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Lawyers Service Newsletter

MARCH 2020

Contents

Editorial

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When I wrote the last editorial for the LS Newsletter in November, little did I think that 2020 would see such radical and fast-moving changes. Many of us are now routinely working from home, having to self-isolate and coping with a national lock down that has no immediate end in sight. It is to say the least, a worrying and uncertain time for us all.

In the hope of being able to offer some consistency, AvMA is exploring alternative ways in which we can continue to provide education, medical and legal updates. In the longer term it is hoped that some of these alternatives may provide additional efficiencies for our LS members, in the short term we want to continue to provide our services as best we can.

In the meantime, thank you for bearing with us at this difficult time in our national history, we are sorry for the cancellation of any of our LSGs and the necessary rescheduling of our conferences.

This edition of the Newsletter features a separate section for Lawyer Service Updates. The LS Update section contains information on matters such as: NHS Resolution's Early Notification Scheme (ENS); HSIB; NHS Resolution's Mediation report and developments on the government's proposed FRC scheme– to mention but a few topics covered. Due to sickness AvMA is looking for a part time temporary caseworker. Our conference manager, Ed Maycock has a message regarding our forthcoming conference events - AvMA's annual conference due to take place in Bournemouth in June 2020 has been postponed. Please see the update section for more information.

For a good overview of the main worries about the ENS process, I am pleased to recommend **Kerstin Scheel's** article on "*NHS Resolution's Early Notification Scheme – Behind the scene*". Kerstin is a partner at **Royds Withy King**, Bath.

I refer to **Katie McFarlane**, barrister at *Ropewalk Chambers*, article on "*Informed Consent and "wrongful birth*". Katie has looked at this topic with reference to the recent case of: *Mordel v Royal Berkshire NHS Foundation Trust [2019] EWHC 2591 (QB)* and succinctly explores the importance of the way in which healthcare providers obtain a patient's informed consent.

Informed consent is an area of practice which has rightly attracted increased consideration and scrutiny since the 2015 decision of Montgomery. We are pleased to feature **Helen Budge's** article "*Factual causation in informed consent cases following Montgomery*". Helen is a partner at *Potter Rees Dolan* solicitors and explains why the devil is very much in the detail in consent cases.

Laurence Vick has had an illustrious legal career and is well known for the way he represented some of the families involved in the Bristol heart scandal. We are fortunate to be able to publish Laurence's article "*Lessons learned from the Bristol heart scandal and the 2001 Kennedy Inquiry*". Given the breadth of Laurence's experience in this area, the article will be featured in two parts. This edition of the Newsletter sees part I of that article, which looks at the shocking background facts giving rise to the inquiry. The second part of the article to be published in June, will explore the inquiry itself and poses the uncomfortable question: have things really changed? – this is a compelling and sensitively written piece, I encourage all solicitors, whether junior or senior to read this personal reflection.

Turning to issues of practice and procedure, many of you have reported defendants increasing use of video surveillance to undermine claimants' cases. **John Gimlette** is a barrister practising at **1 Crown Office Row,** his article "*Secrets and lies*" takes a comprehensive look at fundamental dishonesty claims, he highlights the hazards for claimant solicitors, how they might be mitigated and provides case examples where fundamental dishonesty has been found.

Another common bugbear for claimant solicitors is the defendant's dilatory approach to serving documents on time. Our thanks to **Hasina Choudhury**, partner and head of **MacMillan Williams** Adult Claims for sharing her case report of *JK (PR of the estate of LK) v Croydon Health Services NHS Trust & Kings College Hospital NHS Foundation Trust [2019] EWHC 2297* in this case, Hasina successfully resisted the defendant's appeal against the Master's decision not to grant an extension of time or relief from sanctions for late service of their defence.

Christopher Hough is a barrister now practising at **Serjeants' Inn Chambers**, I am pleased to say, he is a regular contributor to our LS Newsletter. We are pleased to include his article on "*Discount on claims for gratuitous care: 33% or lower?*" Another regular contributor to our Newsletter is **Dr Simon Fox QC**, leading counsel also at **Serjeants' Inn Chambers**, his article "*Managing uncertainty in the mechanism of injury*" offers clear and indispensable advice on how to approach surgical cases where the cause of the injury is unclear, it also looks at the effect of the recent Court of Appeal decision in *Schembri v Marshall* on proving causation.

The family in the inquest touching the death of Audrey Allen were represented through AvMA's pro bono inquest service, counsel, was **Tom Semple of Parklane Plowden Chambers**. Following the inquest, the CQC went on to prosecute the care home. Tom's article "*CQC successfully prosecutes local authority following inquest*" looks at the general criteria for CQC prosecutions with reference to the subsequent successful prosecution in Ms Allen's case.

A key factor in Ms Allen's death was that care home staff lacked the relevant training to enable them to care for Ms Allen. More generally, inquests do frequently identify lack of training as being a contributing factor in a person's death. **Marcus Coates-Walker**, barrister at **St John's Chambers**, Bristol case summary of "*the inquest touching the death of Andrew Goldstraw*" also demonstrates this. In that case, the coroner made several prevention future death reports, one of which was the need for improved training for prison healthcare staff, so they could carry out an adequate risk assessment of an inmate's risk of self-harm.

All too often our inquest service sees deaths arising from failings in mental health care. Equally, it is not unusual for coroners to treat these deaths as being sad, but inevitable. Our thanks to **Shantala Carr**, of **Girlings Solicitors**, for her article on "*Claims for preventable suicides*". Shantala candidly acknowledges the difficulties with bringing these claims: proportionality, causation – to name but two issues. However, she also reminds us that despite those difficulties these cases can support "bereaved families to obtain the answers and the accountability they are looking for" They also continue to shine a light on the failures in our mental health service and the need for change.

We welcome your feedback on our LS Newsletter (**norika@avma.org.uk**) and any suggestions for articles you would like to submit for the next edition of the Newsletter due in June. Until then, we hope you and yours manage to stay safe and well!

Best wishes

Lawyer Service Updates

Early Notification Scheme (ENS)

We started this year with two meetings held in London and Leeds respectively, aimed at exploring NHS Resolutions Early Notification Scheme (ENS) Progress report **https://resolution.nhs.uk/wp-content/uploads/2019/09/NHS-Resolution-Early-Notification-report.pdf**. Both meetings were interactive and raised many interesting points.

Several lawyers attending the ENS meetings asked whether the information and documents generated as part of the ENS investigation would be disclosed to them or their client. AvMA has further explored this issue. We refer to Appendix III (p64) of the ENS progress report which effectively says the ENS investigation is carried out under litigation privilege. At a recent meeting with NHS Resolution where we met with Helen Vernon and others, they advised that they encouraged as much relevant information from the ENS investigation as possible be shared with families. However, they confirmed their view that the ENS process does grant them litigation privilege and ultimately, they are not obliged to disclose any documents, reports or information generated as a result of the ENS investigation.

AvMA considers that the stated principles behind ENS investigations are commendable. However, we do have some serious concerns about the scheme, key amongst these are: what are families being told about the purpose of the ENS process? Do they really know what the investigation may mean for them and their baby? Where, if at all, are families being directed to for independent advice and information?

HSIB:

We have previously reported that there is some uncertainty over the future of HSIB maternity investigations; the Health Service Safety Investigations Bill (HSSIB) has removed reference to maternity safety investigations being carried out. AvMA has been trying to find out more about what we can expect in the future and whilst there is no certainty, all the indications are that the maternity programme will remain. We will keep you updated.

Mediation:

In February, NHS Resolution published their report: "Mediation in healthcare claims – an evaluation" **https://resolution.nhs.uk/wp-content/uploads/2020/02/NHS-Resolution-Mediation-in-healthcare-claims-an-evaluation.pdf** The foreword focuses on NHS Resolution's commitment to improving the patient experience. The report refers to 380 clinical mediations taking place in 2018/19, six of those cases ended in a trial of the action – the claimant succeeded in three of the six trials, NHS Res were successful in the remaining three trials. Most mediations took place after proceedings had been issued and most of the successful mediations were in cases where damages were valued between £50,001 - £250,000 (213 cases). According to the report, cases have a better chance of being settled at or shortly after mediation where counsel does not attend for either party.

Message from NHS Resolution:

NHS Resolution has contacted us and asked us to pass on the following message on their behalf. **NHS Resolution** write:

"In light of recent events, and more generally in relation to reducing environmental impact and improving efficiency, we have been reviewing our processes in relation to hard copy correspondence. As you know, we are a largely paperless organisation, but we still receive a significant amount of hard copy post per day. Some of this is Letters of Claim copied to us, as required under the clinical negligence pre-action protocol. Some of it is simply hard copies of correspondence also sent by email. In order to minimise this, we would be grateful if you could assist us by encouraging your members to avoid sending hardcopy documents to us wherever possible and cascading the following:

- *Please can correspondence be sent to us [NHS Resolution] by **email only**. If this is not possible, please contact the allocated NHS Resolution case handler.*

- *Letters of Claim copied to us (as required under the clinical negligence pre-action protocol) should be sent to ClaimsEnquiries@resolution.nhs.uk.*

- *Please note, we are not authorised to accept formal service of court documents.*

NHS Resolution staff have been asked to send all documents by electronic means wherever possible.
We are grateful to you in advance for your co-operation."
End of message.

Fixed recoverable costs in low value clinical negligence claims:

Earlier in March, AvMA attended a meeting with DHSC, to discuss the CJC proposals for a fixed recoverable costs scheme in low value (≤ £25,000) clinical negligence claims. We reiterated our view that the scheme will create problems for access to justice - the commercial reality for many firms is that payment by way of fixed costs does not reflect the complexity of some low value cases. We emphasised the importance of certain categories of case being excluded from the scheme and our concerns as set out in our position statement appended to the CJC report and available on the AvMA website: **https://www.avma.org.uk/?download_protected_attachment=AvMA-Position-Statement-Redacted.pdf**

Most of our criticisms of the process were reserved for the clear failure to seize the opportunity to discuss and explore improvements to patient safety. We discussed how more focus needs to be placed on the availability of a robust investigation process that is carried out early on. A process that gives potential claimants the answers to their questions, addresses the reasons why the breach of duty/clinical failing arose in the first place, and takes steps to try and prevent the same thing happening again, will stave off many clinical negligence actions.

We don't know when the consultation will be held but suspect that it will be soon after the national risks associated with coronavirus abate.

Ian Patterson inquiry

On 4th February, the independent inquiry into the issues raised by Paterson, published its report: **https://www.gov.uk/government/publications/paterson-inquiry-report**. AvMA advised some of the patients and families affected by Paterson and AvMA's CEO, Peter Walsh, gave evidence to the inquiry.

Whilst AvMA, applaud many of the proposals in the report, especially around the private complaint process, we are very disappointed that the recommendations do not include provision for patients/families to have access to a funded independent advice service to help them bring their concerns

The Chair of the inquiry was Rt Reverend Graham James. The report opens with a statement from him, I take this opportunity to include some of his observations which will no doubt resonate with many of you:

- *"This report is not simply a story about a rogue surgeon…It is the story of a healthcare system which proved itself dysfunctional at almost every level when it came to keeping patients safe, and where those who were the victims of Paterson's malpractice were let down time and time again."*

- *"They were initially let down by a consultant surgeon who performed inappropriate or unnecessary procedures and operations. "They were then let down both by an NHS trust and an independent healthcare provider who failed to supervise him appropriately and did not respond correctly to well-evidenced complaints about his practice."*

- *"Once action was finally taken, patients were again let down by wholly inadequate recall procedures in both the NHS and the private sector."*

- *"The recall of patients did not put their safety and care first, which led many of them to consider the Heart of England NHS Foundation Trust and Spire were primarily concerned for their own reputation."*

- *"Patients were further let down when they complained to regulators and believed themselves frequently treated with disdain."*

- *"They then felt let down by the Medical Defence Union which used its discretion to avoid giving compensation to Paterson patients once it was clear his malpractice was criminal."*

- ***"Only by taking their cases to sympathetic lawyers did some patients find themselves heard."***

- *By that stage many others found their exhaustion was too great and their sense of rejection so complete that they scarcely had the emotional or physical strength to fight any further.*

- ***"…It is wishful thinking that this could not happen again."***

- ***"This report is primarily about poor behaviour and a culture of avoidance and denial.*** *These are not necessarily improved by additional regulation."*

Emotionally healthier ways of working in law:

The demands of being a solicitor in private practice can be considerable, surviving let alone thriving in what can often feel like a demanding environment can be challenging. The Open University in collaboration with the charity, LawCare has developed a free course entitled "Fit for Law". The course focuses on emotional competence and professional resilience and aims to promote psychologically and emotionally healthier ways of working in the law. More information and details of the course content can be found here: **https://www.open.edu/openlearncreate/course/view.php?id=3476**

Court and Inquest Hearings:

You may have seen the Lord Chief Justice's update setting out how the court should be conducting itself during this time of self-isolation and restrictions on travel. There is an expectation that telephone and video technology will be used to hold remote hearings where possible, the aim is to ensure that as many hearings in all jurisdictions can proceed. The full update was circulated on 17th March and is available here: **https://www.judiciary.uk/announcements/coronavirus-update-from-the-lord-chief-justice/**

On 26th March, the Chief Coroner issued the following guidance: **https://www.judiciary.uk/wp-content/uploads/2020/03/Chief-Coroner-Guidance-No.-34-COVID-19_26_March_2020-.pdf**.

That guidance makes clear, (paragraph 4) that coroners remain responsible for their own judicial decisions and *"the Chief Coroner cannot direct them to make a particular kind of decision in an individual case or a group of cases."* The guidance goes on to emphasise that no physical hearings should take place unless it is *"urgent and essential business"* and that it is safe to do so. In any event social distancing should be observed.

Inquest hearings should take place remotely where possible and these must be held in public, as such the coroner should conduct those hearings from court (not their homes). Hearings taking place in public *"may mean they take place where only a member of the immediate family is present and with a representative of the press being able to be present"*.

