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Lawyers Service Newsletter

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Contents

CELEBRATING 40 ★ YEARS ★ 1982-2022

Editorial

Lisa O'Dwyer
Director, Medico-Legal Services

A lot has happened in the three months since our last LS Newsletter. AvMA was delighted to host its annual conference in Leeds, the first since 2019! The final Ockenden review into Shrewsbury and Telford Hospital was published. April was the closing date for the consultation on FRC in low value clinical negligence claims, the Health & Social Care Committee also published its report on NHS litigation reform. In May, it was announced that the thematic review of maternity concerns at Nottingham has been taken over by Donna Ockenden, not forgetting that AvMA's CEO, Peter Walsh publicly announced his intention to retire at the end of this year.

With all that in mind, it is appropriate that I start with **Peter Freeman**'s article ***"A change gonna come"***. Peter is a barrister at Temple Garden Chambers, an experienced clinical negligence practitioner and mediator with Independent Evaluation: https://www.independentevaluation.org.uk/evaluations. In this article he considers both the Ockenden report and the FRC proposals, he throws down the gauntlet for NHS Resolution to engage in a meaningful pilot on independent evaluation.

Prompted by numerous previous maternity scandals, maternity care has been an on-going priority for successive governments. So, what does the Ockenden Review tell us that we did not already know? To help answer that question we are pleased to refer to **Janine Wolstenholme**, barrister at Park Square Barristers (Leeds & Middlesbrough) article, ***"Maternity care in England: Some observations on the key findings of the Ockenden Report"***.

We wait for the Court of Appeal to resume their consideration of ***CAM Legal Services Ltd (appellant) v Belsner*** at the end of July, in the meantime, Checkmylegalfees has been focusing its attention on firms' obligations to disclose details of any commission received from ATE insurers. **Ged Courtney** at Kane Knight explores the issues with reference to the recent decisions in ***Edwards & Others v Slater & Gordon UK Ltd*** **and** ***Raubenheimer v Slater & Gordon UK Ltd*** **[2022] EWHC 1091 (QB)**.

Clinical negligence lawyer know too well that the success or failure of their caseload largely rests on the strength of the verbal and written evidence given by the medical experts in the case. The importance of the expert acting independently, impartially and in full recognition that their duty is to

the court, not the paying party cannot be overstated. We are very pleased to include **Jonathan Godfrey**'s article ***"Expert discussions and the joint expert statement – a lawyer free zone"*** which looks at the decision in the case of *Patricia Andrews & Ors v Kronospan Limited* [2022] EWHC 479 (QB) and reminds us that lawyers should not get involved in the joint statement discussions between experts. Jonathan is a barrister at Parklane Plowden who specialises in clinical negligence work and training experts.

Also, practising at Parklane Plowden is **Anna Datta**, in addition to her clinical negligence practice, Anna specialises in Court of Protection work. We welcome Anna's article ***"Taking the mystery out of capacity in clinical negligence cases"***. This topic is particularly relevant given the FRC proposals for a *"bolt on"* fee of £650, to cover the additional work incurred by lawyers when acting for a protected party.

The Justice Committee reported on the Coroners Service back in May 2021, **https://publications.parliament.uk/pa/cm5802/cmselect/cmjust/68/6802.htm**. They were unequivocal in their call for non means tested legal aid to be available in complex inquests and/or those against public bodies, stating this should be implemented by 1st October 2021. The government's response is that since January 2022, it is no longer necessary for families to demonstrate they meet the legal aid means test to secure eligibility for funding. However, they still have to meet the onerous merits test. See the Lord Chancellors update: **https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/1045704/legal-aid-chancellor-inquests.pdf**. While this has made some difference, covering the cost of preparing for the inquest hearing continues to be covered by the low rates allowed under Legal Help although this too is available without means testing the client, providing the merits test can be satisfied. **Lucy Wilton**, partner at Nelsons Solicitors Limited, takes a careful look at these changes in her helpful article ***"Exceptional case funding for inquests, no longer so exceptional"***.

There are firms who do undertake some pro bono inquest work and we are grateful to them for their help. Despite the recent changes to exceptional funding, demand for AvMA's pro bono inquest service continues to outstrip what we can supply, to cope with this we do assess cases against our eligibility criteria, details of which can be found here: **https://www.avma.org.uk/wp-content/uploads/Inquest-criteria.pdf**.

Inquest work can be challenging on several levels, not least emotionally. **Dr Charlotte Connor** (Team Leader AvMA's Medico Legal Services) has over the last four years worked with counsel, **Elizabeth Grace** at Outer Temple Chambers on the ***Inquest touching the death of Connor Wellsted***. It is yet another illustration of how, but for the dogged determination of a family's quest for the truth, the full litany of deception, obfuscation and cover up around Connor's death would have remained out of public view. Our thanks to Elizabeth for her account of the key points from the inquest. It is also worth noting that despite the complexities of this case, Connor's family would still be unlikely to secure legal aid funding despite the recent changes to the ECF guidance – the coroner did not declare the inquiry an Article 2 inquest until the case concluded.

AvMA aims to refer cases which are likely to be of interest to firms. By doing this, we also hope to improve our beneficiaries experience by avoiding them having to unnecessarily retell their account of their often harrowing real life events. To help refine this process we will be circulating short questionnaires to help clarify your interest and specialism in the following areas of work: inquests; mental health; Court of Protection; Special Educational Needs (SEN). Please do take the time to respond to these questionnaires which will be circulated by email in the next two weeks.

NHS Resolution has asked us to draw attention to the fact that as from 2nd June it became mandatory for all their panel solicitors to use the Damages Claims Portal (DCP). They have asked that where claimants intend to issue proceedings they contact NHS Resolution in the first instance, so legal representatives can be nominated to accept service through the portal. For full details please see the notice on NHS Resolutions website: **https://resolution.nhs.uk/2022/05/26/nhs-resolution-signs-up-to-use-the-hmcts-damages-claims-portal/**.

This year sees AvMA celebrating forty years of giving free advice, information and support to members of the public who have experienced an adverse outcome from medical treatment. Our public facing services are needed as much now as they were in 1982 when AvMA first started, likewise our campaigning work on patient safety and access to justice. As an independent charity with no government or other external funding, the generous support and donations received from specialist clinical negligence lawyers has helped AvMA survive. Thank you.

To celebrate our forty years many of you are putting the fun in fundraising by kindly hosting exciting events. On 26th May the in person Southwest LSG event was followed by a fabulous evening in Bristol sponsored by, Frenkel Topping and St John's Chambers - as the photo

demonstrates, a good time was had by all! There are many more events planned, please check the website and see the end of this Newsletter for details of other forthcoming events, including the champagne punting tour, drinks reception and dinner being hosted in Cambridge by Tees on 8th July, some tickets are still available.

Wishing you all a lovely summer!

Best wishes

Alternative Dispute Resolution: *"A change gonna come"*

PETER FREEMAN, BARRISTER
TEMPLE GARDEN CHAMBERS

The Ockenden Report and Fixed Costs Regime for Clinical Negligence: Peter Freeman considers recent developments away from the Courtroom, which will affect the way claims are resolved in future.

The Ockenden Report into Shrewsbury & Telford NHS's maternity services makes for truly shocking reading. The executive summary gives an indication of scale: of 498 cases of stillbirth, one in four cases were found to have significant or major concerns in maternity care which, if handled appropriately, might or would have resulted in a different outcome. In fact, the review considered 1,500 families' experiences, predominantly between 2000 and 2019, and revealed maternity services that failed to investigate, failed to learn and failed to improve and, therefore, failed to safeguard mothers and their babies. Equally shocking is the fact that these findings only came about because of the parents' *"unrelenting commitment"*. Jeremy Hunt MP praised the *"really extraordinary role"* played by the families in investigating and campaigning, but asks why it took their efforts *"rather than the NHS itself to be really hungry to learn from mistakes."*

Changes to maternity services are promised. Everyone hopes that *"a change gonna come."* Regrettably, as Sam Cooke's lyrics point out, *"it's been a long, a long time coming"* and it is too late for the Shrewsbury families.

