and discectomy. In the immediate post-operative period, she suffered with a foot drop, some occasional urinary urgency, saddle area numbness and loss of perineal and vaginal sensation, most of which resolved after 2 years. She was largely self-managing for the years that followed but by the autumn of 2014 worsening back and hip pain started to present and she also began to develop issues with her bowel function. She attended her GP to discuss her concerns and was referred for an urgent MRI which took place on 3 December 2014. . On 9 December, Mrs Remigio had a pre-arranged appointment with her physiotherapist who immediately noticed an acute deterioration in her right foot drop and referred her as an emergency to the A&E department at the University Hospital of Wales, Cardiff. The MRI scan performed on 3 December 2014 showed a recurrent disc prolapse at L5/S1. A possible diagnosis was made of recurrent cauda equina syndrome and she was referred for immediate neurosurgical opinion.

Following a detailed review by the Consultant Neurosurgeon, a decision was made to manage Mrs Remigio conservatively, despite her raising concerns regarding the possibility of a secondary cauda equina syndrome. She was discharged on 10 December 2014.

Her condition did not improve and by 12 December 2014, with worsening saddle anaesthesia and acute bilateral sciatica, she reattended the A&E Department at University Hospital of Wales, Cardiff. She was admitted and immediately referred back to neurosurgery with a diagnosis of cauda equina syndrome. Again, a decision was taken to manage her conservatively. However, following a re-assessment by an additional neurosurgeon, Mrs Remigio underwent further surgery on 14 December 2014. The procedure was difficult; the intra-operative findings were of a recurrent disc prolapse which was removed. The operation was only partially successful in relieving her symptoms. A further re-exploration was undertaken in February 2015. Unfortunately, Mrs Remigio was left with the classic legacy symptoms of cauda equina syndrome, - pain in the lower back and both legs, difficulty walking, numbness in the vagina and perineal region, lack of sensation in sexual function and ongoing bowel and bladder difficulties. Her mobility was markedly reduced and she became wheelchair bound.

The hospital undertook a Serious Incident Review of the treatment provided in December 2014 which conceded a 3.5 hour delay waiting in the ambulance outside A&E for admission and a 24-48 hour delay in arranging the operation on 14 December 2014.

Mrs Remigio initially sought legal advice from a firm of solicitors via her trade union. Expert evidence was obtained from Mr David Sandeman, Consultant Neurosurgeon, which focused on the causative consequences of a failure to arrange surgery on 12 December 2014 or shortly thereafter. The Defendant accepted a breach of duty for failing to arrange surgery on the morning of 13 December 2014 but causation was robustly denied.

The Defendant averred that early intervention would have made no difference to the outcome; they referred to the earlier cauda equina surgery in 2009 and Mrs Remigio's complex underlying condition. It conceded only that it was possible there may have been a better outcome

from the point of view of sexual function and sensation. However, they maintained their robust denial that earlier surgery would not have had any material impact upon the position.

Around this time, Mrs Remigio transferred instructions to Geldards LLP. The medical evidence on causation was highly complex, convoluted and contained many sub-issues. The opinion of the earlier instructed neurosurgeon was becoming concerning on causation, in light of the Defendant's robust denial. Nonetheless, Geldards' agreed to take on the case on a CFA basis and managed to secure ATE insurance to obtain a second opinion on the issue of causation from Nicholas Todd, Consultant Neurosurgeon, in Newcastle. Following a conference with him in May 2019, the focus of the case started to change to the extent that the window of opportunity for intervention potentially opened on 10 December 2014, when Mrs Remigio was first assessed on a ward round by Mr Stephenson, Consultant Neurosurgeon. Mrs Remigio is a highly articulate individual which assisted greatly in the presentation of her evidence. A thorough and detailed witness statement was obtained in relation to her recollection of the conversations with Mr Stephenson on the morning of 10 December 2014. This contained significant detail about the conversation that took place, including Mrs Remigio explicitly explaining that she was well-aware of the important red flags in relation to cauda equina syndrome, and that she knew that intervention was probably required and that she had *"more to lose"* by a delay in surgery. Despite this, the operation did not proceed within the window of opportunity for a successful outcome and she was discharged.