General Notices:

AvMA is recruiting for a part time, temporary caseworker: This is a temporary position for two days per week, over a six month period. Ideally, we are looking for someone with a good understanding of clinical negligence litigation who has a medical or legal background and can start immediately. The job is to assist in the Medico-Legal Department by identifying suitable experts for our Lawyer Service members, training will be provided, you will be well supported by your colleagues and a competitive salary is offered. For more information and a job description please contact Nathan Bacon by email: **Nathan@avma.org.uk**

Laurence Vick, Consultant Solicitor: Some of you may be aware that in January, **Laurence Vick** retired from **Enable Law** where he spent many happy years as a partner. Fortunately, he continues as a Consultant Solicitor and AvMA is delighted to include him as an Honorary Panel Member; his commitment to pursuing better systems, safety and a more level playing field for patients continues.

We are also very pleased to feature Laurence's two-part article on *"Lessons learned from the Bristol heart scandal and the 2001 Kennedy Inquiry"* with part II to be featured in our June edition of the Newsletter.

Dr Simon Fox QC, barrister: Is now practising at **Serjeants' Inn Chambers**

Chris Hough, barrister: Is now practising at **Serjeants' Inn Chambers**

Shantala Carr, solicitor: As of 1st April 2020, Shantala will promoted from senior associate to partner at **Girlings Solicitors.**

AvMA Conferences Postponed Due to Coronavirus

It is with great regret that, in light of the seriousness of the spread of Coronavirus, that we have had to postpone our conferences planned from March – June, including the 2020 AvMA Annual Clinical Negligence Conference, which was due to take place on 25-26 June in Bournemouth. This is obviously a huge disappointment to us, but the decision is necessary for reasons which are beyond our control and of which we are all very much aware. Our priority is the health and safety of our conference attendees and team. The next Annual Clinical Negligence Conference will now take place on **29-30 April 2021** at the Bournemouth International Centre – further details on this and the other rearranged dates appear in the "conference news" section of this newsletter.

NHS Resolution's Early Notification Scheme – Behind the scene

KERSTIN SCHEEL, PARTNER
ROYDS WITHY KING

The initial Rapid Resolution and Redress Scheme consultation:

In March 2017 a consultation was undertaken by the Department of Health (DoH) as to the viability of an NHS run scheme (then entitled "The Rapid Resolution and Redress Scheme") to provide early compensation to children, who, on the face of it, had incurred a neurological brain injury at the time of their birth due to clinical errors in care.

The rapid resolution and redress scheme (RRR) aimed to "introduce a system of consistent and independent investigations for all instances where there may be severe avoidable birth injury, along with access to ongoing support and compensation for eligible babies through an administrative scheme."

The main stated aims were:

- reducing the number of severe avoidable birth injuries by encouraging a learning culture
- improving the experience of families and clinicians when harm has occurred
- making more effective use of NHS resources

This consultation sought views about the proposed scheme, including:

- how the scheme was to be administered
- the eligibility threshold for compensation
- how learning would best be shared and acted on to reduce future harm

One of our clients responded to the consultation and summed up:

> *"Our basic view is that if proper investigations were done at an early stage then with the duty of candour and openness Trusts and doctors would be admitting their mistakes early and would take away the need to litigate the liability stage of the case and we can simply get on at a much earlier stage to value the claim and let the process go on as normal."*

They added:

> *"Families will know that they are likely to get more money through the normal litigation process and will not want to accept a lesser amount of money to simply go through a scheme where there is insufficient support for them. Families whose child has suffered a brain injury want the best outcome for their child and the maximum amount of compensation possible because they are overwhelmingly concerned about what will happen to their child after they pass away. We need a huge amount of support and assistance and this scheme simply does not offer that in any meaningful way, nor is it in a way to us which appears independent. This is a vital factor for us. There must not be a conflict of interest in the parties involved in our daughter's case."*

The consultation response was published by the DoH in November 2017 with a **full response available here**.

The Early Notification Scheme:

No financial redress scheme for families has, as yet, been set up. Similarly, there has been no update from the DoH or NHS Resolution as regards plans for this.

However (at the same time as this redress scheme consultation taking place) on 1 April 2017 NHS Resolution launched "The Early Notification Scheme" (ENS). This required reporting within 30 days from all NHS Trusts of all maternity incidents where babies born at term (≥37 weeks gestation), following a labour, had a potential severe brain injury diagnosed within the first seven days of life. These babies were categorised as those who:

- were diagnosed with grade II hypoxic ischaemic encephalopathy (HIE); or

- were therapeutically cooled (active cooling only); or

- had decreased central tone AND were comatose AND had seizures of any kind.

The **notification form can be found here**.

The plan was that, with early notification, NHS Resolution could begin their own investigations at a much earlier stage.

NHS Resolution stated that: *"...trusts are encouraged to be open about incidents, be candid with families and maximise opportunities to learn from them." They went on to say: "The added benefit of seeking 100% notification is the potential to build a robust database, which would provide valuable insight on what drives these incidents. We aim to analyse the data to facilitate learning and interventions."*

The ENS was not however designed to specifically setup a method by which to financially compensate families early; this is far from the Rapid Redress Scheme's aim.

NHS Resolution note in their review of the scheme in September 2019 that, as well as written apologies, some families were offered "financial support" and "practical advice" on how to access support in caring for their child – but how this was done is very unclear and is not set out in any detailed policy document.

It is presumed in such cases the family instructed their own medical negligence solicitors to enter judgment and quantify the claim as per the current standard practice. However no information is actually published or known about how NHS Resolution advised families to quantify the claim, if at all.

NHS Resolution review of the scheme can be found here.

The review summary states that:

> *"A key ambition of the scheme has been to shorten the time taken to report an incident from years to days, to enable learning to be identified quickly and support to be provided to families when they need it most."*

The report identifies that some 24 families have been provided with a detailed explanation, an apology (an admission of liability), signposting to independent representation and, where the need for compensation has been identified, prompt financial support as well as psychological support. This occurred within 18 months of having the matter reported; better than a number of years, granted, but hardly a speedy response – particularly as the report states in many instances no formal reporting by experts is required and a conference with lawyers has sufficed.

What is not available to anyone outside NHS Resolution is:

- the actual stand alone policy document as to how this scheme works in practice;
- how the notification is investigated and decided upon;
- how NHS legal panel firms are involved in terms of their appointment to investigate liability;
- how experts are instructed; and
- how families are updated and further advised.

Whether or not adjudications on notified cases are fairly, independently and appropriately decided upon is far from clear– the key requirement our client identified when she responded to the consultation on the Rapid Resolution Scheme.

Some of this information is provided at pages 13-15 of the September 2019 review document. It states;

> *"For the first time, cases are analysed by both legal and clinical experts at NHS Resolution, bridging the claims and safety and learning functions of the organisation. The EN team incorporates legal case managers working alongside a clinical panel of senior maternity advisors and obstetric and midwifery clinical fellows under the Safety and Learning directorate."*

It continues: *"Cases are processed based on the liability risk assessment provided by the Trust at the point of notification."* Therefore NHS Resolution are basing this all upon accurate and open reporting of cases from trusts.

Whether or not that is happening remains unclear.

If a trust notifies NHS Resolution that there is a "likely" case of substandard care then NHS Resolution will be instructed to begin a liability investigation immediately; this constitutes only 9% of reported cases. All other cases are internally triaged by legal case managers and clinical advisors to determine the risk of liability. If it is considered that there is a likely case after internal review then the matter is referred out to a panel solicitor; 45% of cases marked as "unlikely" by trusts were escalated to "likely" cases by NHS Resolution.

But who are these clinical advisors? Are they truly independent? It is only once the matter is with the panel solicitors that they then commission independent expert

opinion. Again the question is asked – who are these experts and what is their degree of independence?

It is concerning that, if the internal NHS Resolution team think a case "unlikely", the matter is simply referred back to the trust for learning points. What information is given to the family about their right to have the case independently assessed by solicitors they instruct to investigate the claim? What exact information is given to families about how these conclusions have been reached?

Although NHS Resolution states that in cases where they conclude the care was reasonable, they will signpost families to the charity Action Against Medical Accidents (AvMA). AvMA however confirm that only a handful of families have approached them and that there are some families within the scheme, who have approached AvMA, but were not signposted to them by NHS Resolution. Signposting to independent advice is therefore far from clear or transparent.

NHS Resolution noted that of the 197 cases referred to panel solicitors to investigate 24 families were provided with an admission of liability, which seems a very low figure. They comment: *"Mediation is also an option"*, but it is not explained what the purpose of any such mediation is?

It is also not clear as to whether, or how, families are actually advised to seek independent legal advice following an admission so that quantum can be independently assessed. The report is silent as to whether there is a proactive approach to advising families to then seek independent legal advice or to seek advice from AvMA, and as to how families are advised how to seek specialist clinical negligence legal advice.

As part of this scheme there was an aim to actively inform and involve families affected by a poor birth outcome. The data under this review report notes that only 77% of trusts (who notified NHS R under the scheme) actually advised families that an incident had occurred and in only 30% of cases were the family invited to be actively involved in the investigation. These are not encouraging figures to support the statutory requirements for Duty of Candour.

A further oddity is that there is a second scheme in place run by the Health Safety Investigation Branch (HSIB) which can and does run concurrently with the early notification scheme. This was set up following the Secretary of State for Health announcing a new maternity safety strategy in 2017. The programme started in 2018 and investigates intrapartum stillbirths, neonatal deaths, maternal deaths and cooled babies or those diagnosed with brain injuries; the latter on this list clearly overlaps with investigation criteria under the ENS.

It would be quite confusing for parents to be notified that there will be an HSIB investigation and report prepared and then also notified of an investigation by the ENS; surely this amounts to a duplication of time and NHS resource and could intensify parental upset by repeating their experience with two different bodies? Completed HSIB reports are shared with Trusts and families but are not published openly and therefore their findings remain closed and confidential.

This is not to criticise the aims and work of the HSIB, which is pulling out themes for learning and sharing this generally with Trusts, but where is there public transparency as to their work?

The bigger picture

If the NHS's primary goal is to reduce incidents of fetal harm, then what are they actively doing to enable this? Reporting back and collating information on incidents of harm is of course to be commended, but who reads this information? There is a high turnover of junior staff and midwifery staff, particularly in large teaching hospitals; are they required to review this collated information regularly? I doubt it. In any event this is reporting information and is not the much-needed hands-on update training on the accurate interpretation of CTG traces and/or training on management of obstetric complications during labour.

NHS Resolution set up the Maternity incentive scheme in 2017 whereby trusts would receive a financial incentive if they met 10 safety actions; those who did not meet all 10 requirements would not recover their contribution to the CNST maternity incentive fund, but may be eligible for a small discretionary payment to help make progress against action points not achieved. A **full list of the requirements can be found here.**

Safety action point 8 requires that 90% of each maternity unit staff group have attended an 'in-house' multi-professional maternity emergencies training session in the last training year. This is an excellent requirement and the statistics as to those who have not would be interesting to review. But who is required to fund this training? - likely the trusts themselves. With limited budgets this isn't always feasible and therefore if the NHS wishes to ensure the best possible patient safety then staff training should be of paramount importance and centrally funded to ensure high quality training is available to all staff.

Safety action point 10 requires 100% compliance in reporting to the ENS scheme – which is an excellent

incentive to ensure proper reporting of serious incidents of harm to babies during birth.

Of concern however is a recent report that the Shrewsbury and Telford NHS Trust was paid £953,391 in 2019 as it has certified it met all the requirements under the Maternity Incentive Scheme, when within weeks in November 2019 the Trust's maternity unit was rated "inadequate" by inspectors at the Care Quality Commission. This Trust has been subject to the largest inquiry into maternity care failures in the history of the NHS, focused on avoidable deaths of both mothers and babies.

In addition East Kent Hospitals NHS Trust also certified that it had met the standards under the scheme and was paid £1,475,313 in 2018. This is despite the fact that in early 2020 the BBC revealed that there had been 7 preventable baby deaths since 2016 and the CQC had rated the maternity unit as inadequate.

This must bring into serious question the ability of NHS Resolution to verify and give credence to the criteria of their own scheme.

Conclusions:

The key summary comments from this first review of the operation of the ENE scheme are:

- Put simply, this is not an independent process. It is internally reviewed by the Defendant (NHS Resolution) themselves and not an external body – how is that right?

- Where cases do not result in an admission of liability, are families clearly advised that they still have the right to seek a second opinion through their own legal advisers, and how are they sign-posted to find that specialist legal advice?

- Where cases are rejected, do families receive a copy of the medical opinion on which the rejection was based, or will this be disclosable as part of a subsequent legal claim brought by the family?

- This scheme is very far from the initial Rapid Resolution Scheme which was mooted in April 2017 – what is happening in respect of those plans?

- The fact is, for some families an early admission of liability (without the need for stressful liability litigation) will be welcome and very beneficial in terms of procuring financial compensation to assist in caring for a disabled child.

- However, for those cases rejected under the scheme, which then go on to be successfully litigated, this only goes to add up to 18 months onto the process. It is not clear exactly what information will be provided to them by the NHS Resolution by way of disclosure in any subsequent legal claim, but this should be made available to the families and not be considered legally privileged.

- This scheme is clearly productive in terms of pooling together clinical information as to the causes of poor outcomes for some babies at birth and hopefully, in conjunction with patient safety programmes, will lead to a reduction in injuries caused to babies due to avoidable clinical errors. However, that very much depends upon the action, and in particular the adequately funded training opportunities, which result from this important patient safety data.