Unsurprisingly, MPs are quick to say that the affected families will receive justice *"now"*. However, there is little hope for rapid *"justice"* unless there is rapid change in the NHSR and Court Service. Sometimes one has to point out the absolutely commonplace simply because it has ceased to attract attention. This is not news, but the first two trials I fought in 2022 concerned events that had occurred more than a decade beforehand.

One often hears that the NHS's response to claims against it is too often simply *"to deny, to delay and defend"*[1]. However, in my cases, the problem was not the Defendants' attitude or tactics, but rather the extraordinary delays in getting Costs & Case Management hearings, the massive delays in listing interlocutory hearings and, despite listing appointments and Pre-trial reviews, very late vacating of trials on multiple occasions spanning many years. Regrettably, the Court Service is now very substantially under-funded and under-staffed, and consequently seriously sub-optimal for disputants.

Human beings – families, bereaved parents and doctors - are at the heart of the cases we deal with. Delays, late adjournments of trials and re-listing more than a year into the future are devastating for all involved. I cannot recall any litigants getting to the end of a trial or pre-trial settlement meeting and saying *"that was dealt with quickly"*. And yet, at the end of trials, I routinely hear litigants speak of the importance of feeling listened to, of how impressed they have been with the Judge. In short, it is the trial, with forensic analysis of evidence overseen by a learned and manifestly neutral judicial figure, that is the reason why an English Civil trial is the gold standard of dispute resolution. The best part of the legal system is the part that people simply cannot afford access to, or cannot access easily and within a reasonable timeframe.

Everyone hopes that that lives already blighted for years by the medical system will not be further blighted by the legal system, and that a different attitude will prevail for the Shrewsbury families following this independent review.

We are approaching the 25th anniversary of the Woolf reforms, which promised change. It is nearly 20 years since *Halsey v Milton Keynes NHS Trust*[2] when Dyson LJ (as he then was), recognising the attritional warfare and delay in the Court service, reminded members of the legal profession that *"acting in a client's best interests includes advice on resolving disputes by all appropriate means of ADR."* It is more than five years since the Ministry of Justice acknowledged that years after the Woolf reforms, cases were *"still resolved too late, too expensively, with complex procedures and an adversarial climate, imposing*

1 *Hansard. Debate on Clinical Negligence Claims per Lord Garnier.*

2 [2004] EWCA Civ 267.

costs that sometimes dwarf the value of the contested claim." On 9th March 2016[3], without knowledge of the Shrewsbury NHS scandal, Lord Garnier stated with remarkable prescience:

"Most complainants just want someone to take responsibility and say sorry, and are not after money or revenge. That applies to the bereaved parents of stillborn babies as much as it does to the adult children of an elderly patient who died after a fall from a hospital bed, or who lay for days in agony because of untreated bed sores. The defensive failure to apologise often causes more heartache than the negligence itself and causes claimants to believe they have to sue to get justice. In addition, the NHSLA too often engages in unproductive trench warfare: it must not be seen to be giving ground, so the order goes out: "Deny, defend, delay!*"*

Cases that could have been resolved months and sometimes years earlier end up being settled at the door of the court, or lost after a trial, by which time advocates' brief fees have to be added to all the other costs that have piled up unnecessarily since the complaint was first raised. If ever there was a need for a patient to heal himself, it is the NHSLA in its refusal to free itself from the indefensible, or to see the wood for the trees. Rather than too often denying, defending and delaying in the wrong cases, it should assess, admit and apologise in the right cases.

The Courts have issued ever-sterner warnings that parties should utilise ADR, and maybe at risk of costs sanctions for failing to engage. The NHSR has changed to some extent: it demonstrated a drive towards mediation and undoubtedly the NHSR's preferred mediation providers have successfully mediated settlements, but overall take up is tiny. One questions whether the bereaved families of Shrewsbury would have found satisfaction with a *'no fault / no admission'*, mediated settlement. The same can certainly be said for clinicians who genuinely believe that they have acted appropriately at all times, and there must be better options for meeting the DHSC's stated aims of *"addressing the causes of harm and improving the quality of the NHS"*.

At the same time as the Ockenden Report was being written, the NHSR, the Civil Justice Council and DHSC were working on their proposals for a Fixed Recoverable Costs (*'FRC'*) regime that would surely cover many of those maternity death cases. The DHSC Consultation also makes for pretty shocking reading. I urge all practitioners to read it and make their own minds up as to whether the *"proposal to introduce FRC"* really can be intended for *"ensuring greater consistency and fairness for claimants and defendants when people have been harmed"*, or whether it risks further eroding access to justice. As ever, the Consultation period is short and responses had to be submitted by 24 April, but *"a change is gonna come."*

I will put aside the proposed Fixed Costs, which are an article in their own right, and focus on the proposed resolution. The NHSR have seemingly recognised mediation's shortcomings and concluded that the solution is *"mandatory neutral evaluation."*

Early neutral evaluation (*'ENE'*) came into existence in California in the 1980s. It did not catch on like wildfire in its original form, but rather proved that change is a long time coming. However, by July 2015 it had taken root sufficiently to gain an entry into the CPR[4] and was being widely used in other areas of law. As Norris J pointed out: *"The advantage of an early neutral evaluation process over mediation is that a person with subject matter expertise evaluates the parties' cases in a direct way, and provides an authoritative view of the legal issues of the case and an experienced evaluation of the strength of the evidence."*[5]

ENE took off in personal injury actions; it has been remarkably successful in resolving liability, causation, quantum and even *'fundamental dishonesty'* disputes and, very often, cases where all those issues are in dispute and the parties are, or risk becoming, entrenched in diametrically opposed positions. There is good evidence that parties find the process very much more satisfactory than mediation, and no reason whatsoever that it could not do likewise in clinical negligence claims.

The Court Service is struggling to resolve disputes efficiently and this undoubtedly pains fair-minded, decent Judges whose judgments now frequently include comments such as this by HHJ Stephen Davies: *"I am acutely aware that, as so often occurs, the outcome will be a disaster for one of the parties and, even if not, likely an expensive and ultimately unrewarding result for both."*[6] Having chivvied and warned practitioners to use ADR and avoid litigation, there is now a change to compulsion. HHJ Stephen Davies has now set out a standardised approach for the first CCMCs in cases, whereby there will be an Order for compulsory ENE. The RCJ Masters have also embraced ENE since 2020[7] and the direction of travel can be seen clearly from recent speeches by the Master of the Rolls.

3 *Hansard. Debate on Clinical Negligence Claims.*

4 *CPR 3.1(2)(m)*

5 *Seals & Another v Williams* [2015] EWHC 1829

6 *The Sky's the Limit Transformations Ltd v Mirza* [2022] EWHC 29

7 *Telecom Centre (UK) Ltd v Thomas Sanderson Ltd (February 2020), Master McCloud.*

The questions are really whether ENE should be done within the Court system or outside of it, whether it should be voluntary or compulsory. I have had experience of both *'Judicial'* and *'Independent'* Evaluation, but always on a voluntary basis.

Unfortunately, *'Judicial'* ENE is plagued with the same problems afflicting the Court Service. The Judiciary are running at c. 66% of full complement. There were delays in getting the appointment for the ENE; unfortunately, at the outset, the Judge declared that the *'reading day'* he had required had been filled with other cases and the papers had only just reached him. The case was not resolved. Unfortunately, the future for claims within the Court Service is likely to be one of ever-lengthening delays before resolution, whether that be judicial ENE or trial.