A supplementary Letter of Claim was submitted alleging a failure to act from 10 December 2014. The Defendant's Letter of Response continued to deny liability, stating that the actions taken were reasonable and in any event the causation argument persisted so that, even if surgery had been undertaken on 10 December 2014 or within 48 hours thereof, there would have been no material difference in Mrs Remigio's overall disability. However, the Defendant proposed a round table mediation.

Mr Todd reviewed the Defendant's Letter of Response and maintained his earlier supportive views in respect of breach of duty and causation. He consistently alluded to the fact that there is very little, if any, published literature on treatment options in these circumstances but maintained his firm opinion that a cauda equina lesion (given its legacy and seriousness), whether initial or secondary, should be operated on promptly to decompress the nerves of the cauda equina. No other management option was reasonable.

The Claimant's witness statement together with the expert evidence of Mr Todd and a Schedule of Loss was served on the Defendant ahead of the mediation. The Schedule totalled £3.2M and contained the usual heads of loss to be expected in such a claim to include general damages, past and future care, accommodation, loss of earnings, etc.

Shortly before the mediation, the Defendant served expert evidence from Mr Ian Pople, Consultant Neurosurgeon and a Counter-Schedule of Loss, which argued for a provisional special damages figure in the region of £675,000 if Mrs Remigio was able to establish liability which remained denied.

The mediation was conducted remotely during Coronavirus working restrictions via Zoom, and settlement of damages was agreed at £750,000 plus costs.

The case was an exceptionally complicated one in terms of liability. It was largely through fresh medical evidence and pathological scrutiny of the timeline of events that the earlier allegation of the failure to treat surgically on 10 December 2014 was included and this was fundamental to the success of the claim. Although liability remained denied, this allegation of a failure to treat opened the door to a successful mediation of the claim.

The relevant legal personnel involved were:

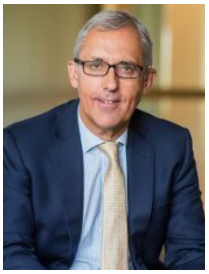
1. Solicitors for the Claimant - Mr Spencer Collier and Amy-Beth Probert, Geldards LLP

2. Counsel for the Claimant - Mr Leslie Keegan, 7 Bedford Row, London

3. Counsel for the Defendant - Mr Owain Thomas, QC, 1 Crown Office Row, London

4. Solicitors for the Defendant – Sarah Watt, NWSSP Legal & Risk Services.

Placement of nasogastric feeding tubes and the *"too long to read"* clinical guidelines



LAURENCE VICK
CONSULTANT SOLICITOR, MEDICAL NEGLIGENCE

The Healthcare Safety Investigation Branch (HSIB) published their final report on 17 December 2020 following their investigation into safety issues surrounding the placement of nasogastric feeding tubes raised. The report raised concerns on a number of levels, not least the reference to practitioners telling investigators that the relevant guidelines intended to address the avoidable problem of misplaced tubes – a Never Event - were *"too long to read"*.

https://www.hsib.org.uk/news/hsib-highlights-patient-safety-risks-nasogastric-tube-never-events/

The HSIB launched its national investigation into the problem of misplaced nasogastric (NG) tubes after reports of a 26-year-old man having 1,450ml of liquid, enteral feed mistakenly fed into his lungs in December 2018 following a motorcycle accident. He suffered a significant deterioration before the error was discovered, even after staff had performed an X-ray, but did recover and was discharged two weeks later.

Misplacement of an NG tube into a patient's lungs rather than his or her stomach and the failure to identify this before the tube is used for feed, fluid or medications constitutes a Never Event: defined by NHS Improvement as a patient safety incident considered to be preventable because there is national guidance or safety recommendations that provide strong systemic protective barriers which should have been implemented by health care providers.