Informed Consent and 'Wrongful Birth'

KATIE MCFARLANE, BARRISTER
ROPEWALK CHAMBERS

ROPEWALK
CHAMBERS
Barristers regulated by the Bar Standards Board

Informed consent and 'wrongful birth': Mordel v Royal Berkshire NHS Foundation Trust [2019] EWHC 2591 (QB)

https://www.bailii.org/ew/cases/EWHC/QB/2019/2591.html

1. Clinical negligence practitioners in this area will be familiar with case law from *Macfarlane & Anr v Tayside Health Board* (Scotland) [1999] UKHL 50 and *Parkinson v St James and Seacroft University Hospital NHS Trust* [2001] EWCA Civ 530 to *Rees v Darlington Memorial Hospital NHS Trust* [2004] 1 A.C. 309, from which the principle of loss of autonomy has evolved to give rise to a cause of action.
2. Although only a first instance decision of the High Court, *Mordel* is of interest because the key legal issues surrounding breach of duty were squarely focused on informed consent.
3. The Claimant visited her GP after finding out that she was pregnant (an unplanned pregnancy) and was given the option to have various standard screening tests, including a test for Downs Syndrome. All six tests offered, including for Downs Syndrome, were accepted and an appointment was fixed for them to be carried out.
4. It was disputed whether, at the scan where the Downs screening was to be carried out, the sonographer did in fact ask The Claimant whether she wanted the test (The Claimant saying no such discussion took place; the Defendant saying that it did but the test was declined). The upshot however was that the test was not carried out and the Claimant gave birth to a child with Downs syndrome.
5. The Claimant's case was that had she had the test, which would have revealed she was in a 'high risk category', she would have proceeded to have a further test that (it was not disputed) would have confirmed her baby had Downs syndrome, and she would have elected to terminate the pregnancy.
6. There were a number of issues for the court to resolve, including: whether the sonographer discharged her duty to obtain the Claimant's informed consent (the second issue); and whether, at the 16 week scan, the midwife (a) had a duty to explore why the test had not been carried out, and (b) discharged that duty (the fourth issue). The Defendant was found in breach of duty on both issues.
7. It was accepted that at the original GP "booking" appointment, where the Claimant was given information and leaflets about the various tests, her informed consent could not have been obtained at this stage – NHS guidance stated that information had to be provided at least 24 hours before a patient is asked to make a decision. It was therefore at the sonography appointment that the Defendant's staff had to ascertain whether informed consent was given.
8. The sonographer's evidence was that she began the consultation with the question *"Do you want to have the Downs screening"* and upon – on her case – receiving a *"no"* in response, proceeded to say *"So we are not doing the screening then, we are just doing a dating scan…"*, to which she received no response. There were no further enquires at this or any other stage as to whether the Claimant had understood the question, what she understood the test to involve and whether it was correct that she had changed her mind from the booking appointment.
9. The Judge held that the sonographer's process of taking informed consent from a patient, which he found probably lasted less than 10 seconds, was an *"inadequate process in all these circumstances because there remains an unacceptable risk that a patient perplexed by [the sonographer's] first question will not be properly informed."*

10. In addition, the failure by the Claimant's midwife to ascertain at the 16-week scan (at which it was still possible to carry out a test for Downs Syndrome) why the test had not been carried out, or confirm she had declined the test, was substandard care. This would only have involved a "*simple and straightforward exploration*" that would place the patient at the centre of the decision-making process.

11. As Mr Justice Jay highlighted in setting out the legal framework, informed consent "*lies at the very heart of decision-making in the NHS*" and, as can be seen from the above discussion, informed consent was at the heart of the issues surrounding breach of duty in this case.

12. In a 'usual' case of absence of informed consent, a patient agrees to and undergoes a procedure or treatment without having been provided with the relevant information to make an informed decision, and later suffers an adverse outcome. When however, a patient agrees not to undergo a procedure/test in circumstances where, had there been provision of adequate information or advice, on balance the patient would have so agreed, the scope of the principle of absence of informed consent is extended somewhat. This case further reinforces the role of clinicians in the 'patient-driven care' model as it is they that have a duty to ensure a thorough procedure for obtaining informed consent, in order to uphold patients' rights of autonomy over decision-making in all aspects of medical treatment.

13. It is worth observing the contrast with failed sterilisation cases, to which an informed consent analysis cannot be applied to the nature of the tort. The right denied in wrongful birth cases however, is not the right to decide the size and circumstances of one's family, but the right to make an informed decision as to whether to proceed with a pregnancy or elect to undergo termination. Analysing wrongful birth cases in terms of informed consent is perhaps a more principled development than the largely philosophical discussion employed in previous cases.

14. *Mordel* underscores the guidance from the department of health on consent for examination or treatment that, "*The seeking and giving of consent is usually a process, not a one-off event.*", and is a reminder that, post-*Montgomery*, issues surrounding informed consent continue to feature prominently in clinical negligence litigation.

Factual Causation in Informed Consent Cases Following Montgomery

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The 2015 decision of the Supreme Court in *Montgomery v Lanarkshire Health Board*[1] fundamentally changed the Courts' approach cases concerning failure to obtain informed consent. However, the Claimant who convinces a judge to favour his/her recollection of events and to determine that he/she was not advised of a material risk, still faces the challenge of establishing causation; often this is far from straightforward for the Claimant and his/her legal team.

In this article, I will review those cases where the Court has grappled with this issue post-*Montgomery* with a view to identifying the types of factual causation evidence that judges find persuasive.

In *Montgomery* itself, the Lord Ordinary rejected the Claimant's evidence that she would have opted for a Caesarean delivery had she been properly advised. This might seem surprising given the candid evidence of Dr McLellan, the treating obstetrician, who stated that Mrs Montgomery "*would have no doubt requested a Caesarean section, as would any diabetic today*". However, this finding withstood the scrutiny of the Extra Division, and it was not until the case reached the Supreme Court that Mrs Montgomery succeeded on causation.

Claimants have tended to do better at first instance since Montgomery was decided, and an analysis of the judgments in those cases suggests that the following factors have been influential when considering factual causation.

1. **The Evidence (or Lack of) of the Claimant**

   Grimstone v Epsom and St Helier University Hospitals NHS Trust[2] concerned a patient who came to hip replacement surgery. Her surgeon recommended relatively new bone-conserving implants in view of her young age and active lifestyle. The prostheses failed and revision surgery was required after 2 years. The Claimant alleged that, if properly consented, she would have chosen an older and more established procedure. McGowan J disagreed and noted her reluctance to directly answer this question when put to her in cross-examination.

   In *MC & JC v Birmingham Women's Hospital NHS Foundation Trust*[3] , Turner J was not satisfied that the Claimants had come anywhere near to establishing causation on the conventional '*but for*' test as there was no evidence from the First Claimant, either in her witness statement or in her oral evidence, about what she would have decided if she had been given an account of the relevant pros and cons of induction of labour.

   The Claimant in *Diamond v Royal Devon & Exeter NHS Foundation Trust*[4] was found by HHJ Freedman to be a truthful and honest witness, but one who was applying the benefit of hindsight when she claimed that she would have had a primary suture repair of an incisional hernia rather than a mesh repair (which had prevented her from having another child). Stewart J similarly found, in *Keh v Homerton University Hospitals NHS Foundation Trust*[5] , that the deceased's widow was having difficulty disregarding hindsight when he claimed that, if his wife had been advised that she was at increased risk of requiring an emergency Caesarean section, she would have undergone the procedure electively. Of significance was Mr Keh's evidence that his wife would probably have followed medical advice.

1 [2015] UKSC 11
2 2015] EWHC 3756 (QB)
3 [2016] EWHC 1334 (QB)
4 [2017] EWHC 1495 (QB)
5 [2019] EWHC 548 (QB)

2. **The Patient's Attitude to Risk**

In *Montgomery*, the Supreme Court determined that the Lord Ordinary had focused on the risk of severe injury to the baby (which was very small) and should instead have considered the much greater chance (9-10%) of a shoulder dystocia simply occurring, which in itself constituted an obstetric emergency with a significant potential for maternal injury. Had Mrs Montgomery received this information, the Court found that she would have rejected vaginal delivery, a finding which was of course consistent with Dr McLellan's evidence at trial.

Middleton v Ipswich Hospital NHS Trust[6] was mid-trial when the Supreme Court gave its judgment in *Montgomery* and had a similar factual matrix. In that case, the HHJ McKenna accepted the mother's evidence about her approach to risk, namely that she was fairly risk averse, and that it was the identification rather than the quantification of risk which would have swayed her judgment. Furthermore, the Judge was convinced by evidence of Mrs Middleton's parental devotion that she would have been deterred by the personal inconvenience of a Caesarean section and would have preferred to shoulder the risk of injury herself. The considered and cautious nature of the Claimant was also a factor in *Thefault v Johnston*[7] .

SXX v Liverpool Women's NHS Foundation[8] Trust concerned the delivery of twins where there was a close family history of neonatal death of a twin following vaginal delivery. The Judge readily accepted that the parents had considerable anxiety about the prospect of vaginal delivery of twins and would therefore have requested a Caesarean section. Further, the Consultant to whom they would have been referred confirmed that he would have agreed to this "*despite it being probably safe to aim for a vaginal delivery*" in view of the family history.

In *Hassell v Hillingdon Hospital NHS Foundation Trust*[9] the Claimant was rendered tetraparetic by spinal surgery. Dingemans J considered the fact that she had decided to go ahead with the surgery despite being warned of the risk of developing a hoarse voice, which would have caused difficulties in her role as a teacher, but determined that this was in its nature a very different risk from that of paralysis, which she had been warned of, but only on the day of surgery and this was insufficient to obtain informed consent.

Webster v Burton Hospitals NHS Foundation Trust [2017] EWCA Civ 62 is a particularly interesting case on the question of risk. In finding that the Appellant would have opted for induction of labour had this choice been offered to her, the Court of Appeal considered the mother's background (a university degree in nursing) and her decision making in the pregnancy to that point. At 32 weeks' gestation, admission had been advised due to a risk of placental abruption, but she had signed a discharge form. Her explanation was that she lived close to the hospital and, as a sufferer of anxiety, felt she would do better at home. It is easy to see how this could have played against the Claimant, but the Court found that it demonstrated a willingness on the part of the mother to take responsibility for her pregnancy; in other words, she was able to process medical advice and decide what risks she was willing to take and the steps that she might take to mitigate them.

Attitude to risk was also a determining factor in *Mills v Oxford University Hospital NHS Trust*[10] where the Claimant lacked capacity and the crucial evidence on factual causation was given by his wife. Mrs Mills told the Court that, if her husband had been advised by the treating surgeon that he wished to employ a new technique he "*would have run a mile*". Her husband was averse to taking unnecessary medical risks, to the point that he was annoyed at his wife for giving blood. The Judge therefore concluded that Mr Mills would have opted for surgery but would have chosen the conventional procedure on the basis that he was risk averse and unlikely to be concerned by the marginal cosmetic benefit of the new technique.

In *Mordel v Royal Berkshire NHS Foundation Trust*[11] the Judge rejected the Defendant's argument that the Claimant would have taken an arithmetical approach when assessing risk. "The notion that this particular Claimant would have weighed up 1:X risk of Down's syndrome (whatever X was) against a 1-2% risk of miscarriage is implausible. She would have made the assessment in a far less precise manner."

6 *[2015] EWHC 775 (QB)*
7 *[2017] EWHC 497 (QB)*
8 *[2015] EWHC 4072 (QB)*
9 *[2018] EWHC 164 (QB)*
10 *[2019] EWHC 936 (QB)*
11 *[2019] EWHC 2591 (QB)*

3. **The Objective Assessment**

In *Montgomery*, the Supreme Court determined that the correct approach to materiality of risk is "whether, in the circumstances of the particular case, a reasonable person in the patient's position would be likely to attach significance to the risk, or the doctor is or should reasonably be aware that the particular patient would be likely to attach significance to it".

Judges have applied this approach to factual causation, quite specifically so in *Thefault v Johnston*. In that case Mr Justice Green found that the Defendant had failed to give the Claimant full and accurate advice about the risks and benefits of a discectomy. The Judge approached factual causation initially from a predominantly objective standpoint to arrive at the prima facie position. His conclusion was that a patient in the Claimant's shoes would have been most concerned about the prospect of surgery easing her back pain and that such a patient, if adequately informed, would have declined surgery or at least deferred it pending a second opinion. He then applied this to the Claimant's evidence; it was her understanding that the prospect of the surgery resolving her back pain was very good and had she known that it was 50/50 she would have declined the surgery.

Stewart J made some brief observations on causation in *Olosson v Lee*[12] , having already found for the Defendant on breach of duty. This case concerned chronic pain post-vasectomy. The Judge concluded that had the Claimant been advised that the risk was 'not uncommon' or '5%' he would probably still have gone ahead. Influencing factors including the fact that the Claimant and his wife wanted to avoid barrier methods of contraception (thus requiring his wife to find an alternative means) and that, while '*every person is an individual'* all 4 experts had given evidence that they had never personally encountered chronic pain as a factor which was off-putting to men when considering vasectomy.

Diamond v Royal Devon & Exeter NHS Foundation Trust [13] (discussed above) was appealed and one of the grounds was that the Judge at first instance had been wrong to rely on a test of '*rationality*'. The trial judge held that, if the Claimant had been offered a sutured repair, it would have been "*objectively and subjectively...irrational*" for her to have accepted that offer, given the likelihood that it would fail. The Appellant argued that she had a right to make decisions which others might perceive to be irrational. The Court of Appeal determined that the Judge had been scrupulous in his assessment of the Appellant and her evidence and that he met the requirement in *Montgomery* by not only taking account of the reasonable person in the patient's position, but also giving weight to the characteristics of the Claimant herself.

4. **Previous medical history**

In *Middleton*, the Claimant's mother had had a very traumatic birth with her first baby, followed by what she considered to be a successful delivery of her second child, but unbeknownst to her this had in fact been complicated with a mild shoulder dystocia. Her third baby was bigger and the Judge was satisfied that, had she been aware of all of the facts, she would have opted for a Caesarean section to avoid the risk of a further traumatic delivery, and this would have been supported and/or encouraged by her husband who had been a witness to the previous events.

The Claimant in *Thefault* had previously rejected surgery, and this was therefore an influential factor in concluding that she would have done so on this occasion. In *Hassell* the Claimant had undergone elective surgical procedures before, but had also tried conservative treatments, albeit with mixed results. The Judge accepted that she would have wanted to explore these conservative treatments first and would probably have recovered in the meantime.

By contrast, in *Duce v Worcester Acute Hospitals NHS Trust*[14] , the Claimant had rejected attempts to steer her towards treatments other than surgery to relieve her pain, and so she was always going to face an uphill challenge in establishing that she would not have gone ahead with surgery. This was also the finding in *Houndsworth v Luton and Dunstable University NHS Foundation Trust*[15] where HHJ Freedman held that the Claimant was determined to have surgery and would have gone down that route whatever was said to her.

5. **The Defendant's Advice**

In *Montgomery* it was determined that "*the question of causation must also be considered on the hypothesis of a discussion which is conducted without the patient's being pressurised to accept her*

12 *[2019] EWHC 784 (QB)*
13 *[2019] EWCA Civ 585*
14 *[2018] EWCA Civ 1307*
15 *[2016] EWHC 3347 (QB)*

doctor's recommendation." Nonetheless, clinicians are still entitled to recommend a treatment path to the patient, and indeed there are many circumstances in which they would be criticised for failing to do so. The Court must therefore assess the impact of appropriate clinical advice on the decision that the Claimant would have made.