Whether because of the lack of resources or the state of the Court backlog, recent pronouncements indicate a determination to shift the battleground to *'pre-issue'*, thereby avoiding litigation completely. Thus, pre-issue, independent evaluative solutions are likely to become the norm in future.

Practitioners' experiences of Independent Evaluation are a world away from those of the Court Service. At its core is the appointment of a Deputy High Court Judge with subject matter expertise that is respected by both parties. Once appointed, that Evaluator guides the parties through a *'Directions'* phase and onwards towards an Evaluation of the likely outcome at trial. The Evaluator, who is already familiar with the papers, has the Evaluation bundle at least a week in advance of the Evaluation. Delays and adjournments are unheard of. The parties benefit from all the finest qualities of a civil trial, without any of the worst qualities of the system. The time taken from start to finish can be reduced from years of litigation to weeks or months. To quote one lawyer who routinely has his clients' disputes evaluated: *"it is the legal equivalent of private health; no waiting lists, best Consultants, best chance of a cure"*. Deputy High Court Judges, such as David Pittaway QC and Andrew Lewis QC, have deserved reputations for excellence in Independent Evaluation of the most difficult cases. There is something very striking when witnessing claimants and defendants mingling after their Evaluations: they feel listened to; they feel as if they have had an equivalent to their day in Court; they feel that lessons have been learned and, vitally, they feel that justice has been done.

Compulsory ADR does not sit easily with me, even though it has been described as *"both legal and potentially an extremely positive development."*[8] There should be no need for compulsion: for practitioners on both sides, who know the state of the Court system and take seriously their duty to act in the best interests of their clients, the landscape of dispute resolution has already changed to ENE. The DHSC/ NHSR proposals are greatly concerning: there is something deeply unsettling about telling the bereaved parents of Shrewsbury that they are forced to take a certain course of action prescribed by their opponent, and at the same time capping the recoverable fees at very modest sums.

Just as the Ockenden Report's findings came too late for the Shrewsbury families, so the DHSC / NHSR's proposals for *'mandatory neutral evaluation'* are unlikely to be implemented in time. However, whether the DHSC / NHSR are serious about affecting change for good can easily be tested: there is already an established system of Independent Evaluation with expert Deputy High Court Judges; so the question is whether the NHSR are willing to voluntarily engage in the already established system of Independent Evaluation in order to ensure that the Shrewsbury families do get justice *"now"*.

As we have seen from the reforms of Woolf and Jackson, not all change imposed on parties in dispute is for the better. It is regrettable that the Court Service and NHSR feel it necessary to make ENE compulsory, but far more so that they appear determined to ensure that it is their system and their fee regime. I challenge the DHSC / NHSR to engage urgently in a meaningful pilot scheme with AvMA, so that changes made now will be optimised.

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8 *Civil Justice Council's Report:* Compulsory ADR', *June 2021.*

Maternity Care in England: Some observations on the key findings of the Ockenden Report

JANINE WOLSTENHOLME, BARRISTER
PARK SQUARE BARRISTERS

The Report[1]

• Published 30th March 2022, the Report is an Independent Review of Maternity Services at The Telford and Shrewsbury Hospital NHS Trust (*"The Trust"*).

• Unprecedented in its size and scale in the NHS's history, it drew upon the experiences of almost 1,500 families, experiencing almost 1,600 clinical incidents, which mainly occurred between 2000 and 2019.

• The author hopes the report will profoundly change maternity care now and in future years, not only at the Trust, but across England.

• The final Report followed the first report (published December 2020)[2] and identified several new themes to be urgently shared across all maternity services in England with a view to bringing about essential and positive change.

• The review panel comprised a multi-disciplinary clinical review team of doctors and midwives working in maternity services in the NHS and covered all aspects of clinical care in maternity services including antenatal, intrapartum, postnatal, obstetric anaesthesia and neonatal care.

Main Findings

• The panel found the Trust failed to safeguard mothers and their babies, having failed to investigate, learn, and improve, such that otherwise avoidable deaths eventuated.

• Of the twelve maternal deaths reviewed none of the mothers had received care in line with best practice and only one was investigated by external clinicians.

• Internal investigations repeatedly failed to recognise system and service-wide failings to follow appropriate procedures and guidance. This led to a failure to identify serious omissions in care. In some cases, women were held responsible for the outcome.

• 25% of the 498 stillbirths reviewed revealed significant or major concerns in maternity care which if managed appropriately may, or would, have resulted in a different outcome.

• In almost two thirds of cases of hypoxic brain injury to the child there were significant or major concerns in the care provided to the mother.

• In almost a third of neonatal deaths reviewed, the panel identified significant or major concerns in the maternity care provided to the mother that may, or would, have resulted in a different outcome.

• Staff were overly confident in their ability to manage complex pregnancies and babies diagnosed with fetal abnormalities during pregnancy, with a reluctance to:

  - o refer to colleagues from the wider disciplinary team,
  - o escalate concerns in antenatal and postnatal settings,
  - o refer to specialists such as paediatric surgeons and geneticists in tertiary units.

• There were multiple delays in admission to labour wards during induction of labour, assessment for emergency intervention during labour, and review by consultants in postnatal settings. This led to discharge followed by emergency readmission, because patients were extremely unwell, and last-minute involvement of obstetric anaesthetists, thereby compromising the ability to properly assess women for urgent obstetric interventions.

• Failure to follow national clinical guidelines in various aspects (monitoring fetal heart rate, maternal blood pressure, management of gestational diabetes and

1 *Ockenden Report - Findings, Conclusions and Essential Actions from the Independent Review of Maternity Services at The Shrewsbury and Telford Hospital NHS Trust, 30th March 2022*

2 *Ockenden Report – Emerging Findings and Recommendations from the Independent Review of Maternity Services at the Shrewsbury and Telford Hospital NHS Trust, 10th December 2020*

resuscitation), combined with failures to escalate and work collaboratively (as set out above) resulted in several poor outcomes including sepsis, hypoxic brain injury and death.

• Some of the delays and lack of collaborative working flowed from the culture at the Trust, with midwives being fearful of escalating matters to consultants. Others resulted from staffing and training gaps at the Trust.

• Women and families accessing maternity care at the Trust were not given the opportunity to voice concerns about the care received.

• The Trust leadership team was found to be in a constant state of change. It lacked continuity and the Board did not have oversight or a full understanding of the issues with maternity services.

• Investigations, if carried out at all, were inadequate and failed to identify underlying systemic failings and in some cases the maternity governance team inappropriately downgraded serious incidents to a local investigation methodology to avoid external scrutiny. Consequently, lessons were not learned, mistakes were repeated, unnecessarily compromising the safety of babies and mothers.

• External reviews by the CQC and local CCGs during the previous decade missed opportunities to improve maternity services sooner, notwithstanding repeated concerns being raised by families.

Some observations

60 local actions were identified specifically for the Trust however, noting many of the issues highlighted are unlikely to be unique to Shrewsbury & Telford, the review team identified fifteen areas of Immediate and Essential Actions to be considered by all trusts providing maternity services in England. These include significant investment in the entire maternity workforce, multi-professional training, suspension of the Midwifery Continuity of Carer Model until safe staffing levels are established, improved accountability amongst senior staff, improved investigations involving families, and timeous implementation of change following investigations.

The review panel concluded only a robustly funded, well-staffed and trained workforce will be able to deliver adequate maternity services across England. However, even with significant cash investment announced, factors such as the concerning attrition rates amongst maternity staff, the time it takes to train such staff, and thereafter develop the necessary practical post qualification experience, and the impact of the pandemic on the NHS generally, mean it will take a significant period of time for the maternity services to reach a level the report authors, and no doubt the clinicians and patients within them, aspire to.