In spite of patient safety alerts and warnings and reports of clinical negligence claims and inquests over the last 15 years, the incidence of NG related Never Events has continued to rise. Between September 2011 and March 2016, there were 95 incidents of a misplaced tube reported by NHS staff. The latest data shows there were 14 incidents between April and September 2020: alarming statistics given that incorrect placement has the potential to cause severe complications and avoidable harm.

In 2017 a Regulation 28 Prevention of Future Deaths report was issued by the Coroner for Cumbria to the North Cumbria University Hospitals NHS Trust following the deaths of Amanda Coulthard , 57, at Carlisle Cumberland Infirmary the previous year and Michael Parke, 40, at West Cumberland Hospital Whitehaven in 2012. Both had NG tubes inserted into their lungs – a *"failing of the highest magnitude"* according to the Coroner who concluded that both had died from neglect.

A number of NHS staff admitted to the HSIB investigators that they knew of the existence of the guidelines issued by the Society of Radiographers in 2012 intended to avoid this preventable error but had not read them as they were *"too long to read."*

The HSIB said staff had suffered from *"inattentional blindness"*, missing what should have been visible because, the HSIB suggested, their attention had been diverted elsewhere out of concern to avoid a worsening in the condition of an often critically ill patient.

The HSIB investigation revealed systemic problems which left patients at increased risk of harm. As well as the failure of staff to read and heed the guidelines, there was no consistency in training staff in how to carry out testing or interpret results, and no adequate system to check their competence. Performing an X-ray or pH testing of acidity of fluids from the stomach as methods of checking correct NG tube placement were potentially unreliable. There was no standardised method of interpreting X-rays. It would be beneficial if chest X-rays for acutely ill patients were interpreted and reported by a radiologist, or a radiographer who has undertaken training. The report should include the position of an NG tube if one is present on a chest X-ray. Manufacturers of pH testing strips used different colour coding with no universal process for reading them.

The HSIB recommended a national programme of training and a formal NHS-wide system of accreditation for those qualified to clinically evaluate and record their findings.

The HSIB called for improvements in the design of devices as well as in the reporting of safety incidents.

The failure of individual Hospital Trusts to ensure awareness and implementation of the established guidelines by their

staff through rigorous clinical governance came as a major surprise.

As a misplaced NG tube constitutes an avoidable Never Event, a negligence claim on behalf of an injured patient would be difficult to defend. Ignorance of a relevant, authoritative, well-known guideline would be unlikely to afford a defence. There are a number of arguments that could be raised to challenge the legitimacy and relevance of a guideline, but I doubt that a Court would be sympathetic to any suggestion that a guideline should not apply because it was too long for practitioners to read. There must be a presumption that doctors should be aware of current guidelines as part of the duty to reasonable skill and care, even in those specialties in which keeping up to date with journals and guidelines constitutes a significant burden.

In recent years there has been a significant increase in clinical guidelines and protocols issued at local, national and international level by professional bodies, regulators, Royal Colleges, NHS Trusts and other organisations. Their aim is to promote best practice in a standardised way, ensuring a consistent level of care, ultimately leading to improvements in patient safety, reducing avoidable harm and in turn driving down the cost of negligence claims against the NHS.

Medical practitioners have not always been receptive to guidelines. In general practice doctors complained of a *"flood"* of guidelines twenty years ago and the impression is that clinicians do indeed feel that they face a deluge of guidelines from multiple sources. GPs, after all, will often see patients with multi-morbidities, so compliance with a number of single disease guidelines is not without its difficulties.