In *Middleton* the Claimant's mother struggled to say under cross-examination what she would have done if she had been advised against a Caesarean section. Fortunately for her, the Judge concluded, from the evidence provided by the Trust, that it would not have tried to persuade her to have a vaginal delivery.

However in *Diamond* the Court heard evidence that, if the treating surgeon had advised the Claimant of the possibility of a suture repair of her hernia, he would also have advised her that this was unlikely to be successful and such advice would have been reasonable. It was held that this would have influenced the Claimant's decision.

6. **The Claimant's Response to the Adverse Outcome**

This was an interesting feature of *Mordel*, a '*wrongful birth*' claim where the strength of the Claimant's reaction to discovering that her newborn baby had been diagnosed with Trisomy 21 persuaded Jay J that she had not been applying hindsight when she denied that she had refused Down's syndrome screening and gave evidence that, if screened as high risk, she would have agreed to invasive testing and subsequently undergone a termination.

It was also a consideration in *ABC v St George's Healthcare NHS Trust & Ors*[16]. This was not an informed consent case in the conventional sense; it concerned a decision not to disclose a patient's hereditary, fatal condition to his pregnant daughter in accordance with his wishes, and the Claimant failed on breach of duty. However, the causation aspect of the claim turned on factual causation; whether, if informed of the diagnosis, the Claimant would have undergone testing and a termination of pregnancy within a short timeframe. Yip J determined that the Claimant's evidence that she would have been tested "without hesitation" was given truthfully but with the benefit of hindsight, noting that when she was advised of her father's diagnosis (after her baby was born) she took 2 years to be tested and, perhaps more significantly, did not then inform her pregnant sister.

The cases considered above make clear that that the Claimant must overcome a significant evidential hurdle to establish factual causation, and that judgments on the issue are often finely balanced. The Claimant under cross-examination will have his/her evidence minutely tested, and it is apparent that NHS Resolution are not shy about taking consent cases to trial. The potential pitfall for the Claimant's team is to rely simply on an assertion that he/she would not have proceeded. It is clear that there needs to be a much wider discussion taking into account all the objective and subjective factors around the issue. To a cliché, the devil is definitely in the detail in consent cases.

16 *[2020] EWHC 455 (QB)*

Lessons learned from the Bristol heart scandal and the 2001 Kennedy Inquiry – Part 1

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Part 1 of a 2-part article

'*All changed, changed utterly*' said Richard Smith in the BMJ in 1998 in the aftermath of the 90s Bristol heart children scandal, borrowing from the line in W.B Yeats' Easter 1916. Writing after the GMC had found the surgeons Wisheart and Dhasmana and former chief executive Roylance guilty of serious professional misconduct but before the Public Inquiry, Smith predicted that the culture of British medicine would be transformed by the "*once in a lifetime*" drama of Bristol.

But did it? The families caught up in the scandal who fought so hard for the Public Inquiry certainly hoped so. Sadly, the litany of high-profile medical scandals that have followed one another relentlessly in the decades since Bristol - from Mid Staffs and Morecambe Bay, disgraced breast surgeon Ian Paterson and his involvement in NHS and private surgery , through to Shrewsbury and Telford (emerging as the biggest maternity scandal in the history of the NHS) and most recently East Kent with reports of more than 130 cases of babies suffering brain damage due to oxygen deprivation at birth over a 4 year period - show that this did not prove to be the case.

Professor Sir Ian Kennedy's 2001 Inquiry report with its 198 recommendations definitely did bring about major improvements in audit, governance, publication of surgical outcomes, and accountability within the medical profession. Self-evidently though, looking at all of these terrible scandals, Bristol did not succeed in bringing about the desired sea-change in the wider culture of the NHS. Nor did it produce what was going to be a root-and-branch reorganization of pediatric child surgery in this country which could have formed the basis of a blueprint for future reconstruction so that expertise and services can be concentrated in centers whose data demonstrated that they produce the best outcomes. So comprehensive and all-embracing were the Kennedy recommendations that it was hoped this, the largest and most expensive Public Inquiry in the history of the NHS, following in the wake of the longest ever GMC disciplinary hearing, would be definitive and would avoid the need for further Inquiries.

Disturbingly but presciently, Kennedy admitted on publication of his report that in spite of the abundance of NHS bodies and frameworks that had been created since the scandal broke he could not be confident that it would be possible to prevent another Bristol.

These are some of my personal reflections after representing the families as joint solicitor at the Public Inquiry and handling the claims of parents of children who died or survived but suffered brain damage and other serious injury in operations performed at the unit in Bristol by the two surgeons in the 90s. This has given me an insight into the world of heart surgery and paediatric cardiac surgery in particular with its own unique features and implications for the availability of data, and the development of the law of consent and the duty candour.

This quote from one of the nurses who accompanied many of the parents as they took their children to the operating theatre sums up the Bristol situation at that time. This nurse who later gave evidence to the Public Inquiry told the BBC in an interview before the GMC decision how she had wanted to voice her concerns about the surgeons operating at the unit: but

"There was a sense amongst the nurses generally that 'we've let the baby down' - there were times when I wanted to pick up the baby and just run out of the operating theatre, bundle it into the car with the parents and take them anywhere else."

What an indictment. A key member of staff who felt unable to raise her concerns who was placed in an intolerable position. Many within and outside the Trust in Bristol were aware of the danger to which already very poorly children were exposed but failed or were unable to act.

The background

The story was played out in the GMC hearings, Public Inquiry and the national media, casting huge scrutiny on the hospital in Bristol and those who had put the lives of children born with congenital heart defects at additional risk. Equally a picture emerged of the difficulties faced by those who sought to expose the failings at Bristol. From 1991 Dr Steve Bolsin attempted to raise concerns with his superiors at the Trust, including fellow clinicians and managers, over the alarming surgical mortality rates he had noticed after his arrival from the Royal Brompton in 1988. Dr. Bolsin - later described as the 'gnawing conscience' of the NHS - did his best to escalate those concerns through all levels of authority up to the top of the NHS, Department of Health and the Royal Colleges. All refused to heed his warnings and children continued to die at an alarming rate or survive but sustain neurological injuries leaving them with often severe disabilities.

Joshua Loveday

The death of Joshua Loveday who underwent an arterial switch operation at Bristol in January 1995 at the age of 16 months became the pivotal event in the Bristol story and the catalyst for the GMC hearings and Public Inquiry into surgery carried out at the unit over the previous 10 years.

Mandy Evans, Joshua's mother, last saw her son alive on 12 January 1995, just after 7am. The surgeon assigned to carry out this complex operation was Janardan Dhasmana, the second of the two surgeons carrying out adult as well as the paediatric surgery at Bristol. Unbeknown to Mandy and Joshua's father Bert Loveday Dhasmana's survival rate for these operations was well below the national average – so far below that, on the evening before Joshua's operation, a secret eleventh-hour crisis meeting was held at the hospital. Despite concerns raised by Dr Bolsin it was decided that the operation must go ahead.

By the following afternoon Joshua was dead, after eight hours on the operating table. When later describing this meeting, at which he pleaded with his colleagues not to allow the operation to be carried out, Bolsin said he was overruled: he had been in a minority of one and his colleagues insisted that it must proceed. Professor of General Surgery Gianni Angelini had contacted the Department of Health and asked it to intervene and stop the surgery. Officials contacted the Trust's chief executive Dr Roylance who said this was a clinical matter in which he had no right to intervene. The Department of Health said it had no legal power to halt the operation.

Supra-regional status and the "learning curve"

The two surgeons Wisheart and Dhasmana were keen to keep Bristol at the forefront as a leading paediatric cardiac surgery unit, for which it received additional funding at that time as a supra-regional centre. Seemingly blinded to the unfolding dynamics, Joshua's surgeon Dhasmana appeared unaware that there was a problem. In his evidence to the Public Inquiry, he said he was shocked to learn of the severity of the situation, and why people had been so concerned about his '*learning curve*.' This proved to be a controversial issue for the Inquiry: is it acceptable for surgeons to have a learning curve and if so ,should patients be warned that the surgeon is still gaining experience? In fact, Dhasmana had never performed the 'switch' procedure himself but had assisted another surgeon on one occasion, five years previously. Dhasmana conceded that, when starting a new procedure, he did anticipate some infant fatalities as he improved his skills. In his words:

'*Nobody exactly knew what a learning curve was except for saying that, whenever you start any new operation, you are bound to have unfortunately high mortality . . . I do not think any surgeon wants to be seen as in a way practising with his patients, but that is the definition of "learning curve"*

Joshua's parents knew nothing of Bolsin's eleventh-hour attempts to stop the operation going ahead, or of Bristol's record for child heart surgery, or Dhasmana's inexperience in the arterial switch.

GMC disciplinary hearings

The GMC disciplinary proceedings in 1998, against surgeons Wisheart and Dhasmana and the Trust's former Chief Executive Dr John Roylance, focused on the unit's mortality rates for the arterial switch and atrioventricular (AV Canal) operations. It wasn't ideal to convene a GMC disciplinary hearing and decide who would be charged and what those charges would be before a wider public inquiry. The GMC hearings lasted 63 days and resulted in findings of serious professional misconduct against all three. Wisheart was struck off. Dhasmana was suspended from carrying out paediatric cardiac surgery for three years but cleared to continue adult cardiac surgery (conclusions arrived at without any analysis of his adult surgical outcomes, hence the "*would you let him operate on you?*" question put by Jeremy Paxman to the Health Minister Frank Dobson on that evening's BBC Newsnight – to which Dobson replied without hesitation "*No*"). Both surgeons had lacked insight into their shortcomings and

had failed to call a halt to their operations in the face of clear evidence that they were achieving unacceptably high mortality rates.

The statistical analysis carried out for the public inquiry found that measured on the basis of 30 day mortality Bristol was "an outlier, and not merely 'bottom of the league'" and that a "*divergence in performance of this size could not be explained by "statistical variation, systematic bias in data collection, case mix or data quality*"

Roylance, as a qualified doctor, fell under the GMC's jurisdiction and was struck off for failing to heed warnings and allowing the surgical failures to continue. It was hoped this would stand as a warning in the future for NHS managers who ignore concerns brought to their attention by whistle-blowers.

The aftermath of the revelations

I met Joshua's parents during the GMC hearings. Haunted by his son's death, Bert Loveday became progressively more depressed and disoriented; he had never been in any kind of trouble before but was persuaded to take part, keeping watch, in an armed robbery. He was sentenced to three years in prison and, unable to cope, was found hanging in his cell at Winson Green Prison, Birmingham, a month into his sentence. He was one of three, possibly four, Bristol parents from the 90s tragically caught in the eye of this developing storm to commit suicide.

Feeling quite wrongly and unfairly that they had let their children down, parents punished themselves for not asking probing questions and allowing incompetent surgeons to operate on their children. Unique in my experience was having clients say they hoped our experts would be unable to find negligence: in effect, wanting to lose their cases.

This was an inevitable consequence, repeated in subsequent large-scale scandals, of staff who knew of the failings at the unit on the one hand turning a blind eye and allowing the situation to get out of control or, on the other, like the nurse mentioned earlier, fearing reprisals if they were to raise concerns. h

Steve Bolsin's position became untenable after the Joshua Loveday operation and he had to emigrate with his family in 1995, to take up a position in Geelong, Australia. where he was soon elevated to Professor. Feted in Australia for his role in the Bristol scandal and his subsequent work in the development of governance and clinical audit Professor Bolsin was belatedly awarded the Royal College of Anaesthetists' Medal in Cardiff in 2013 in recognition for all he had done for patient safety. Interviewed in 1998 Bolsin said that to avoid a repeat of this kind of disaster we must 'never lose sight of the patient'

Media reports: the "Killing Fields" and the "Departure Lounge"

The lack of action over Bristol in the face of all the media reports had been extraordinary. Dr Phil Hammond, '*MD*' in Private Eye, first exposed the problems at the unit under the '*Killing Fields*' and '*Departure Lounge*' headlines in 1992, nine years before the publication of the Kennedy report. There were then no significant reports in the media until three years later, with Matthew Hill's BBC Close-Up West regional news programme in April 1995 and the Daily Telegraph's '*hospital took 6 years to act over baby deaths*' report of 1 May 1995. These were followed by the seminal Channel 4 Dispatches documentary of 28 March 1996, and the Times 1 April 1996 article: 'Why did they allow so many to die?'

It was hard to believe that heart surgery had been allowed to continue at the unit in spite of the lurid headlines in the media and the concerns expressed at senior consultant level - and that it took so long for anything to be done. Apart from suspicions or sixth senses confirmed in hindsight, no parent at the time of the operations had any inkling of the problems at the unit. Wisheart retired in 1995 with the highest grade A Merit Consultant Award, payments from the Department of Health worth a reported additional £40,000 a year. As well as his being senior of the two surgeons, performing adult as well as paediatric cardiac surgery, he held the position of Medical Director of the Trust. His replacement as surgeon heading the unit Ash Pawade who arrived from Melbourne in 1996 was achieving close to zero mortality when he gave evidence to the GMC in 1998. Dhasmana was dismissed by the Trust in 1998 after parents were unwilling to let him operate on their children and he had "*lost the trust and confidence of his colleagues*." He later lost his claim for unfair dismissal and breach of contract in which he had argued that he had been treated unfairly and made a scapegoat for the wider failings of the unit.

What occurred amounted to a betrayal of trust – not only by the surgeons but also by all those at Bristol and elsewhere who knew of the appalling death rates achieved by the unit. Parents of sick children in need of life-saving surgery had to cope with the cards they had been dealt. Bristol offered hope but, in so many cases, delivered despair.

Part 2 of this article will be published in the June edition of the Lawyers' Service Newsletter.

Secrets and Lies

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JOHN GIMLETTE explores the merciless world of 'fundamental dishonesty'

Dishonesty is bad for our health, or at least our pockets. For claimants, a finding of fraud can be disastrous, and they risk losing everything. Even where liability's not in dispute, a patient who's suffered serious injury risks having his or her claim dismissed. Worse, he or she may also face costs bill running into tens of thousands of pounds. It's bad for that patient's lawyers too. The chances are they won't get paid, and all they're left with is a heap of debts.