An area of particular concern for the panel was the failure to listen to patients at various stages of their care. By way of example, following the publication of first report, in December 2020, all trusts were required to consider the issue of Informed Consent as an essential action. More specifically, *"All Trusts must ensure women have ready access to accurate information to enable their informed choice of intended place of birth and mode of birth, including maternal choice for caesarean delivery."* Women must be *"enabled to participate equally in all decision-making processes"* and *"women's choices following a shared and informed decision-making process must be respected"*.

Though it must be right that, like any patient receiving medical care, women are provided with full and accurate information to enable them to make an informed choice at each stage of their maternity care, in the short term, at the very least, while there remains a maternity staffing crisis it seems this will be difficult to facilitate.

The review board also remains concerned that NHS maternity services and their trust boards are still, in 2022, failing to adequately address and learn lessons from serious events occurring, with the absence of transparent and independent investigations a significant aspect of the report.

Though trusts will continue to carry out their own internal investigations, and the HSIB will be replaced by a Special Health Authority to oversee maternity investigations, coroners' courts would be well placed to carry out this role where a death occurs. An inquest is inquisitorial, rather than adversarial, in nature where a coroner, an independent judicial office holder, is required to seek out and record the facts detailing how a person came by their death. The family of the deceased is at the centre of the process.

Uniquely, coroners have a statutory duty to issue a report where during an investigation they discover circumstances that create risk of future death (Prevention of Future Death (PFD) reports). PFD reports must be issued to persons, organisations, or agencies with the power to take preventative action and could therefore include clinical commissioning groups and NHS England. PFD reports and responses to them, which are also mandatory, are published with the intention that experiences can be

shared nationally to improve public health, welfare, and safety.

However, coroners only become involved where a baby shows independent signs of life. Consequently, only neonatal deaths, and not stillbirths, are investigated. The Government carried out a consultation in March 2019[3] to consider a law change to enable coroners to investigate still births from 37 weeks however, to date, it has not been progressed. Whether the publication of this Report now leads to change remains to be seen.

3 https://consult.justice.gov.uk/digital-communications/coronial-investigations-of-stillbirths/

Edwards & Others v S&G UK Ltd and *Raubenheimer v S&G UK Ltd*

GED COURTNEY
KAIN KNIGHT COSTS LAWYERS

KAIN KNIGHT
COSTS LAWYERS - LEADING THE WAY

The ongoing dispute between Slater & Gordon (S&G) and a group of their former clients, represented by CheckMyLegalFees.com (CMLF), continues to generate interest. The most recent appeal addressed a number of issues concerning case management of such matters.

The recent appeal concerns decisions of the Senior Courts Costs Office (SCCO) last year. In the matter of *Raubenheimer v Slater & Gordon UK Limited* [2021] EWHC B12 (Costs) the Court was asked by the Claimants to compel the Defendant to respond to Part 18 requests concerning the ATE premiums paid by Claimants and alleged secret commissions. Separately, in July the Court in *Edwards & Ors v Slater & Gordon UK Limited* [2021] EWHC B19 (Costs) was asked determine two points in relation to a cohort of around 130 Claimants. Firstly, did the Court have discretion to order standard disclosure per CPR 31 and if so, should it? Secondly, whether or not those cases should be stayed or alternatively should there be an order for security for costs?

Raubenheimer

The Claimant alleged that the Defendant had taken secret commissions in relation to ATE policies purchased on his behalf. Whilst it was accepted that the Court of Appeal had found that the ATE premium was not a disbursement and therefore not subject assessment (see *Herbert v HH Law Ltd* [2019] EWCA Civ 527), the Claimant felt that the Court could still make adjustments when it came to determine the cash account at the conclusion of the assessment. The Defendant argued that this wasn't the case and the resolution of the cash account was nothing more than an arithmetical step. The Court agreed with the Defendant and found that as an ATE premium could not be challenged in a s.70 assessment and accordingly the Defendant could not be compelled to respond to the request.

Edwards

In s.70 assessments the typical directions require the solicitor to permit their client to inspect the file of papers. Due to the nature of the dispute here, it was argued by the Claimant that mere inspection would not be sufficient and additional material such as call recordings of the initial sign up process should be disclosed. The Defendant objected citing that CPR 31 did not apply to s.70 assessments, partly due to the fact that they were not *"claims"* once the order to assess had been made. The Court found that whilst inspection was typical and appropriate in most cases, it was able to order disclosure where appropriate. Given the issues in this case disclosure was appropriate, although it was felt that both parties should give disclosure if such an order was made.

The second point the Court was asked to determine in *Edwards* was the Defendant's application for a stay/an order for security for costs. The Defendant sought security not from the Claimants themselves, but from their lawyers. This application centred around the indemnity given to the Claimants by CMLF. It was alleged that the indemnity offered amounted to illegal insurance or alternatively meant that CMLF were acting champertously. The Defendant pointed to extracts from CMLF's own retainer documents, which said that higher than normal hourly rates were payable as a consequence of the indemnities offered. It was alleged that CMLF lacked the sufficient capital adequacy to satisfy the indemnities offered to the Claimants and it left S&G in the unattractive position of potentially having to enforce costs orders against the Claimants themselves. The Defendant questioned whether this was something that the Claimants were even aware of. Conversely, CMLF argued that notwithstanding some versions of its retainer suggested higher hourly rates were sought in exchange for an indemnity, in truth this wasn't the case. This was shown by the fact that the hourly rates were the same as in retainers which didn't include the indemnity. Finally, as the indemnity was not the principle object of the contract, it being primarily for litigation services, it could not be regarded as a contract

for insurance in any event. As such there would be no suggestion that CMLF was illegally insuring the Claimants.

The Court accepted CMLF's argument and found that the provision of the indemnity was merely a subsidiary element of CMLF funding model. This model was similar to that considered by the Court of appeal in *Sibthorpe*, there it was found to be permissible. The Court dismissed the Defendant's application.

The Appeals

The decisions of the SCCO were appealed by both parties and were heard together in April this year and Richie J delivered his judgement promptly thereafter. The judgement itself is substantial and goes into far more detail that is practical to include here, although I've sought to summarise the key points.

The Disclosure Point

The Defendant appealed on the basis that CPR 31 did not apply to Part 8 claims and further that the Claimants' statement of case was not sufficiently particularised to identify what material may be relevant. There were two questions that Court had to consider. Was there a discretion to order disclosure, and if yes, should that discretion have been exercised here? At para 129 & 130, the judge addressed the first point;

"[129] On policy grounds I take into account that it is in the interests of the parties to a part 8 claim and the interests of the Courts and of Justice, that the Judges dealing with such claims can make whatever case management decisions they should need to make so as fairly to elicit the issues and to permit the parties to prove their claims and to achieve justice in accordance with the overriding objective in CPR r.1.1. I also consider that the power to order disclosure is useful, for the purpose before a SOCA is made, of determining whether a hybrid hearing is needed within part 8 or a transformation order should be made (transforming part or all of the part 8 claim into a part 7 claim) and to identify the scope of the issues and to decide which judge should hear which issues. Disclosure should not be the normal order in SOCAs because it is not usually needed and this judgment should not be taken as a licence to apply in all part 8 claims. [130] I rule that CPR part 31 (the power to order disclosure) does apply to the part 8 claims by these Claimants and the Judge was right so to conclude."

As to the second point the Court focused on the need for evidence to demonstrate that the Claimants gave their *"informed consent"* to be charged in the manner they were. At para 141, Richie J said;

"[141] The Claimants sought standard disclosure of the Slater and Gordon retainers and the audio recordings of the signing of the retainers and all other documents relating to the pleaded issues. The Judge granted it. The Defendant did not want to give any of these and appeals the order for standard disclosure. Should I grant the appeal on the grounds that disclosure is not usually ordered in Part 8 claims? I see no reason in justice to do that. Should I grant the Appeal on the basis that there is no power to order disclosure? I have already ruled that the Court had such power. Should I interfere with a case management decision on the basis that I disagree with it? I do not disagree with it. In addition I have taken into account the case law on my powers in appeals set out above and dismiss this ground of appeal. The disclosure order stands and should be complied with in my judgement."