In 2003 Professor of Cardiology, John Hampton, wrote *"Guidelines—for the obedience of fools and the guidance of wise men"*

https://pdfs.semanticscholar.org/88be/52abb7babfbecc4c72af540db838f15b1762.pdf Clin Med. 2003; 3: 279–284

Guidelines are just that: **guidance**. *"Guidelines, not tramlines,"* said Professor David Haslam, then Chair of NICE in a lecture to the Royal College of Physicians in June 2016. They provide doctors with a guide to options and recommendations as to best practice, to be consulted as a support to clinical decision-making. Guidelines have the potential to improve the quality of clinical decision-making and ultimately change beliefs. Provided they are seen to be authoritative, reflecting evidence-based research, guidelines may play an important role in persuading doctors to abandon outdated practices. Life will hopefully become increasingly difficult for the maverick doctor or surgeon.

We don't know yet if the existence of relevant guidelines has resulted in improved safety standards. The Sepsis 6 guidelines are perhaps the closest we get to Commandments: protocols that are clear and unambiguous, known and respected universally and which must be obeyed. Greater awareness of sepsis and the sepsis guidelines among medical professionals and the public will inevitably have resulted in earlier diagnosis and treatment, but we don't yet know if this has resulted in a decrease in negligence cases coming forward. Sadly, we still see reports in the press of hospitals failing to comply with the guidelines.

Guidelines and protocols are likely to play an increasingly important part in clinical negligence litigation. The impact on the litigation process, though, is difficult to assess due to the lack of reported cases in which their relevance and validity and the weight to be afforded to a guideline and the implications of compliance or non-compliance have been fully argued and tested in Court.

This article first appeared in the Medico-Legal Magazine earlier this year.

Inquest into the deaths of Peter Hussey and Stephen Oakes

THOMAS BEAMONT
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On 19 April 2021, HM Assistant Coroner for Stoke on Trent, Margaret Jones concluded an inquest which considered amongst other things, processes of procurement in the NHS.

Background

Peter Hussey was an 81-year old man who had undergone an anterior resection of the bowel, with loop ileostomy, in October 2016. His ileostomy was reversed on 4th December 2017 at RSUH. On the evening of 5th December 2017, he was noted to be vomiting. A nasogastric tube was fitted, but he continued to vomit, and a chest x-ray confirmed an aspiration pneumonia. Peter was transferred to the ITU, but deteriorated and died at 8pm on 12th December 2017.

Steve Oakes was a 59-year old man who in 2016 was diagnosed with lung cancer. On the evening of 21st December 2017, he was admitted to RSUH with a history of abdominal pain and vomiting. A scan showed a remediable bowel obstruction, and changes suspicious of a left lower lobe infection. As his stomach required decompression, a nasogastric tube was placed. However, early in the morning of 23rd December 2017 was vomiting past the tube, and a scan showed that he had aspirated, which led to an aspirational pneumonia. He died at 8.30pm that evening.

Exceptionally, an inquest was held in respect of both Mr Hussey and Mr Oakes, as the same NG tube was used in respect of both men.

The inquest was convened in accordance with Article 2 of the European Convention on Human Rights, on the basis that it was arguable that there was a systemic failure in the procurement of the NG tubes at the hospital.

The manufacturer, Enteral GBUK, were an Interested Person to the inquest, along with the hospital Trust.

On a probono basis, AvMA instructed Catherine Meenan, of Cloisters, to represent Peter's family, and Tom Beamont, of 1 Crown Office Row, to represent the family of Steve.

The hearing

As a consequence of the Covid-19 pandemic, the inquest was heard virtually over six days from 12-19 April 2021.

The Coroner heard that in accordance with an international Directive, Enteral GBUK had manufactured size 14 *'Carefeed'* nasogastric tubes to contain an *'En-fit'* connector. The effect of the connector was to decrease the size of the bore in the tube such that it would no longer function to decompress or drain in an emergency context. The Coroner heard that the manufacturer's sales representatives were unaware of this limitation.