It wasn't always like this. There was once a time when fraud was largely a defendant's problem. As long as the fraudulent claimant recovered *something*, he usually recovered some costs too (albeit pruned in varying degrees). One thing was sure: dishonesty alone was almost never enough to get his or her claim struck out. Back then, such a remedy was seen as '*a draconian step ... always a last resort*': *Summers v Fairclough* [2012] UKSC 26. In that case, a claim for over £800k was reduced to just over £88k after some embarrassing surveillance. Even then, the Supreme Court was persuaded that striking-out would be a disproportionate solution.

All of that was about to change.

The concept of 'fundamental dishonesty appears

In 2013, the Jackson reforms introduced the QOCS regime, to encourage access to justice. A key element is that PI claimants aren't liable for costs if and when they lose. However, under the rules, there are exceptions. One such is CPR 44.15, which provides that a claimant can be liable for costs where his/her claim has been struck out for abuse of process, failing to disclose reasonable grounds for bringing proceedings or conduct *'likely to obstruct the just disposal of proceedings'*. He might, for example, have failed to give proper disclosure, as in *Kraszewski v UK Insurance Ltd* (31 December 2018, Hastings CC).

The other exception is in cases of fraud. Under CPR rule 44.16, where the unsuccessful claimant has been '*fundamentally dishonesty*', he loses his costs protection. The power, however, can only be exercised where that claimant has lost at trial or has discontinued. In theory, it can also be exercised where the parties have settled but this is to be regarded as '*exceptional*'; see CPR PD 44 para 12(4)(b)

Successful (but dishonest) claimants weren't, of course, immune from sanction. They could still deprive of costs (or made to pay them under 44.15), but there was still no power to strike out their claims on the basis of dishonesty alone.

A new power to dismiss claims for dishonesty

Two years later, a more far-reaching sanction was introduced. For dishonest claimants (and their unfortunate lawyers) the consequences can be very severe.

Under Section 57 of the Criminal Justice and Courts Act 2015, the courts were given a new power to dismiss claims in their entirety where they are found to be '*fundamentally dishonest*'. In such circumstances, it doesn't matter that part of the claim is genuine or valid; the *whole* claim is dismissed: section 57(3). Not only does the claimant recover nothing by way of damages, he or she may be liable for the defendant's costs. It follows that claimant's solicitors will not get paid.

The draconian effect of the section is well illustrated by the case of *Sammut v The Dudley Group NHS Foundation Trust (2019)*, Deputy HC Judge Allen. The Claimant had suffered a significant bowel injury following surgery, and the Defendant admitted a breach of duty and causation. The extent of the injury was, however, disputed. The Claimant claimed £½ million, asserting that both her employment prospects and her social life had been severely curtailed. However, social media revealed that she was out at clubs and pubs, and dancing. At trial, the judge found the claim to be fundamentally dishonest, and dismissed it in its entirety.

At what stage can a claim be dismissed?

Before dismissing a claim, the court must be satisfied that '*the claimant is entitled to damages in respect of the claim*'. In other words, the order cannot be made unless and until the claimant has established that he/she is entitled to *some* damages (i.e because liability has been established): section 57(1)(a).

Usually, the power will only be exercised at the quantum stage – but not always. In *Patel v Arriva Midlands Ltd and, Zurich Insurance Plc [2019] EWHC 1216 (QB)*, the court held that, provided liability was established, a claim could, in certain circumstances, be dismissed without the need for a quantum hearing. In that case, the claimant had suffered serious injuries after being hit by a bus. Liability was conceded. Meanwhile, he affected to be mute, immobile and unresponsive. However, surveillance evidence showed him to be out and about (shopping etc). Prior to the quantum hearing, the Defendant applied under section 57. HHJ Melissa Clarke found that section 57(1)(a) did not require her to first carry out a quantum assessment before fundamental dishonesty could be found. The application *may* be determined at any time after the claimant's entitlement to damages is established. Whether, in any case, it *should* be determined before a quantum trial will depend on whether it can be determined justly at that time. This will depend on all the circumstances.

In that case, it was held that a full hearing was unnecessary; no evidence could explain the inconsistencies between the Claimant's presentation and the surveillance evidence. Thus, the judge dismissed the entirety of the claim, the court being satisfied that no substantial injustice would be caused in so doing. Key to the case was the fact that injury hadn't simply been exaggerated, it had been *faked*. This will not always be the case, and in some cases, it may be possible to '*explain away*' the disparities, and hence it may be necessary to proceed to a quantum hearing.

The criteria to be applied before dismissal

There are a number of criteria that must be met before the power can be exercised. First, the claim must be '*a claim for damages in respect of personal injury*', and the Claim Form must have been issued on or after 15 April 2015. The power cannot be exercised retrospectively; see sections 57(1) and 57(9).

Second, power is to be exercised on the application of the Defendant: section 57(1)(a). However, the claimant may also apply, where it is a counterclaim that is in question: see section 57(8).

Third, the court must be satisfied '*on a balance of probabilities*' that the claim is fundamentally dishonesty: section 57(1)(a). The burden of proof lies on the Defendant.

It is not necessary for the Defendant to plead the point that a claim is fundamentally dishonest: see *Howlett v Davies [2017] EWCA Civ 1696; [2018] 1 W.L.R. 948, CA*. The court may make a finding in this regard provided that the claimant has had fair notice of the challenge to his or her honesty, and has had an opportunity to deal with it.

Little mercy for those who are dishonest

Where the court is satisfied of fundamental dishonesty, it must dismiss the claim, '*unless it is satisfied that the claimant would suffer substantial injustice if the claim were dismissed*'; see section 57(2).

It is hard to see how the exception would ever apply. It is not enough for the claimant to show that he or she would lose out on a significant award of damages: see *London Organising Committee of the Olympic and Paralympic Games (In Liquidation) v Sinfield [2018]* EWHC 51 (QB); [2018] P.I.Q.R. P8 ("the LOCOG case") at paragraph 89.

Will the dishonest claimant be liable for all the Defendant's costs?

No, almost never. Where a claim is dismissed, the Claimant is generally required to pay the Defendant's costs. However, the Defendant doesn't get all his costs. The court has to deduct from the assessed costs the sum (of damages) which would have been awarded but for the dismissal.

It works like this. First, the court has to ascertain these notional damages and record the amount: see section 57(4). Next, this sum is deducted from '*the amount which it would otherwise order the claimant to pay in respect of costs incurred by the defendant*'; see section 57(5). Thus, in cases where the notional damages are higher than the assessed costs, the costs recoverable by the Defendant are nil. In *Summut* (the bowel surgery case, above), the notional damages were assessed at £123,540, and the Defendant was entitled to enforce its costs over and above that amount.

However, in cases where the notional damages are low, the Claimant could end up being liable for a substantial sum. In *Patel* (the man who was hit by a bus), the '*honest*' element of the claim was assessed at £5,750, and this was all that was deductible from a sizeable costs bill.

When is a claim 'fundamentally dishonest'?

There is no statutory definition within Section 57. However, when the concept was first introduced (in CPR 44.16, supra), there were several cases that dealt with the phrase.

In *Gosling v Hailo (29 April 2014 unreported)*, HHJ Moloney QC held that '*a claim is fundamentally dishonest if the dishonesty goes to the root of either the whole of the claim or a substantial part of it*'. In that case, the claimant had suffered a knee injury due to a defective ladder. He claimed around £17k for future care but surveillance evidence was produced showing that he did not suffer the disability as alleged. The judge found that the claimant '*was deliberately dishonest, in that knowingly and dishonestly he gravely exaggerated his symptoms to the doctors and to the court... '*, and that the effect of his dishonesty was '*fundamental*'.

This approach was approved by the CA in *Howlett v Davies [2017] EWCA Civ 1696; [2018] 1 W.L.R. 948, CA*. Thus, was a '*cash for crash*' case. The courts had no difficulty finding fundamental dishonesty. The CA held that the corollary term to '*fundamental*' would be a word with some such meaning as '*incidental*' or '*collateral*' (para 45).

Menary v Darnton (13 December 2016, unreported, HHJ Iain Hughes QC) was another '*Cash for crash*' case. The judge held that the word '*fundamental*' relates to '*some characteristic that inevitably goes to the root of the matter ... A peripheral matter would not be fundamental in this sense*'. Likewise, it does not include the '*exaggerations, concealments and the like*' that accompany personal injury claims from time to time.

The court also made the point that '*the fundamental dishonesty is related to the claim and not to the Claimant*'. In other words, it is not enough to show that the claimant is a dishonest individual.

How relevant is the scale of the fraud?

In the *LOCOG* case, the C had an accident while volunteering at the London Olympics and broke his arm. Liability was admitted. He claimed a total of £50k. One head of claim was for gardening expenses of £14,785. On investigating the claim, the Defendant found that the gardening invoices were forged. The trial judge declined to find that the dishonesty was fundamental.

On appeal, Knowles J reversed that decision. A claimant should be found to be fundamentally dishonest if, by his dishonesty he has '*substantially affected the presentation of his case, either in respect of liability or quantum, in a way which potentially adversely affected the defendant in a significant way, judged in the context of the particular facts and circumstances of the litigation*' (para 62). Here, the conduct of the claim was fundamentally dishonest: '*the largest head of damage was evidenced by the dishonest creation of false invoices and by a dishonest witness statement*'. Both pieces of dishonesty were premeditated and maintained over many months, until LOCOG's solicitors uncovered the true picture.

In some cases, a finding has been made even though the fraud only went to a relatively small part of the claim. For example, in *Kamara v Builder Depot Limited* (1 May 2019), the injured claimant brought a claim for £200k. This included a claim for £3,250 for paid care, based on false invoices. HHJ Baucher found that '*this was substantial ... and went to both the root and heart of the claim*.'

Examples of Fundamental Dishonesty

The dishonesty may relate to liability e.g. lying as to the occurrence of an accident (that never happened) as in *Howlett*; or lying about the factual basis upon which a medical negligence claim was founded as in *Razumas v MoJ [2018] EWHC 215 (QB)* (a prisoner lied as to the treatment he'd received whilst at liberty); or lying as to the circumstances of an accident as in *Pinkus v Direct Line [2018] EWHC 1671 (QB)*.

Equally, the fraud might relate to quantum issues. It might involve lying as to the need for crutches etc, as in *Gosling*; or maintaining an untrue head of claim (gardening £14k), supported by false invoices, over several months, as in the LOCOG case; or lying about whether there'd been a return to work (as a taxi-driver), in support of an earnings claim, as in *Stanton v Hunter* (31 March 2017) Liverpool CC; or faking an invoice for commercial care as in *Kamara*, above; or lying as to a potential job offer as in *Sammut*, above. In some circumstances, it might involve failing to make full disclosure: *Haider v DSM Demolition Ltd [2019] EWHC 2712 (QB)*.

A Claimant may be guilty of fundamental dishonesty even though he says nothing, and merely acts out a sick role; see *Patel v Arriva Midlands Limited, Zurich Insurance Plc [2019] EWHC 1216 (QB)* (C hit by a bus).

Other hazards for claimant's solicitors

Apart from the risk of not being paid (despite the claim being at least partially meritorious), there are other risks. If an adverse costs order is made against a Claimant on the basis of a finding of fundamental dishonesty it

is questionable whether ATE insurance will cover such costs. That can leave solicitors significantly out of pocket.

There is also the possibility of wasted costs litigation: in at least one reported case, the claimant, once exposed, blamed his solicitors, claiming he'd been poorly advised. In *Wright v Satellite Information Services [2018] EWHC 812* (QB), the court was critical of a poorly drafted Schedule, which had confused the Claimant (and thus he wasn't dishonest). '*It is very important*,' noted the judge, '*that lawyers draft the schedule in such a way that the facts to which the client is attesting are clear. Failing to do so is failing in their duty both to the client and to the court*' [para 28].

How to reduce the risk of fraud

Provide clients with a clear warning about fundamental dishonesty (and make a note of the warning). He or she should also be advised that, in the event of a finding of dishonesty, there is also a risk of contempt of court proceedings, brought under CPR r.32.14(1). The penalties can be severe. In *George Eliot Hospital NHS Trust v Elder* [2019] 4 WLUK 127, the Claimant claimed £2.5 million following failed surgery, alleging severe disability. Liability was admitted. The Defendant then produced evidence from social media (e.g the claimant on a hen party in Ibiza), demonstrating a gross exaggeration of the claim. She was given an immediate sentence of 5 months imprisonment.

Undertake careful research into your client's circumstances. Where appropriate check Facebook and WhatsApp (etc), DWP records, and Personnel records, and do company searches. Where the client claims severe levels of incapacity, and where this is questionable, ask to see bank statements. Review the evidence at each stage (i.e service of pleadings, witness evidence and expert evidence). Ensure the claimant understands the importance of the statement of truth.

Conclusion

Since the introduction of section 57, the courts have proved assiduous in stamping out fraud, and have shown increasing boldness in dismissing claims. Fortunately, fraud is very rare in the world of clinical negligence. But those of us who represent claimants must keep a careful look-out for it. It's not only bad for us, it can be devastating for our clients, and we must do all we can to protect them from their own '*moment of madness*'. There are some tragic stories out there, of good, genuine claims laid waste by dishonest embellishment. We need to ensure that this doesn't happen to our clients, and – if we cannot protect them from themselves – then we need to have a very clear idea of when we should abandon the claim.

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JK (PR of the Estate of LK) v Croydon Health Services NHS Trust and King's College Hospital NHS Foundation Trust [2019] EWHC 2297

HASINA CHOUDHURY, PARTNER
MW SOLICITORS

The case was an appeal against the decision not to grant an extension of time or relief from sanctions following late service of the Defendants' Defence to a clinical negligence claim brought by the Claimant. The clinical negligence claim arose following the death of her husband after a series of alleged failures in the care provided by the Defendants leading to a fatal delay in coronary artery bypass surgery. It was submitted that absent these failings, successful surgery would have been performed before the time of his death. The Defendants had sought several extensions of time for serving their Defence which had been agreed by the Claimant and granted by the Court. Nonetheless, the Defendants still failed to serve their defence by the agreed extension and were 5.5 weeks late. The Defendants denied both breach of duty and causation in their Defence and made applications for an extension of time for serving the Defence and for relief from sanctions. This application was heard by Master Gidden and dismissed. Applying the three-stage test in *Denton v. TH White Ltd [2014] EWCA Civ 906* the Master found that the Defendants' default in serving their Defence was serious and significant; there was no good reason for the default; and that when considering all the circumstances the relevant application was the application for relief from sanctions which had not been made promptly.