The Stay / Security for Costs / Illegal insurance point

The Judge was not persuaded to grant the Defendant's appeal for a number of reasons. The Court felt that it was difficult if not impossible to identify a premium which was allegedly paid for the indemnity. In such circumstances it would be wrong to regard CMLF as providing illegal insurance. The Court opined that the indemnity was *"more akin to a business expense used for marketing purposes than an insurance contract term"*. The Judge felt that CMLF has taken on the potential expense not as an insurer, but as a business person. At para 189, Richie J found;

"[189] Taking the above into account I rule that these CFAs had the character of a lawyer's business deal, for the provision of legal services, made with members of the public in a particular category (ex-claimants in PI claims). I rule that the indemnities were a minor or ancillary term in that business model. I rule that the CFAs were not insurance contracts, even if the indemnities were insurance terms (which I have ruled they were not)."

Having found that there was no illegal insurance the Court addressed security for costs and surprisingly found that an order could not be made against CMLF. In doing so, the Court found that providing an indemnity did not mean that CMLF *"had contributed or agreed to contribute to the Claimant's costs"*. The judge also opined that to allow a stay/security in these matters would impede access to

justice and the fact that the Defendant may not be paid due to CMLF's alleged impecuniosity was not sufficient.

The Part 18 Point

Surprisingly the High Court also found for the Claimant on this issue. The Master's decision seemed well reasoned and it seemed that the binding guidance in *Herbert* should have meant that any consideration of the ATE premium should have been beyond the scope of the s.70 proceedings. Unlike Master Rowley, Richie J did not agree that the determination of the cash account was a merely arithmetical process. The Court found at para 219;

[219] Here I consider that the Judge fell into error. In my judgement the Cash Account cannot be signed off in the SOCA and no order can be made by the CJ for sums to be paid to or by the Defendant or the Claimants unless the items in the Cash Account are accurate and certified by the CJ. If they are in dispute, that dispute must be resolved before the final SOCA order can be made between the parties.

Citing the fact that it was not yet determined whether or not these matters would proceed in a hybrid fashion, with some elements being dealt with by the Chancery Division, where the Court could consider the secret commissions, it was important that these questions be responded to so that the Court could get properly to grips with the issues ahead of the next case management hearing.

In my view the Court's decision on this issue is very much on its own facts. In many cases where similar Part 18 requests are made, there is no evidence to suggest a secret commission has been taken and in such circumstances the court could reasonably regard these requests as fishing expeditions. It is also clear that the significant number of claimants here and the potential for a hybrid Part 7 Chancery hearing may have played a part.

The Defendant has sought permission to appeal to the Court of Appeal and there certainly are threads that can be pulled at regarding the Court's reasoning. A great number of matters are currently stayed pending these cases and given that these appeals relate to case management decisions, it is unclear when we will have a final end to these matters. With *Karatysz v SGI Legal* and *Belsner v CAM Legal Services Ltd* due to be heard in the Court of Appeal before the summer, practitioners can at least hope to have a degree of clarity on key issues in relation to s.70 Solicitors Act assessments.

Expert Discussions and the Joint Expert Statement – A lawyer free zone

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Consideration of *Patricia Andrews & Ors v Kronospan Limited* [2022] EWHC 479 (QB)

Introduction

Joint expert discussions bring hope and fear to lawyers in equal measure. It is the one stage of the litigation process which is off limits to lawyers so far as the litigation process is concerned. It is the proverbial unknown. On the one hand, your instructed expert may pull out all the stops and, in your eyes, return in gilded glory; on the other, your instructed expert may, in your eyes, fold like a pack of cards, game over.

The lawyers' role in the substantive content of expert discussions is properly *in absentia*. The independence of experts and the primary duty of the lawyers and experts to the court is paramount.

In the recent case of *Patricia Andrews & Ors v Kronospan Limited* [2022] EWHC 479 (QB), Senior Master Fontaine, crystallised the position, and spelt out in no uncertain terms that instructing solicitors and the expert are not to discuss the content of the joint expert discussions and the joint statement. Each should be aware of the duties that they owed to the court.

To enter into discussion risks exclusion of the expert evidence relied upon.

The Facts

The matter concerned a group action by 159 residents alleging that the defendant was liable to them in nuisance due to dust, noise and odour emissions from its wood processing plant.

Expert reports on dust analysis were exchanged in April, 2021 with a joint discussion as between the experts commencing the following month.

After a period of several months (no joint report having been finalised) it came to the attention of the defendant's solicitors that the claimant's expert had been forwarding *"work in progress"* copies of the joint statement to his instructing solicitors and that he had sent over the initial draft on an unsolicited basis.

The matters having come to light, the defendant made application contending that the only option to the court was to revoke the claimants' permission to rely on their expert. It was advanced by the defendant that the expert was not truly independent but rather that he had acted as an advocate for the claimants.

The expert concerned had been acting in his capacity for a period of 3 years and had incurred fees of £225,000.

Over the period in question, the claimants' solicitors had made 68 comments on the drafts that had been sent to them, most of which were typographical, or by way of query.

It was also established that the expert and the claimants' solicitors had entered into email and telephone discussions in which the content and progress of the joint statement was discussed as between them.

The Hearing

The claimants contended that the approach suggested by the defendant was potentially calamitous as it would involve significant delay in instructing another expert and result in further significant cost.

Senior Master Fontaine noted that while many comments made by the claimant solicitors were inconsequential *"many others commented or made suggestions on issues of substance"*. The claimants' solicitors had themselves accepted 16 comments on this premise. In sending over the first draft unsolicited, Senior Master Fontaine considered that such could only have been the case because the expert sought the solicitors' views.

The claimants' solicitors accepted that *"it was wrong for an expert to solicit input from their instructing solicitors during the process of drawing up a joint statement, just*

as it is wrong for solicitors to provide that input" and furthermore that *"there was serious transgression of the rules by the claimants"*.

Senior Master Fontaine observed that her primary concern having seen the communications passing between the respective parties, was that the expert's approach *"strongly suggests that he regards himself as an advocate for the claimant, rather than an independent expert whose primary obligation is to the court"*. The stance draws parallels with the dicta of Black LJ in *EXP v Dr Charles Simon Barker* [2017] EWCA Civ 63 (albeit a conflict of interest case) in which he stated that *"our adversarial system depends heavily on the independence of expert witnesses, on the primacy of their duty to the court over any other loyalty or obligation..."*. It is also worth noting in this context, albeit from a different jurisdiction, the dicta of Judge Davis in the South African case of *Scheneider NO & Others v AA & Another* (5) (SA) 203 (WCC), who said:

"Agreed an expert is called by a particular party, presumably because of the conclusion of the expert, using his or her expertise, is usually in favour of the line of the particular party. But that does not absolve the expert from providing the court with an objective and unbiased opinion , based on his or her expertise, as is possible..."

Notwithstanding that there would be difficulties in revoking the claimants' permission to rely on the expert, Senior Master Fontaine considered that the transgressions undertaken by him and the claimants' solicitors were such that the court had no confidence in his ability to act in accordance with his obligations as an expert witness. She further enforced the position by specifying that *"the basis upon which the claimants received permission to rely on [x] as an expert witness , namely his duties under CPR 35.3, 35 PD paras 21 and 2.2, has been undermined"*. In so doing, it is also worth observing that the expert had breached those duties expected of an expert as set out by Creswell J in the quintessential case of *"Ikarian Reefer"* [1993] 2 Lloyd's Rep 68.

Senior Master Fontaine succinctly remarked that it *"it is important that the integrity of the expert discussion process is preserved so that the court, and the public, can have confidence that the court's decisions are made on the basis of objective evidence"*.