At the hospital, all NG tubes were replaced with the Carefeed tubes. However, there was no consideration of the instructions for use, and the Coroner found that the committee responsible for their purchase did not understand the tubes' function. As a result, the hospital were under the mistaken impression that the tubes could be used for emergency drainage. The Coroner found that they were purchased with inadequate product evaluation and trials.

The Coroner found that while there were a number of concerns raised across various wards that the tubes were not functioning, there was no review of their procurement. There was a failure by staff to report the difficulties with the tube. There were four similar, but non-fatal, incidents following the deaths of Peter and Steve before the tubes were taken out of use.

Findings

The Coroner found that the use of an unsuitable nasogastric tube, a failure to recognise that the tube was inadequately draining, and a failure to consider alternative

methods of treatment contributed to the deaths of both Peter and Steve.

The Coroner also found that miscommunication between the manufacturer and the hospital Trust possibly contributed to their death.

Prevention of future deaths

Following the inquest, the Coroner wrote a Prevention of Future Death Report to several national and international organisations, raising the following matters of concern:

1. Enteral (GB) UK

The Coroner considered that the product description was insufficient, and sales staff were not trained to recognise and advise on the limitations of the Carefeed tube.

2. University Hospital of North Midlands

The Coroner was concerned that there was no full evaluation of the tube, and that no alternative action was considered by nursing staff once the tubes began to malfunction. The Coroner was also concerned that those conducting Root Cause Analysis reports were not compulsorily trained.

3. Nursing Times Publications Editor

The Coroner heard evidence that as recently as 2019 the Carefeed tubes continued to be promoted in the Nursing Times as suitable for performing drainage.

4. NHS England and NHS Supply Chain

The Coroner considered that the problem with the procurement of Carefeed NG tubes may not be limited to RSUH, but is a wider problem which merits industry-wide investigation and change.

5. International Standardization Organization

Finally, the Coroner wrote to the body responsible for setting international standards which mandate the proportions of the NG tubes, raising concern about the limitation of the 14 size tube as a result of the En-Fit connector.

Opportunities

On behalf of Fosters solicitors:

FOSTERS
SOLICITORS SINCE 1761

Fosters solicitors are looking to bring on a full time lawyer/case worker/paralegal to help drive forward our Inquest and HRA practice. The role will involve case investigation, review of disclosure, managing cases through the inquest process, attending hearings where appropriate, liaising closely with counsel throughout the inquest process, and thereafter managing subsequent HRA and/or medical negligence claims to settlement. The majority of matters Fosters deal with involve the avoidable death of mental health patients, but we are keen to expand into other areas of Inquest work, such as prison deaths. Knowledge of the Legal Aid funding process would be an advantage.

Fosters Solicitors is an AvMA accredited firm and a long standing member of INQUEST. The role will be based in our Norwich office with an expectation that the candidate will want a degree of flexible working.

Please email dgabell@fosters-solicitors.co.uk if you wish to discuss further.

Run the Great North Run or Great South Run for AvMA

As Covid restrictions come to an end we are excited have places available in two fantastic running events this autumn. So if you can't wait to get your running shoes back on and give yourself a really worthwhile target to aim for, apply for a place today! You can help raise money for people affected by avoidable harm in healthcare while taking part in one of the biggest running events this year.

We have limited places which are available on a first come, first served basis. There is a registration fee of £40 payable on confirmation of your place (This is to cover part of the cost to us of acquiring places in the race). You must also commit to a minimum fundraising target of £500.

Apply for your place today at www.avma.org.uk/support-us/run-for-avma

Contact communications@avma.org.uk with any questions.