The Defendants appealed, on the basis that an application for relief from sanctions was not required, since the order granting the final agreed extension for serving the Defence did not expressly provide a sanction for non-compliance. The High Court dismissed the appeal, finding that firstly, there was no need for the Defendants to make an application for relief from sanctions given that neither CPR rule 15.4 nor the Court's orders extending time for service of the Defence prescribed a sanction in the event of default following *Salford Estates (No. 2) Limited v. Altomart [2014] EWCA Civ 1408.*

Secondly, whilst the Master was therefore in error in proceeding on the basis that an application for relief from sanctions was required, this was an application for an extension of time made after the expiry of the relevant period and the three-stage test in Denton still applied.

The question on the appeal was thus whether the error in approaching the third stage of the Denton test by treating the relevant application as the application for relief from sanctions (as opposed to the application for an extension of time for serving the Defence) was a material misdirection such that his decision could not stand. Having considered the relevant circumstances addressed by the Master, including the Defendants' wrong assumption that a yet further extension would be "indulged" which was pivotal to the master's decision on this point, the master's misdirection was ultimately not material.

If, though, Mrs Justice Lambert was wrong in her decision about this and the Master's decision should be set aside, it was agreed that she should go on to exercise her discretion afresh, rather than remitting it back to the Master; and in these circumstances she would also refuse the appeal. Amongst other things, when considering the third stage of the Denton test, the application for an extension of time for service of the Defence had not in fact been made promptly. The Defendants' initial application for an extension of time had been made by fax; and filing an application which attracts a fee by fax is permissible in only exceptional and rare circumstances of unavoidable emergency, which had not been the case here.

Discount on claims for gratuitous care: 33%, or lower?

CHRISTOPHER HOUGH, BARRISTER
SERJEANTS' INN

SERJEANTS' INN

For many decades, the courts have been willing to compensate injured Claimants for the gratuitous care they may have been provided with as a result of the injuries sustained (held on trust for the carer following ***Hunt v Severs*** [1994] 2 AC 350, HL.

In the well-known case of ***Evans v Pontypridd Roofing*** Ltd [2001] P.I.Q.R. Q5, Lord Justice May stated at para 25:

> *'In my judgment, this court should avoid putting first instance judges into too restrictive a straight-jacket, such as might happen if it was said that the means of assessing a proper recompense for services provided gratuitously by a family carer had to be assessed in a particular way or ways. Circumstances vary enormously and what is appropriate and just in one case may not be so in another. If a caring relation has given up remunerative employment to care for the claimant gratuitously, it may well be appropriate to assess the proper recompense for the services provided by reference to the carer's lost earnings. If the carer has not given up gainful employment, the task remains to assess proper recompense for the services provided'*.

Giving the courts flexibility, gives the parties opportunities to challenge the assessment of the number of hours, the hourly rate (whether basic daytime rates or aggregate rates to reflect care being provided at the weekend and antisocial hours), and the discount to be provided.

This article looks at just one aspect: the discount to be provided.

It is conventional to allow this discount to reflect the fact that the carer will not have to pay tax or national insurance (payable by a commercial carer) and, because the carer often lives in the same house, will not have to take the time and incur the expense of travelling to work does not arise when a relation provides the care is well established; see ***Whiten v St George's Healthcare Trust*** [2011] EWHC 2066 and ***Totham v King's College Hospital NHS Foundation Trust*** [2015] EWHC 97.

In the vast majority of cases the Defendant Trust will argue for a 33% discount. This often includes reference to **Evans** (referred to above) where May LJ observed at para 37 that:

> *'...If the carer has not given up gainful employment, the task remains to assess proper recompense for the services provided. As O'Connor LJ said in Housecroft v Burnett, regard may be had to what it would cost to provide the services on the open market. But the services are not in fact being bought in the open market, so that adjustments will probably need to be made. Since, however, any such adjustments are no more than an element in a single assessment, it would not in my view be appropriate to bind first instance judges to a conventional formalised calculation. The assessment is of an amount as a whole. The means of reaching the assessment must depend on what is appropriate to the individual case'*.

Although, as May LJ said, also in **Evans**:

> *"I am not persuaded that the reasons for making a discount which may be regarded as normal should result in a deduction greater than 25%."*

There have been many other cases where the courts have considered the "normal" discount to be 25% (see the review in ***A & Others v National Blood Authority*** 2001 Ll Med 187 (@ 274 per Burton J and ***Whiten*** per Swift J.

Whilst Defendants may argue for a one-third discount (without success as far as I can see), it is open for Claimants to argue for a lower rate. In ***Miller v Imperial College Hospital NHS Trust*** 2014 EWHC 3772 per HHJ Curran sitting as an HCJ, the trial judge discounted his assessment of gratuitous care by just 20% where a woman with an amputated leg was provided with her son (who lived nearby but not in the same house). We also argued that tax and NI rates had changed radically since **Evans** was decided.

It is even still possible to get no discount in cases of the most severe disability (see ***Parry v NW Surrey HA*** (Penry-Davey J. unreported) and ***Lamey v Wirral HA*** (Morland

J Kemp A4-106 and ***Newman v Marshall*** Folkes [2002] EWCA Civ 591). In **Newman**, the Court of Appeal refused the defendant's appeal in a case where the judge had given no discount from commercial rates, even though the care provided by the claimant's wife was being provided gratuitously. Ward LJ observed that, as per *Evans*, there was no conventional discount that should be applied but instead each case depends on its own facts.

It is always worth arguing for a lower discount, particularly if the person doesn't live in the same house, provided care outside normal day hours or where the care is particularly complex and skilled (often after training had been provided). Nothing ventured, nothing gained.

In short, 33% is unlikely. 25% likely, but probably the ceiling.

Managing Uncertainty in the Mechanism of Injury

SERJEANTS' INN

DR SIMON FOX, QC
SERJEANTS' INN CHAMBERS

- Lessons from the recent cases of

-Saunders v Central Manchester NHS Trust 2018 EWHC 343 QB

-Collyer v Mid Essex NHS Trust 2019 EWHC 3577 QB

-Schembri v Marshall 2020 EWCA Civ 358.

Surgical cases often provide difficulties for Claimants because it is not always clear how the alleged negligent injury occurred – nothing being noted at the time and the injury only becoming apparent post operatively. In the first two of these recent cases Claimants failed on breach because they could not prove the probable mechanism of injury, let alone that it was negligent. This is quite common in surgical cases because of the limited evidence as to the surgery itself - usually just a short operation note.

Claimants also often have difficulty in proving whether and how a breach has been causative of an injury. In *Schembri v Marshall* the Court of Appeal give us a useful reminder of some important principles.

I set out in this article a summary of these cases, the principles they illustrate and some practical lessons to be learnt from them and my own experience in such cases over the last 25 years.

Saunders v Central Manchester University Hospitals NHS Foundation Trust

2018 EWHC 343 QB.

Before Mrs Justice Yip.

The Claimant was a 60-year-old undergoing elective surgical reversal of an ileostomy. He was discharged well at 3 days post op but there was a deterioration and readmission 5 days post op. His large bowel was found to be entirely ischaemic and removed. The mechanism of ischaemia was not readily apparent.

The Claimant had a past medical history of myocardial infarction, ischaemic heart disease, he was a smoker, had high cholesterol and hypertension. The surgeon was a senior experienced consultant.

The Claimant's case was that the mechanism of injury was ischaemia caused by the surgeon damaging the superior mesenteric artery by excessive traction or torsion through lack of proper care during the ileostomy reversal

The Defendant's case was that the mechanism of injury was that it was caused by pre-existing atherosclerosis causing arterial thrombosis resulting in mesenteric infarction and was coincidental and otherwise unrelated to the surgery.

The following were of note –

- Neither mechanism was described in the literature;
- The Judge reminded herself of **Barnet v Medway NHS Foundation Trust 2017 EWCA Civ 235** and the importance of not resorting too readily to the burden of proof being on the Claimant to find the case not proved. It was better to decide which mechanism is likely after evaluating the evidence;
- The Court can draw inferences to make findings of fact in the absence of direct evidence on the mechanism, rather than passing the burden of proof to the Defendant (Res Ipsa Loquitur);
- The Court can also find that all of the proposed mechanisms involved a failure of proper skill and care – see **Thomas v Curley 2013 EWCA Civ 117** – a bile duct injury case.

The Judge found the following -

- The timing of the onset of symptoms, proximity of injury to operation site, pattern and extent of damage, Claimant's anatomy and past medical history - all assisted in demonstrating the mechanism of the injury;

- The treating surgeon was *"a generally careful witness"*;
- The delay of 4 days between operation and onset of the deterioration and the fact that the surgery was anatomically remote from site of injury both went against a link with operation and the Claimant's mechanism;
- Of the two competing mechanisms, spontaneous thrombosis could not be excluded. The surgeon reported nothing untoward during procedure. The Claimant's expert evidence did not persuade Judge that traction or torsion were likely to have occurred;
- The Judge therefore was not satisfied that the injury was caused during operation, let alone through surgical negligence and the claim failed;
- In essence, in line with Barnet v Medway, the Judge had tried to find a likely mechanism but failed, so did resort to the burden of proof being on the Claimant.

Collyer v Mid Essex Hospital Services NHS Trust 2019 EWHC 3577 QB – December 2019

HHJ Coe QC sitting as High Court Judge.

The Claimant underwent an elective laryngectomy – the removal of his larynx for recurrent cancer. He had received radiotherapy to the area the year before. He was diabetic. Post operatively the Claimant was found to have almost complete paralysis of his tongue. It was agreed that this was caused by injury to both hypoglossal nerves (also known as the 12th cranial nerve).

The effect of this is that the Claimant was completely unable to speak as he could not form words with his tongue. It also made it very difficult for the Claimant to swallow.

Bilateral near total permanent hypoglossal nerve palsy (as here) had not been previously reported as a complication of laryngectomy, whether negligently or not.

The Claimant argued that the injury was caused by negligent surgery on the basis that -

- The total absence of previous reports gives rise to a presumption of negligence;
- The probable mechanism was inappropriate manipulation of the nerves, partial transection or suturing;
- Radiation neuropathy played no part as it does not occur until 4 years after the radiotherapy;
- The injury could not have occurred if the surgeon had been exercising all reasonable skill and care;
- After the operation the surgeon said that he was very sorry and had "just nicked the nerve";
- However the Claimant's expert agreed that the surgeon exercised skill and care if he carried out the operation as set out in his statement;

The Defendant argued that there was no negligence on the basis that -

- The surgeon had been a consultant for 25 years, had done over 100 laryngectomies without this complication;
- Surgery in the Claimant was more difficult than normal due to his comorbidities, short neck and quite densely scarred tissues;
- The surgery was complex but appeared to go well;
- Transection of the nerve would require the surgeon to be dissecting at some distance (1cm) from the normal location of dissection in the procedure (the suprahyoid muscles) and to have done so on both sides and to the same extent and missed the twitching of the muscles as would normally be apparent when he damaged nerves;
- There was no evidence that one let alone both nerves were included in the closing sutures and such a suggestion is implausible as the suture line was 2cm away from the normal location of the nerves;
- A plausible and probable mechanism is pressure from retraction – normally necessary at certain parts of the operation - on a background of hypoglossal nerves made more vulnerable by radiotherapy (known to cause some damage to the irradiated area) and diabetes (in the form of a peripheral neuropathy here affecting the cranial nerves);
- The bilateral nature of the injury itself suggests a generic factor;
- Alternatively, the injury could have been caused by compression from anaesthesia or changes in neck position.

The operation note recorded an uneventful and conventional laryngectomy. There was a factual dispute as to whether the tongue paralysis was apparent immediately post operatively or 3 days later.

The judge summarised the law -

- **Rhesa Shipping v Edmunds and Fenton 1985 1 WLR 948 ("the Popi M") (HL)** – There was no obligation on the Defendant to prove their mechanism, it was always open to the Court to conclude that the cause remained in doubt, a judge must be satisfied on the evidence that the Claimant's mechanism is more likely to have occurred than not;
- **O'Connor v The Pennine Acute Hospitals NHS Trust 2015 EWCA Civ 1244** – eliminating other proposed mechanisms is not in itself sufficient to find the remaining mechanism occurred, that mechanism still has to be probable;
- To succeed here the Claimant had to prove that he had probably suffered his injury by one of his proposed mechanisms – manipulation, transection or suturing.

The Judge found –

- There was immediate post op paralysis and the injury was therefore sustained during the course of the operation;
- None of the proposed mechanisms by either side were found to be probable (the highest some got was possible);
- The mechanism for the injury remained unexplained and in those circumstances the Claimant has failed to prove his case on the balance of probability.

Schembri v Marshall 2020 EWCA Civ 358 – March 2020

Lord Justices McCombe, Holroyde and Phillips.

The Defendant/Appellant GP admitted negligently failing to refer the deceased to hospital with a pulmonary embolism where she would have been treated with anticoagulants +/- clot busting drugs. She collapsed and died at home the next morning. The trial judge found that, with appropriate referral by the Defendant GP, she probably would have survived. The GP appealed the judge's finding on causation.

The Court of Appeal approved the trial judge's "*common sense and pragmatic view*" of "*the evidence as a whole*" in which he looked at both the statistics and factors specific to the Claimant. In dismissing the appeal they also remind us of the following cases/principles in proving causation in clin neg cases –

- **Drake v Harbour 2008 EWCA Civ 25** – Merely proving an injury is consistent with a breach of duty does not establish breach if it is also consistent with other credible non negligent explanations, however –
- If a Claimant proves negligence and the loss was of a kind likely to have resulted from such negligence, this will ordinarily be enough for the Court to infer that it was probably so caused, even if the Claimant is unable to prove positively the precise mechanism;
- **Wardlaw v Farrar 2003 EWCA Civ 1719** – Judges are entitled to place weight on statistical evidence, but they must also look at the evidence specific to the Claimant;
- **Gregg v Scott 2005 2 AC 176** – Statistics will often be the main evidential aid in causation but are not strictly a guide as to what would happen to a particular Claimant.