Albeit that the litigation process was well progressed, no trial date had been set by the court, and in the circumstances, the claimants were allowed to rely on a new expert. A distinctly cooler climate would have been felt had matters surfaced at trial, where no substitution would have been permitted.

Summary

The ratio is clear. Leave well alone. The decision in *Andrews* highlights the importance of the objectivity and transparency involved in the joint statement discussions as between the experts. Until the joint statement has been signed off and distributed by the experts there should be no contact as between the expert and their instructing solicitors on the content of the statement by way of conversation, email or otherwise. The experts are effectively to be placed in a protective bubble during the course of discussions.

The tenor of *Andrews* repeats that said by HHJ Davies some 4 years earlier in *BDW Trading Ltd v Integral Geotechnique (Wales)* Ltd [2018] EWHC 1915 (TCC), in which he stated that *"the expert should not ask solicitors for their general comments or suggestions on the content of the draft statement"*. He emphasised that *"it is important that all experts and all legal advisers should understand what is and what is not permissible as regards the preparation of joint statements"*.

As a solicitor, if approached by the expert as to the content of a joint report, a polite no and a clarification of the duties owed to the court will suffice. Take cognisance of what was said by Fraser J in *Imperial Chemical Industries Ltd v Merrit Merrall Technology Ltd* [2018] EWHC 1577 at [237] in that:

"the principles that govern expert evidence must be carefully adhered to, both by the experts themselves, and the legal advisers who instruct them. If experts are unaware of these principles, they must have them explained to them by their instructing solicitors. This applies regardless of the amounts in stake and in any particular case, and is a foundation stone of expert evidence...".

Taking the mystery out of capacity in clinical negligence cases

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In clinical negligence work capacity may often be an issue. When it does come up, it can feel complicated and make us reach for the law books. The purpose of this article is to take the mystery out of capacity and provide a pragmatic guide as to how these types of cases should be approached.

Where to start

It is crucial that capacity is determined at an early stage in litigation because it determines how the case is going to be run. The starting point for any capacity assessment is the two-stage test under the Mental Capacity Act 2005:

1. Does the person have an impairment of their mind or brain, whether as a result of an illness, or external factors such as alcohol or drug use?

2. Does the impairment mean the person is unable to make a specific decision when they need to? A person is unable to make a decision if they are unable to understand the information relevant to the decision, retain that information ad use or weigh up that information as part of the process of making the decision.

A central principle of the Mental Capacity Act is that capacity is time and decision specific. A common incorrect assumption is that because a claimant lacks capacity in one area of their lives, they would also lack capacity to litigate. As a consequence, a reliable early assessment of capacity to litigate is fundamental.

Assessing capacity

If it is suspected that a claimant lacks capacity due to a long-term condition, such as dementia, it may be possible to take a proportionate approach and either obtain a capacity assessment from the claimant's treating clinician and/or General Practitioner or ask an instructed medical expert to comment on it in their medical report.

However, if capacity is a potential issue between the parties, expert evidence from a Neurologist or Neuropsychiatrist will be required in order to provide a detailed assessment that the Court requires.

With any capacity evidence, it is important to look at it with a critical eye. Something that both legal and medical practitioners frequently get wrong, is that the person who asserts a lack of capacity has the burden of proof. The claimant therefore has to *'prove'* nothing. In *SS v LB Richmond upon Thames* [2021] EWCOP 31, His Honour Judge Hayden commented that the phrase in a report that the *'patient failed capacity assessment'* was *'awkwardly expressed'*. He went on to reiterated that an assessment of capacity is *'not a test that an individual passes or fails'*, but an evaluation of whether the presumption of capacity is rebutted. Whilst poor choice of language may not be fatal to a capacity assessment, it could undermine the credibility of the professional undertaking it and, as a consequence, the conclusions that they reach.

It is also imperative to consider what the experts have taken into consideration when undertaking their assessments. In the case of *PH v A Local Authority* [2011] EWHC 1704 (Fam) the Court cautioned against capacity evidence being based upon on a single interview. This was also reflected in the case of *Martin v Salford Royal NHS Foundation Trust* [2021] EWHC 3058, where the Court preferred the evidence of the Defendant's expert who had conducted psychometric testing. but had also spent time observing the Claimant in a *'real world setting'*.

A theme in the case law is that evidence that takes a holistic view of a claimant, rather than snapshot is likely to be favoured. As a consequence, providing the expert with the medical/ social care records and witness statements will assist with any assessment. Furthermore, it is important to ensure that the expert clearly states in their report the evidence that they have considered and the detail of their interview with the claimant.

Appointing a litigation friend

A person *'who lacks capacity to conduct the proceedings'* is a protected party under CPR 21.1(2)(d) and a litigation

friend will therefore need to be appointed. Interestingly, there is no requirement in the Civil Procedure Rules that medical evidence is required to prove that a claimant lacks capacity. In the case of *Hinduja & Ors* [2020] EWHC 1533 (Ch), the Defendant argued that, in the absence of medical evidence, the Court did not have sufficient evidence to conclude that the Claimant lacked capacity to conduct the proceedings. This was rejected by Falk J, who reiterated that whether a judge needs medical evidence to enable them to determine whether an individual is a protected party depends on the circumstances of the case. It would however be advisable to ensure that the certificate of suitability properly addresses the test in the Mental Capacity Act 2005 and that some form of medical evidence is filed in support. The extent of the medical evidence is likely to depend on the facts of the case.

Limitation

Under the s.28 Limitation Act 1980 there is an extension of limitation in the case of disability, which includes someone who lacks capacity within the meaning of the Mental Capacity Act 2005 to conduct legal proceedings.

However, it is a common misconception that if the claimant does not have capacity to conduct litigation, limitation does not run. This is not always the case. Practitioners should be aware of the (very old!) case of *Prideux v Webber* (1661) 1 Lev 263, which is still good law. This makes clear that once the limitation period starts to run it cannot be stopped. This means that if the claimant lacked capacity at the time of the negligence and did not regain it at any time thereafter, then the limitation clock will not run. If, however, the claimant has a period of capacity (however brief) at any point after the date of negligence, then the limitation period starts to run and will continue to run. It is therefore advisable that practitioners who are representing a claimant who lacks capacity periodically re-consider whether their capacity status has changed.

A recent cautionary tale is the case of *Aderounmu v Colvin* [2021] EWHC 2293 9, where the Claimant's solicitor assumed that the Claimant lacked capacity and therefore the 3-year limitation period did not apply. The Court considered all the evidence including medical reports, the medical records and witness evidence, and found that the Claimant had capacity and therefore the claim had been issued outside of the limitation period.

Cost budgets

Where capacity is an issue, there is inevitably additional work that is required in running the case. For example, there is likely to be additional medical evidence to consider, a litigation friend appointed and increased difficulty in obtaining instructions. It is therefore important that this is reflected in the cost budget and that all phases of litigation are appropriately budgeted for. Failure to consider the impact of capacity at the cost budgeting stage, is likely to lead to an overspend or a budget is particularly restrictive.

Evidence

Where a claimant lacks capacity, the case is likely to be reliant upon witness evidence other than that of the claimant. As a consequence, practitioners may need to ensure that witness statements from the claimant's family/ partner are particularly detailed regarding issues such as pain, suffering and loss of amenity, and care claims. Capacity may therefore effect the strength of the evidence and the litigation risk of proceeding to trial.

Settlement

As capacity is decision specific, legal practitioners must be cautious in routinely claiming Court of Protection and professional deputyship/trust costs in cases where the claimant lacks capacity to litigate. For example, in *Martin v Salford Royal NHS Foundation*, despite being a protected party, the Judge concluded that the Claimant had capacity to manage her finances and therefore she was not entitled to Court of Protection and Deputy costs.