Great North Run

When: Sunday 12 September 2021

Where: Newcastle to Southshields

Distance: Half marathon

Great South Run

When: Sunday 17 October 2021

Where: Southsea, Portsmouth

Distance: 10 miles

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

Essential Medicine for Lawyers

Mornings of 30th June & 1st July 2021, online

This essential conference, coming to you online for the first time, has been structured to ensure delegates gain a good grounding in the key areas of the major body systems. The increased understanding gained will underpin your future medical learning in relation to clinical negligence and enable you to apply medical knowledge to your cases. Each speaker will address the essential areas on which clinical negligence solicitors need to have a sound understanding, including an introduction to the anatomy and physiology, useful terminology and an examination of the common conditions that affect these systems, their symptoms and standard procedures for diagnosis and treatment. The effects of Covid on the medical areas will also be featured. The importance of applying medical knowledge to your cases and choosing the right expert will also be presented. The conference will run from 09.30 – 13.00 on 30 June and 1 July. The presentations will be pre-recorded and the speakers will join us live for Q&A at the end of both mornings. Booking now open.

Court of Protection conference

30 September 2021, Hilton Leeds City Hotel

Since its inception in 2007, the Court of Protection has made crucial decisions to try to protect the well-being of vulnerable individuals. In a rapidly-evolving legal environment, AvMA's third annual Court of Protection conference will examine the current state of litigation and the challenges and responsibilities facing those who work in this important area.

Look out for details on more events coming soon! For further information on our events:

Specialist Clinical Negligence Panel Meeting

1 December 2021, RSA House, 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 Wednesday 1st December. Registration and a networking lunch will commence at 12.30, with the meeting starting at 13.30 and closing at approximately 17.15. AvMA's Christmas Drinks Reception, which is also open to non-panel members, will take place immediately after the meeting. The event provides an excellent opportunity to catch up with friends, contacts and colleagues for some festive cheer! Booking will open in September but put this date in your diary now!

32nd Annual Clinical Negligence Conference

24-25 March 2022 (Welcome Event 23rd March), Royal Armouries Museum, Leeds

Join us in Leeds for the 32nd AvMA Annual Clinical Negligence Conference (ACNC), the event for clinical negligence specialists. The very best medical and legal experts will ensure that you stay up to date with all the key issues, developments and policies in clinical negligence and medical law. Networking is also a big part of the ACNC experience. On the evening of Wednesday 23rd March we will be holding the conference Welcome Event at the SkyLounge at the Doubletree by Hilton Hotel in Leeds, and the Mid-Conference Dinner will be held on the Thursday evening at the Royal Armouries Museum. Early bird booking will open in September 2021, with the programme available in December 2021.

www.avma.org.uk/events

e-mail conferences@avma.org.uk

AvMA Medico-Legal Webinars

For full programme and registration details,
go to www.avma.org.uk/events
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Mediation in Clinical Negligence Cases

Paul Balen, Director, Trust Mediation

Andrew Hannam, Consultant and Mediator, Enable Law and Trust Mediation

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Injury, Pain and Anxiety

Professor George Ikkos, Consultant Psychiatrist in Liaison Psychiatry

Royal National Orthopaedic Hospital NHS Trust

On-demand webinar available from 2 June

The session will cover conceptual, psychological, physiological and clinical aspect of pain and fear.

The objective of the session is to inform attendees of the evolving clinical and scientific understanding of pain, especially in relation to motivational and psychophysiological issues.

At the end of this webinar, you will understand the complex psychophysiology of pain in action, the importance of the interaction of physiological and psychological factors and their mediation through the underlying physiology.

Respiratory Medicine: Medico-legal issues arising

Professor Howard Branley, Consultant in Respiratory Medicine

Live webinar - 17 June 2021, 10:30 am

This webinar aims to help clinical negligence solicitors understand common respiratory conditions and the failure to diagnose and treat appropriately.

Book your webinar on **www.avma.org.uk/learning**

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

Journal of Patient Safety and Risk Management

The Journal of Patient Safety and Risk Management, published in association with AvMA, is an international journal considering patient safety and risk at all levels of the healthcare system, starting with the patient and including practitioners, managers, organisations and policy makers. It publishes peer-reviewed research papers on topics including innovative ideas and interventions, strategies and policies for improving safety in healthcare, commentaries on patient safety issues and articles on current medico-legal issues and recently settled clinical negligence cases from around the world.