Practice points for surgical breach cases where the mechanism of injury is unclear -

- Look for an obvious cause first - you might be lucky;
- If not, then look for all the potential/plausible causes and for those you can rule out;
- Remember you have to prove one is the *probable* cause (and that it amounts to negligence), proving the *most likely* cause is not enough;
- Alternatively identify all the plausible causes and prove that each of them would amount to negligence – the Thomas v Curley approach (above). I have secured 100% liability in a laparoscopic bowel injury case by proving that the 3 potential mechanisms would all amount to negligence;
- That is a much better approach than trying to rely on Res Ipsa Loquitur. Res Ipsa is rarely applicable or successful in clin neg cases;
- The Claimant's past medical history can be relevant. Previous surgery or radiotherapy to the area can mean the surgical field is scarred making iatrogenic injury less culpable;
- Proximity of injury to operative field makes a surgical injury more likely;
- A clear, detailed and unremarkable operation note can make a claim more difficult;

- The experience of the surgeon can be relevant. Having said that, my successful laparoscopic bowel injury case was against a surgeon who trained other surgeons on the technique;
- A delay between surgery and symptoms makes a link with surgery more difficult;
- Defendants are likely to challenge firstly whether the injury occurred during surgery, secondly the probable mechanism and thirdly whether it amounts to negligence. A Claimant needs to win on all 3;
- Claimants can lose these cases at trial not because the defence argument is preferred, but simply on the basis that the Claimant has not discharged their burden of proof – detailed preparation of lay and expert evidence on the mechanism is key.

Practice points for proving causation where the mechanism of injury is unclear-

- Prove a precise mechanism if you can;
- If you can't, prove that the outcome is precisely what is likely if the breach occurred;
- A good starting point is that the appropriate treatment is advised specifically in order to prevent that outcome;
- Ensure your experts have the statistics which are relevant to the issue;
- Make sure they consider all the factors relevant to your specific claimant;
- Ask your experts for their experience of outcomes in such cases;
- Ask them what they would have expected to happen with this claimant;
- And put all of these together to arrive at their conclusion;
- Invite the Judge to adopt the *"common sense and pragmatic view"* of *"the evidence as a whole" recommended by the Court of Appeal*.

CQC successfully prosecutes local authority following inquest where AvMA represented the family

TOM SEMPLE, BARRISTER
PARKLANE PLOWDEN CHAMBERS

In 2019, Derbyshire County Council ('the council') became the first local authority to be successfully prosecuted by the Care Quality Commission ('CQC'). This followed an inquest into the death of Miss Audrey Allen, who was a resident at a care home operated by the council. She suffered a fall at the care home that ultimately led to her sadly passing away on 16 April 2016. I was instructed by Dr Charlotte Connor of AvMA to represent Miss Allen's family at the inquest on 23-25 April 2018.

The inquest highlighted significant issues in the care provided by the care home and the Coroner concluded that her the death was avoidable. It is perhaps unsurprising that the council admitted that it failed to provide safe care and treatment when enforcement proceedings were brought by the CQC. On 9 December 2019, the council was fined £500,000 for the breach. It was further ordered to pay a £170 victim surcharge and £5,124 in costs.

This article discusses the general criteria for CQC prosecutions in respect of care and treatment, how it applied to Miss Allen's case and the implications for practitioners with similar cases going forward.

CQC Prosecutions

Since 1 April 2015, the CQC has been able to bring enforcement proceedings against registered care providers where there have been failures to provide safe care and treatment.

Under the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 ('the regulations'), care providers must ensure that:

- Care and treatment are provided in a safe way (Regulation 12). This includes:
- Carrying out risk assessments as to the health and safety of service users;
- Taking all reasonably practicable steps to mitigate any such risks to service users;
- Ensuring staff are sufficiently qualified;
- Ensuring the premises is safe;
- Ensuring equipment used by service users is safe;
- Ensuring there are sufficient quantities of medicine and equipment available;
- Ensuring medicines are safely managed;
- Adequately preventing, detecting and controlling the spread of disease; and
- Working with other persons where care and treatment is shared with or transferred to other persons (see Regulation 12(2) for the full wording).
- Service users must be protected from abuse and improper treatment (Regulation 13).
- Service users must be provided with sufficient nutrition and hydration (Regulation 14).

Under Regulation 22(2), it is an offence if a registered care provider fails to comply with the above regulations if such a failure results in:

> (a) avoidable harm (whether of a physical or psychological nature) to a service user;
>
> (b) a service user being exposed to a significant risk of such harm occurring; or
>
> (c) in a case of theft, misuse or misappropriation of money or property, any loss by a service user of the money or property concerned.

Therefore, even when harm is not caused but a significant risk is identified, a prosecution can still be brought.

It is a defence, however, if the registered care provider proves that it took all reasonable steps and exercised all due diligence to prevent a breach of any of those regulations (Regulation 22(4)). Parallels can be drawn with common law negligence.

The CQC advises that prosecuting every breach may not be proportionate, but every potential breach should prompt some action. Factors it will consider include whether the evidence is sufficient, credible and appropriately recorded, stored and retrievable. Serious, multiple and persistent breaches will also inform the appropriate enforcement action.

The case of Miss Allen

My article following the inquest into the death of Miss Allen fully detailed the background of her case. This can be found in the June 2018 edition of the AvMA newsletter (**click here**) from page 32.

In summary, Miss Allen had dementia and was a resident at The Grange Care Home, operated by the council. The Grange was not a specialist care provider for those with dementia and many staff members at the inquest considered that they lacked the relevant training to care for Miss Allen. Furthermore, due to a poorly orchestrated re-structure of senior staffing, the Grange lacked sufficient senior staff to ensure that care was supervised, and paperwork was completed.

Most significantly, however, Miss Allen was considered to be a high risk of falls. Despite this, the Grange did not carry out a falls risk assessment on admission. The inquest heard that she then suffered multiple falls at the Grange, none of which prompted a review into what falls prevention measures should be adopted.

On 25 March 2016, she suffered a fall in her wheelchair after being left alone to eat her evening meal. The following day, after Miss Allen became unresponsive, she was admitted to hospital. A routine chest x-ray which revealed multiple rib fractures. The Grange had not advised the medical staff that Miss Allen had suffered a fall the day before. Despite treatment, Miss Allen developed a haemothorax and her condition deteriorated. She sadly passed away on 16 April 2016.

At the inquest, the Coroner concluded that she died as a result of injuries sustained on 25 March 2016. Had risk assessments been made and preventative measures been put in place, it was likely that Miss Allen's death would have been avoided. He further found that the lack of planning was due to a reduction of senior care home staff.

Comment

The Coroner was obliged not to make a finding that would indicate criminal or civil liability. Accordingly, he did not explore or comment on whether the Grange had taken all reasonable steps and exercised all due diligence to prevent a breach of the regulations (the defence under Regulation 22(4)). However, he did explore the care provided by the Grange in the context of how it was that Miss Allen came to suffer a fall on 25 March 2016 and whether that was the likely cause of her death.

In light of what was heard at the inquest, one can identify factors that would justify the CQC bringing enforcement proceedings against the council:

- The staff at the Grange felt unqualified to provide care and treatment to Miss Allen due to her advanced care needs (cf. Regulation 12).
- There was a lack of senior staff to ensure that care was being provided safely (cf. Regulation 12).
- Risk assessments into Miss Allen's falls risk were not done on admission or after suffering multiple falls at the Grange (cf. Regulation 12).
- Mitigating steps to reduce the risk of a fall, beyond informal observations, were therefore not taken (cf. Regulation 12).
- Avoidable harm was suffered, in that Miss Allen sustained multiple falls, the last of which causing injuries that led to her death, thus crossing the threshold for an offence under Regulation 22(2).
- The breaches happened repeatedly, the last of which being the most serious as it likely caused Miss Allen's death, in the Coroner's opinion.
- There was evidence to support the above findings from the live and documentary evidence provided at the inquest.

The above might also explain why the council admitted failing to safely provide care and treatment (Regulation 12) at the first magistrates hearing on 6 June 2019. The fine of £500,000 against the council would have been higher were it not for the early admission. The council have since advised that they have revised their falls prevention policy, increased staffing and implemented compulsory falls training for staff.

Although the CQC were present during the inquest, they were not an active participant. The burden therefore fell upon the Coroner and the family to ensure that issues in the care provided by the Grange were fully explored. Knowledge of the fundamental duties of care providers within the regulations will help shape the questions that should be put to witnesses, which will assist with the making of any enforcement decisions. A successful prosecution where care has been lacking will provide some reassurance to service users and families that care providers are being held to account. It will also no doubt assist in any civil proceedings where harm has been suffered.

Service users and families would be well advised to inform the CQC of any complaints they have raised with the care provider. The CQC generally cannot investigate such complaints, but it can help identify where a care provider has failed to notify the CQC of possible breaches and inform subsequent inspections and enforcement decisions.

Inquest touching upon the death of Mr Andrew Goldstraw

MARCUS COATES-WALKER, BARRISTER
ST JOHN'S CHAMBERS

St John's CHAMBERS

Facts

Mr Andrew Goldstraw was a 43-year-old man with a significant history of alcohol dependency, substance abuse, depression, deliberate self-harm and attempts to take his own life. In or around 2015, Mr Goldstraw started a relationship with Ms Stacey Coleman. At times when Mr Goldstraw had consumed excessive alcohol, the relationship became abusive. In October 2018, Mr Goldstraw assaulted Ms Coleman and attempted to stab her in the head. He was arrested, charged with GBH and remanded in custody at Her Majesty's Prison (HMP) Winchester on 23 October 2018. On the morning of 14 November 2018, Mr Goldstraw was found hanged in his prison cell having used bedsheets to create a ligature from the window frame. On post-mortem examination, toxic levels of Fluoxetine and therapeutic levels of Mirtazapine were found in his blood and urine. Further, the breakdown product of '5F-ADB' (a synthetic cannabinoid substance, more commonly referred to as '*Spice*') was found in his urine.

The most relevant background can be summarised as follows:

- In 2014, Mr Goldstraw was diagnosed with depression with symptoms that had been present for a couple of years. This had been exacerbated by his children being taken into care. He attended A&E with suicidal ideation. He stated that the main trigger for his symptoms was a feeling of hopelessness following relationship problems / breakdown. He was referred to a psychiatrist.
- In 2015, he attempted to end his life by inhaling fumes from household chemicals mixed together in the bathroom whilst sealing the room with masking tape. He had a breakdown contributed to by his relationship finally breaking down, child protection issues, being charged with assault and having difficulty living on his own together with the recent death of both parents and estrangement from his family who had taken a restraining order out on him.
- In 2017, Mr Goldstraw tried to hang himself with a dressing gown cord following an argument with his partner. He had also taken an overdose of Mirtazapine. This was described as an impulsive overdose with no planning involved. He was transferred to prison following an assault and was due to be released in July 2017. He did not have accommodation in place following his release because there was a restraining order in place preventing him returning to his partner's property. As a result, he stated that he was thinking about taking his own life after release. Upon release, he was able to return to his partner's address because the restraining order had been lifted. However, he was worried about the lack of support that was in place for the problems with his mental health. He was very concerned about how he would cope upon release and felt he needed mental health support. Mr Goldstraw was then remanded at HMP Winchester for another assault. On induction, he is noted to have said to mental health staff that he had: (a) no mental health history; and (b) no history of self harm or suicide attempts.
- In July 2018, Mr Goldstraw was admitted to A&E following an impulsive overdose of his partner's Tramadol following an argument where she had said she was going to leave him. It was noted that his risk is impulsive and will increase with alcohol misuse and with a change of circumstances such as his relationship ending.
- On 23 October 2018, Mr Goldstraw was remanded in custody at HMP Winchester. He underwent an initial screening and induction process at reception. Further, he was assessed by healthcare staff on various occasions (including mental health nurses and the substance misuse team). Following an initial period of detoxification on C-wing, he was transferred to B-wing on 11 November 2018.

- At or around 21.00 on 13 November 2018, Mr Goldstraw was seen alive in his cell by a prison officer as part of a roll check of inmates. A further roll check was allegedly undertaken at or around 06.00 on 14 November 2018, which indicated that a full complement of inmates were alive and well in their cells. However, at or around 07.15, Mr Goldstraw was found hanged in his cell. It was subsequently admitted that the roll check carried out by the prison officer at 06.00 was never in fact completed despite her signing to confirm that she had completed it.

HM Deputy Coroner (HMC) Simon Burge held a two-week Article 2 inquest with a jury into Mr Goldstraw's death at Winchester Coroner's Court. HMC gave Interested Person status to: (a) Ms Coleman; (b) HMP Winchester; and (c) Central and North West London NHS Foundation Trust (the "Trust" responsible for the provision of healthcare at the prison).

Issues

The key issues explored at the inquest were:

- **Time of death**: The precise time of Mr Goldstraw's death was unknown. He was last seen alive in his cell during the roll check at 21.00 on 13 November 2018. He was found at or around 07.15 on 14 November 2018 by officers who described his body as cold to touch, pale and stiff. The Pathologist to the inquest was not prepared to give an exact time of death but was able to say that if rigor mortis was present when he was found, then Mr Goldstraw had likely been dead for a number of hours.
- **The failure to carry out a roll check at 06.00**: The prison officer responsible was dismissed for gross misconduct following disciplinary proceedings. The question of whether this failure had caused or contributed to Mr Goldstraw's death ultimately fell away given the post-mortem evidence that he was likely to have been already dead at 06.00.