In accordance with CPR 21.10 any settlement made on behalf of a protected party needs the approval of a Court. This can be advantageous when considering settlement, as the approval of the Court can be used to encourage a defendant to make a more generous offer in order to ensure approval. In more complex cases, it's important to ensure that any advice filed in support of approval fully explains the reasons for the settlement, including the litigation risk of proceeding to trial.

Practice Points

The crucial point in any case involving capacity is to always ensure that capacity is assessed at an early stage in proceedings and that it is regularly reconsidered as the case is progressed. Failure to do so, is likely to lead to both procedural and evidential problems which may be highly problematic as the claim progresses.

Exceptional Case Funding For Inquests No Longer So Exceptional

LUCY WILTON, PARTNER
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Legal aid for inquests is currently available only through the Legal Help scheme or by way of Exceptional Case Funding ('*ECF*'). Prior to 12 January 2022, family members applying for ECF for an inquest into the death of a loved one had to undergo means assessment, as well as a (difficult to satisfy) merits test.

However, the former has now been abolished for all ECF inquest applications made after that date. Furthermore, those who had previously been granted ECF but had to make financial contributions no longer have to do so.

This is hopefully a positive step towards increasing the number of people eligible to receive legal aid in what will surely be one of the most difficult experiences of their lives. However, applicants will still need to overcome the merits hurdles set out in The Civil Legal Aid (Merits) Criteria Regulations 2013 (and expanded upon in the Lord Chancellor's Exceptional Funding Guidance (Inquests)).

Merits test for ECF for inquests

These essentially require an applicant to establish either that:

• This is an *'Article 2'* type inquest (i.e. there is considered to be a duty to hold an investigation into whether the State has arguably breached its obligations under Article 2 of the European Convention on Human Rights, namely the *'right to life'*); or

• There is a *'wider public interest'* in relation to both the applicant and the inquest. Basically, this requires them to show that provision of advocacy services for that individual for the inquest is likely to produce significant benefits for a class of persons other than the applicant and their family.

What does ECF cover for inquests?

For those who pass the merits test, ECF can cover:

• Instruction of an advocate;

• Preparation for hearings (including a conference with counsel); and

• Advocacy at the pre-inquest review and/or inquest hearing.

It can also cover another legal representative attending the hearing(s), if this is considered justified.

Are there any limitations to ECF?

There are various limitations to ECF including that:

• It will not cover the drafting of witness statements or written submissions to the coroner, nor other work which may be beneficial prior to hearings but fall short of *'advocacy preparation'*. If the applicant wishes to obtain legal aid to cover the costs involved in those steps, they would need to apply for Legal Help. Fortunately, if a successful ECF application is made after 12 January 2022, Legal Help can also be available without means-testing.

• It will not cover experts' fees, although if the coroner has concluded that the expert must attend (because their evidence is relevant to the investigation) then the coroner should pay the expert's fee for attending the hearing.

• It will not cover interpreters' fees, but again the coroner should pay these.

It is important to be aware that applications for ECF can take a long time to be processed. The Legal Aid Agency's Provider Pack (Inquests) Jan 2022 suggests that they *"aim"* to make a decision on such applications within 25 working days, i.e. five weeks.

If there is any urgency to the application, e.g. an imminent inquest hearing, then this should be made clear when the application is submitted (which is done on form CIV ECF2 (INQ), sent by e-mail to ContactECC@justice.gov.uk). However, the Legal Aid Agency has made clear that they are unlikely to consider an impending pre-inquest review to be urgent.

A key aspect to make clear to applicants is that, even though ECF will no longer be means-tested, the statutory charge will apply to any compensation that they receive as a result of related legal proceedings. For example, if they make a successful clinical negligence claim as a result of the circumstances giving rise to the death, then the Legal Aid Agency could seek to recoup from the compensation any shortfall in the inquest-related costs recovered from the defendant in those proceedings.

The future of the merits test

INQUEST, with the support of AvMA and others, has long been campaigning for automatic eligibility of family members for legal aid where a State body (such as an NHS trust) is also involved in the inquest and will be legally represented. Effectively, this would do away with the merits test in this type of case and would significantly expand the group of people entitled to legal aid for inquests.

On 31 March 2022, the House of Lords voted for an amendment to the Judicial Review and Courts Bill which would have provided an automatic entitlement to legal aid in the above circumstances. Unfortunately, the Government had previously come out against expanding eligibility in this way and so unsurprisingly the Lords amendment did not make it through to the enacted legislation.

This is clearly a blow for bereaved families (and those representing them). However, they can perhaps take some comfort in knowing that the campaign for wider legal aid for inquests seems to be attracting greater support in some parts of the legislature than ever before.

Inquest touching the Death of Connor Wellsted

Outer Temple

ELIZABETH GRACE, COUNSEL
OUTER TEMPLE CHAMBERS

I first met Connor's foster parents, Barbara and Shazia, in 2018, having read a thick bundle of papers that Charlotte, my AvMA caseworker had put together ahead of the inquest.

Those papers, beautifully prepared though they were, could never have expressed to me the joy with which Connor had lived and the tragedy of how he had died. I was only able to understand that once I met Barbara and Shazia, who had fought for transparency and honesty as to how their little boy had come to pass away while staying at The Children's Trust. Their dignity and their strength over the past four years while waiting for the Inquest to conclude has been an extraordinary testament to them as a family.

Connor was a joyful, exuberant child. His five years were not without their obstacles, but Connor lived every moment of those five years fully. As a newborn, Connor suffered a cardiac arrest which resulted in a brain injury: this left him with complex needs. It was shortly after that incident, at the age of just five months, that Connor came into his foster parents' care with an extremely guarded prognosis. This did not deter them. With their love and dedication, Connor made remarkable progress, despite the limitations of his brain injury.

This is how Connor came to stay at The Children's Trust for a second period of rehabilitation. Connor was a well child, and his stay at the Trust was simply to help him develop his mobility and communication skills. His death was sudden and unexpected.

On the morning of 17 May 2017, Connor was found deceased in his cot at around 7.45am. Nursing staff discovered Connor sitting upright in the corner of his cot, with a rigid cot bumper on his neck. By the time Barbara was called from her on-site accommodation, the bumper had been moved. She was told he had died in his sleep. She knew that something was wrong, and that what she was being told could not be right.

The purpose of an inquest is to answer four statutory questions: who the deceased was, when they died, where they died, and how they died. Where Article 2 of the European Convention on Human Rights, the right to life, is engaged, the fourth question is read to mean *"by what means and in what circumstances"*, which allows a Coroner to undertake an enhanced investigation into the death. An Article 2 inquest is only available where the death occurs while the deceased was in the care of the state.

The Coroner, Dr. Karen Henderson, found in relation to Connor's death that Article 2 was engaged. She was satisfied that Connor had been trapped by the rigid padded board that had lined his cot, and that the board had been found on his neck, and not on his chest as had been stated by some of the Trust's witnesses. The Coroner was concerned at the use of the cot and the bumpers, and found that the steps and system in place for its safety were wholly inadequate. The Coroner further found that from the point of Connor's death, a narrative that the bumper had been on his chest had resulted in a negative impact on her investigation, the investigations of the Police, the Coroner's Officer, and the Coroner's Pathologist, as well as the Trust's own Serious Incident Report and its addendum. The Coroner was concerned by the lack of enquiry by those on duty and those in senior management positions at the Trust.

Ultimately, the Coroner found that Connor had died as a result of airway obstruction, and was satisfied that the Trust had failed to keep Connor safe in his cot. The Coroner also indicated that she would make a Prevention of Future Deaths Report, sometimes called a "*PFD*" for short. A Coroner must issue a PFD where the Coroner is of the view that action should be taken to prevent future deaths. Here, the Coroner was deeply concerned by the lack of transparency and insight, and found that remedial action to date had been inadequate. The Coroner took the view that this was sufficiently serious for her to make a PFD.