AvMA members can benefit from discount of over 50% when subscribing to the Journal, with an institutional print and online subscription at £227.10 (+ VAT), and a combined individual print and online subscription at £177.22 (+ VAT).

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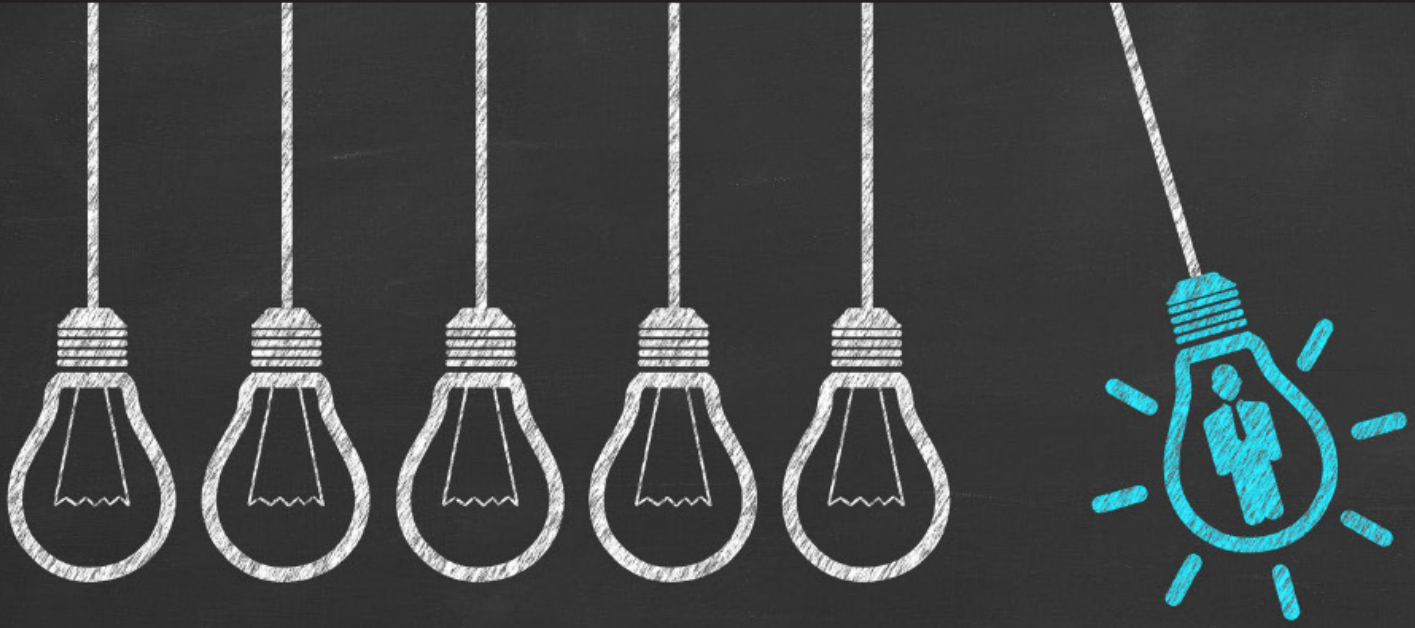
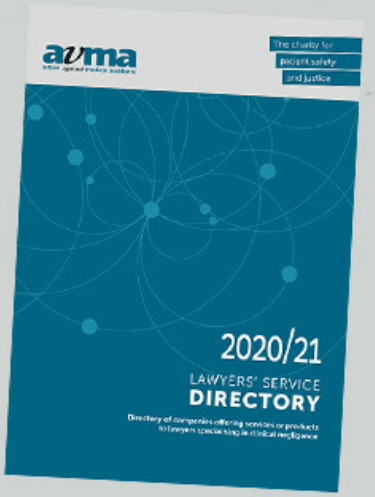
sophie.north@sagepub.co.uk



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
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