I was privileged to be instructed by Charlotte at AvMA to ensure that Barbara and Shazia's voices were eventually heard. Though nothing can ever fill the huge void left by Connor's death, I hope that the Inquest process gave Barbara and Shazia the answers they needed as to how Connor died.

Forthcoming conferences, webinars & events from AvMA

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

Representing Families at Inquests: A Practical Guide

15 September 2022, Gatehouse Chambers, London

The important work conducted by AvMA's inquest service is the basis for this conference, which is designed to be a comprehensive guide to the practice and procedures when representing a family at an inquest. The programme will be available and booking will open Summer 2022.

AvMA Specialist Clinical Negligence Meeting

Afternoon of 2 December 2022, Leonardo Royal London St Paul's Hotel

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. Registration and a networking lunch will commence at 12.30, with the meeting starting at 13.30 and closing at approximately 17.00. Booking will open in September 2022.

AvMA 40th Anniversary Gala Celebration

Evening of 2 December 2022, Leonardo Royal London St Paul's Hotel

Booking is now open for AvMA's 40th Anniversary Gala Celebration! Join us to celebrate the great work that AvMA has achieved in striving to improve patient safety and justice for people affected by medical accidents. The need for our work remains as great as ever. We help over 3,000 people every year with advice and support and we continue to fight to preserve access to justice for victims of clinical negligence and for better patient safety.

The evening will commence with a drinks reception followed by a fantastic three-course meal with wine, live entertainment, dancing and some special surprises! It will be the perfect event to entertain clients and/or reward staff, on an evening that will bring together the key people from the medico-legal and patient safety worlds.

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Court of Protection conference

2 February 2023, Hilton Leeds City Hotel

AvMA's Court of Protection conference returns on 2 February 2023 to examine the current state of litigation and the challenges and responsibilities facing those who work in this important area. The programme will be available and booking will open in November 2022. Please e-mail conferences@avma.org.uk for further details on the conference or information regarding exhibiting/sponsoring.

33rd Annual Clinical Negligence Conference (ACNC)

23-24 March 2023 (Golf Day & Welcome Event 22 March) 2023, Bournemouth International Centre

Join us in Bournemouth on 23-24 March 2023 for the 33rd 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. Early bird booking will open in September but put the date in your diary now!

Please e-mail **conferences@avma.org.uk** for further details on the conference or information regarding exhibiting or sponsoring at #ACNC2023.

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

www.avma.org.uk/events

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Manchester, Thursday 14 July 2022

Kindly sponsored by Deans Court Chambers and INNEG. For details and to book click here: **https://www.pic.legal/the-avma-pic-manchester-curry-night-14-july-2022/**

Leicester, Thursday 6 October 2022

For details and to book click here: **https://www.pic.legal/leicester-curry-night/**

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For more information contact Paula Santos,

paulas@avma.org.uk or by phone **0203 096 1106**

Tees

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Eastern Region AvMA Fundraiser

CELEBRATING 40 YEARS

hosted by Tees

Friday 8th July 2022
Selwyn College, Cambridge, CB3 9DQ

Champagne punting tour 6pm
Drinks reception 7pm
Dinner 7.30pm
Carriages 10.30pm

Punting sponsored by

HSP Harley Street Pagination

Drinks reception sponsored by

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Champagne punting tour £30 per person
Dinner £80 per person
Table of 10 – £800
Dress code Black Tie
Book tickets… events@teeslaw.com

We very much welcome offers for donation of a raffle prize.

Run and fundraise for AvMA in the Great North Run

We still have a few places available to run in the Great North Run 2022. 57,000 determined and dedicated runners make the Great North Run the World's biggest and best half marathon – famous for its warm North East welcome, unbeatable atmosphere and the millions raised for good causes.

When: Sunday 11 September 2022

Where: Newcastle to Southshields

Distance: Half marathon

If you would like to take part in this iconic event and raise money to help people affected by avoidable harm in healthcare, please email **communications@avma.org.uk** to register your interest. Don't delay as we have limited places available. If you are successful in receiving one of our places we ask you to cover the £83 registration fee and to aim for a minimum fundraising target of £300.

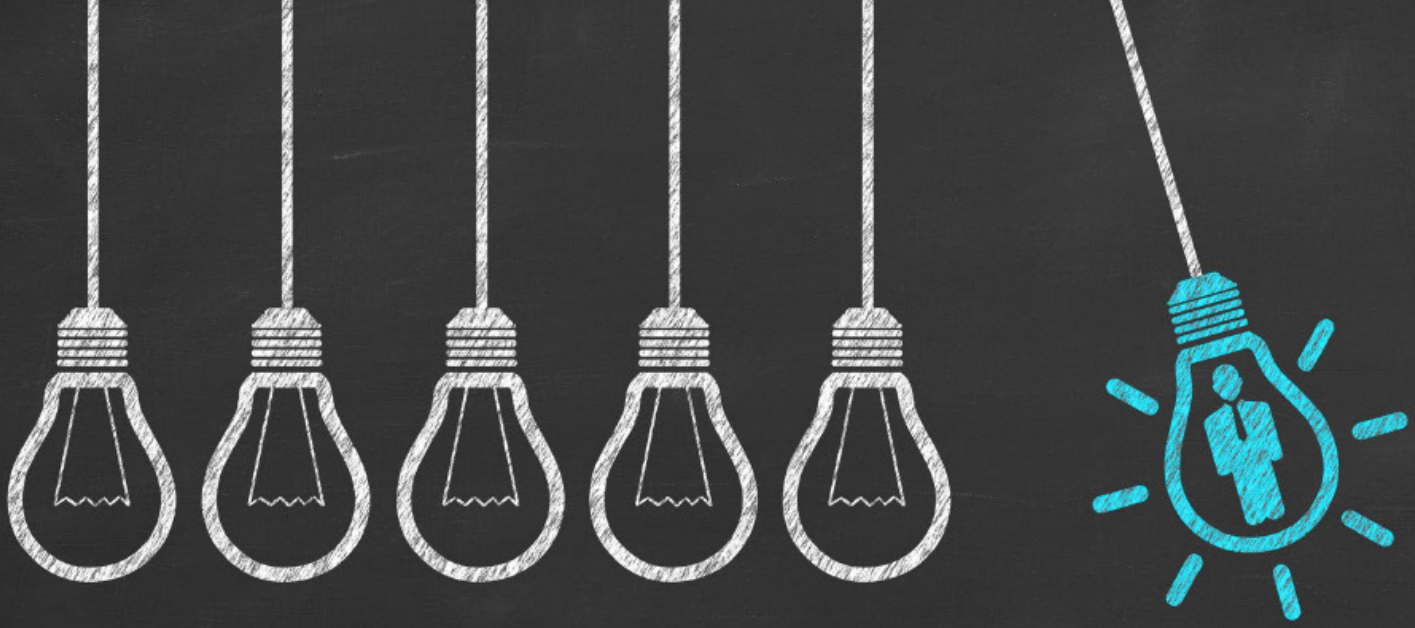
Journal of Patient Safety and Risk Management

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).

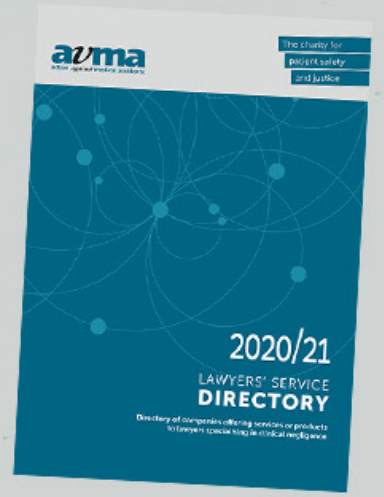
If you would like more information about the journal, or are interested in subscribing, please contact Sophie North, Publishing Editor on

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
- Court of Protection deputyship and personal injury trusts
- Medical records pagination, collation and review
- Investment managers

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

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