Risk of deliberate self-harm / suicide:

- This was the most significant issue explored at the inquest. HMC called a number of witnesses from the prison service and the Trust to give evidence about the assessment and management of Mr Goldstraw's risk of deliberate self-harm and suicide whilst at HMP Winchester in October / November 2018.
- The key tool used by the prison in this regard is the "*Assessment, Care in Custody and Teamwork*" (ACCT) procedure. Prison and healthcare staff are encouraged to open an ACCT even if there is the slightest concern about an inmate's risk of self-harm / suicide. Once an ACCT is opened, the inmate receives a structured assessment of their risk and a case management plan is put in place to help them through a time of crisis. The ACCT procedure allows staff to carry out periods of observation, have greater communication with the inmate and ascertain a deeper level of understanding of their risk and how best to manage it. In the absence of opening an ACCT, there was no mechanism for adequately monitoring, discussing or understanding the level of risk an inmate posed to themselves during their time in prison.
- Prison officers that assessed Mr Goldstraw were aware of the relevant risk factors and triggers contained with PSI 64/2011. These include (but are not limited to): a previous history of self-harm and suicide, breakdown in personal and family relationships, alcohol and substance abuse, the nature of offence a person is charged with (specifically domestic violence), impending court dates, the presentation of an inmate and what is said during assessments. However, officers deferred to the more qualified mental health nurses to conduct a detailed assessment of Mr Goldstraw's risk. Despite that, during the exploration of their evidence, it became clear that Mr Goldstraw had divulged relevant information during his interactions with officers that was not passed onto healthcare staff. For example, he had requested help with his mental health and with managing his anger and impulsive behaviour. However, officers did not have access to his medical history and were not aware of his previous attempts to take his own life. Therefore, they were only working with fragments of Mr Goldstraw's overall story which they deemed insufficient to start the ACCT procedure.
- When Mr Goldstraw was assessed by various healthcare staff (including mental health nurses and members of the substance misuse team) they accepted that they had access to his medical history. This was stored on the Trust's record management database ("*SystmOne*"). This included Mr Goldstraw's significant history of deliberate self-harm and attempts on his own life. However, not one of the healthcare staff that assessed Mr Goldstraw were aware of his history during their assessment. Instead, they had focussed solely on his presentation and what he told them during their assessment. Mr Goldstraw had told

them he was not feeling depressed or suicidal and had no plans to self-harm or take his own life. On that basis, they assessed him as presenting no risk of self-harm / suicide. In evidence, they accepted that: (a) they had failed to take account of Mr Goldstraw's significant previous history of attempts on his own life of which they should have been aware; (b) they had failed to identify that Mr Goldstraw had provided false information to medical professionals previous in relation to his history of mental health, self-harm and suicide; (c) in addition to other risk factors that were not properly identified this resulted in an inadequate assessment of the risk Mr Goldstraw posed to himself; (d) had they been aware of Mr Goldstraw's history an ACCT should have been opened; and (e) this could have prevented Mr Goldstraw's death.

The provision of anti-depressant medication: Despite Mr Goldstraw's significant history of substance abuse (including multiple overdoses of prescription medication), he was allowed to hold a week's worth of anti-depressants (Fluoxetine and Mirtazapine) in his own possession at one time. In evidence, staff on behalf of the Trust accepted that Mr Goldstraw should have been assessed as high risk of holding medication 'in-possession' and should have had it dispensed by the prison one pill at a time where staff could watch him take it. In addition, Mr Goldstraw had failed to pick up a prescription on 9 November 2018 which was considered a missed opportunity to identify possible non-compliance. Had this been investigated, it arguably could have identified that Mr Goldstraw was stockpiling his medication.

The use of synthetic cannabinoid substances (5F-ADB or '*Spice*'): The post-mortem evidence stated that Mr Goldstraw had traces of the breakdown product of 5F-ADB in his urine which indicated that he had taken Spice at some point before his death. The pathologist could not be clear when any such substance had been taken or how long before death. However, evidence from other inmates on B-wing was that Mr Goldstraw had been "off his head on Spice" the day before his death. The pathology and toxicology evidence showed that 5F-ADB and even its breakdown product can have potent psychological and psychotic effects on a person's state of mind that can last for days after it has left their system.

Conclusion

The jury returned a narrative conclusion. They accepted the following medical cause of death from the post-mortem report: *1(a) Ligature Suspension*. However, they added the following to (2): *Adverse psychological state due to combination of drugs and medication taken*. They stated as follows:

We, the jury, conclude that Andrew Goldstraw did and intended to take his own life. We base this on the following evidence: a significantly high number of triggers relating to his situation at the time, his history of attempts of suicide as well as the suicide letters found at the scene. It is more likely than not that he was going to take his own life at that date due to the significant anniversary of the date.

Mr Goldstraw was failed by multiple bodies in their duty of care and all they could have done to keep him alive. This included multiple failures of training and a lack of verification, a lack of cross-services communication (both verbal and systematic) and a lack of proactive background checks. An ACCT should have been opened, *the absence of which more than minimally contributed to Mr Goldstraw's death*. It would have resulted in awareness of his risk factors and would have resulted in cross-service communication.

He should not have been allowed to be in possession of his medication. It is more likely than not that it would have affected his psychological state. He had taken Spice. The evidence from the pathology report, as well as statements from fellow inmates, supports this. We agree that medication, in combination with Spice, would have had a more than minimal contribution to his death. The toxic levels of Fluoxetine and the adverse psychological effects of Spice will have had a more than minimal effect on his psychological state of mind and were a more than minimal contributing factor in the medical cause of death.

Prevention of Future Deaths

A number of steps have now been taken in an effort to improve the assessment and management of an inmate's risk of deliberate self-harm / suicide. These include: a new risk assessment template, weekly multi-agency safety intervention meetings, the introduction of a scheme whereby all prisoners are now assigned a key worker and a joint bulletin to staff stressing the importance of sharing information.

However, following the conclusion of the inquest, HMC agreed to write a Prevention of Future Deaths report to address a number of ongoing concerns relating to: (a) the adequacy of the Trust's computer system (SystmOne); and (b) the training of healthcare staff assessing an inmate's risk of self-harm / suicide.

In particular, HMC stated as follows:

SystmOne makes it difficult for a doctor or mental health nurse to ascertain the key information needed to undertake a risk assessment and to decide whether or not to open an ACCT. Too much reliance is placed on the individual prisoner presentation and how he answers a series of pre-set questions.

At best, SystmOne makes it difficult for a mental health nurse to ascertain the relevant information and at worst it actively misleads them. For example, a search can be made of the "*Journal*" section but this would rely on the exact words being searched (such as "*suicide*" or "*deliberate self-harm*") and it would then be necessary to go through the various entries (in Mr Goldstraw's case spread over 111 pages) using the "*Key Word Search*" function. Further, the functions that would (on the face of it) serve to assist in this situation (such as the "*Summary*" page or "*Active Problems*" section) were not populated with the information relevant to an accurate assessment. It was conceded by the legal representatives acting on behalf of the Trust that the "*Summary*" section is "*very limited in its contents*" and is not routinely used by healthcare staff within the prison in order to gain an insight into a prisoner's past medical history.

The "*Active Problems*" section of SystmOne is subdivided into a number of distinct areas and it appears to be wholly inadequate in terms of identifying key areas of concern such as the risk of suicide or deliberate self-harm. The only information contained in the "*Active Problems*" section of SystmOne in Mr Goldstraw's case was four years out of date. None of the relevant information was contained in "*Active Problems*" but a great deal of irrelevant information was there!

The "*Communications*" section of SystmOne contains a chronological record of correspondence with the hospital, GP surgery and psychiatric units. However, the "*Key Word Search*" facility does not function at all and short of going through all of the correspondence there is no way of identifying the key information needed to undertake an effective risk assessment. The "*Communications*" section in Mr Goldstraw's case amounted to 83 pages. Although the relevant information concerning Mr Goldstraw's mental health issues was contained within the "*Communications*" section of SystmOne there was no way of easily extracting it.

Accordingly, a busy, under pressure mental health nurse or doctor is very likely to struggle to find the relevant entries using SystmOne, which may explain why (in Mr Goldstraw's case) too much reliance was placed on how he presented during interview. A prisoner who chooses not to disclose his true state of mind or suicidal ideation is unlikely to come to the notice of the healthcare staff whose job it is to identify the risk that he may pose to himself because SystmOne does not facilitate this.

There also appeared to be a lack of training in relation to the effective use of SystmOne. In particular, it was not clear whether any steps had been taken to ensure that the staff who were working at the prison at the time of Mr Goldstraw's death had been retrained or had their competencies assessed in light of the failures identified. There is a real concern that some staff are still failing adequately to carry out assessments of a prisoner's risk of suicide / deliberate self-harm.

Claims for preventable suicides

SHANTALA CARR, PARTNER
GIRLINGS SOLICITORS

Claims for preventable suicides

Statistics relating to mental health and suicides

According to the charity Mind and an adult psychiatric morbidity survey last published in 2016, 1 in 4 people in the UK will experience issues with their mental health each year. Mental health conditions span a wide spectrum of illnesses with examples including depression (3.3%), generalised anxiety disorders (5.9%), mixed anxiety and depression (7.8%) and post-traumatic stress disorder (4.4%).

Of those, 20.6% have suicidal thoughts and 6.7% have made suicide attempts. According to the Office for National Statistics, 6,507 suicides were registered in the UK in 2018, which represented an increase of 11.8% from the previous year.

Medical negligence claims

Medical negligence claims involving fatalities have historically largely focussed on negligence surrounding physical ailments which have led to the death of the patient. However, the same principles of a medical negligence claim can be applied to mental/psychological ailments although certain aspects have to be taken into particular consideration.

Breach of duty

When a patient with mental health problems seeks advice and treatment from a healthcare professional (such as GP, A&E, an acute hospital setting or a specialist mental health setting), the patient and his/her family can reasonably expect the professional to use their medical judgment to treat the patient and keep him/her safe. Unfortunately, this is not always the case. At times, failings by mental health professionals can lead to patients attempting suicide leading to either serious injuries or death.

Some of the following are examples of failings which may amount to a breach of duty:

- A failure to recognise that someone is suffering an acute mental health crisis
- A failure to recognise that a chronic condition has significantly deteriorated
- A failure to recognise or act upon warning signs of a suicide risk
- A delay or failure in providing necessary treatment, including an admission to a hospital or another facility
- A lack of communication between healthcare professionals
- A lack of monitoring medication changes

Unlike a lot of serious physical ailments for which patients bring claims, a patient's mental health symptoms can greatly fluctuate on a daily basis, often even throughout the day. To make things more complicated, diagnosing a mental health condition can be difficult as many mental health symptoms and therefore diagnoses overlap. This can lead to difficulties for healthcare professionals to accurately assess a patient, diagnose and treat them at any particular time, particularly if the patient has a long-standing history of mental health problems. A patient may be feeling very low and suicidal at home in the morning but by the afternoon, when they see a professional, they may be feeling better or may mask or minimise the symptoms and real thoughts they are feeling.

Great care therefore is required by medical negligence practitioners in taking a balanced view on assessing breach of duty, based not only on the family's account of events or that of an individual who survives an attempt, but also based on the medical records and local protocols and policies. It is of course vital to obtain independent expert evidence on breach of duty and causation.

Causation

As with a medical negligence claim for negligence surrounding physical ailments, causation is a key element

that has to be proven in claims arising out of suicides or attempted suicides.

Causation in these cases presents a particularly difficult hurdle for claimant lawyers. As stated above, mental health symptoms and diagnoses are far from straight forward and can be unpredictable. Indeed, defendant lawyers will often raise the prospect of a reduced life expectancy for someone with mental health issues. It is therefore vital that a medical negligence practitioner carefully examines the likely treatment that would have been provided and the prognosis but for the breaches and whether, on balance, they would have recovered sufficiently not to take their own life. Again, expert evidence is of course key but careful evidence gathering should take place, including information relating to any previous mental health history and any related treatment and recovery, the patient's personal background including support of family and friends and the patient's employment background.

Quantum

Practitioners will be aware of the complex rules surrounding fatal claims under the Law Reform (Miscellaneous Provisions) Act 1934 and the Fatal Accidents Act 1976, which equally apply to cases involving suicide. The test of proportionality can be restrictive in cases involving a deceased patient who had no spouse, children or any other dependants. In such cases, practitioners can be in a difficult situation where they are being contacted by a family who have lost a loved one to suicide as a result of potentially very serious failings by a mental health service but are faced with the potential of incurring disproportionate costs in investigating and pursuing the claim, particularly if the claim is defended.

Other claims to consider

Article 2 of the European Convention on Human Rights

In medical negligence claims involving suicide, practitioners should be aware of the possibility of a claim under the Human Rights Act 1998 and in particular Article 2 of the European Convention on Human Rights, which provides that everyone's right to life shall be protected by law. There has been extensive case law on the subject of mental health/suicide claims and Article 2, a key one being that of *Rabone and another (Appellants) v Pennine Care NHS Foundation Trust (Respondent)* [2012] UKSC 2. That case found in favour of the family of a patient who had taken her own life and determined that the NHS must protect patients who are in hospital, or on leave, and at 'real and immediate risk' of suicide. In such cases healthcare professionals are deemed to have assumed responsibility for the patient's welfare and safety, thereby creating an operational duty to take steps to protect the patient from a real and immediate risk of suicide.

Secondary victim claims

In some circumstances, family members may sadly find loved ones who have taken their own life and some family members may be able to bring their own claim as secondary victims.

The law surrounding secondary victim claims is complex and requires (in its simplest form) for:

a) The claimant to be in a sufficiently close relationship with the victim;

b) The event to be sufficiently shocking;

c) The claimant to come across the 'immediate aftermath' of the incident with 'legal proximity' to be proven; and

d) The claimant to have suffered a recognised psychiatric condition as a result.

A separate article on the law surrounding secondary victim claims could easily be written but one of the main aspects of contention in these is the test of 'legal proximity to the event' for which vast case law exists. Nonetheless a secondary victim claim should always be considered where a loved one finds the victim of suicide and suffers a psychiatric injury as a result.

Awareness of mental health failings and suicides

In my experience, families of those who have taken their own lives, genuinely don't have compensation at the forefront of their minds when they enquire about a medical negligence claim. It tends to be a by-product of a quest for answers with families wanting admissions, accountability and apologies from defendants as well as evidence that processes have changed and improved to ensure similar failings do not re-occur leaving another family in the same devastating circumstances.

Some of these clients also want to raise awareness in the wider context such as the family of Tony Collins who instructed me in relation to serious mental health failings by two Trusts. Those failings lead to Tony, whilst an inpatient for a serious suicide attempt, being allowed to abscond from hospital in a wheelchair and take his own life by jumping from the 8th floor of a neighbouring

building. In addition to successfully concluding a medical negligence claim, Tony's family and I appeared on the Victoria Derbyshire show and BBC South East News in an attempt to raise awareness of failing services with a view to getting mental health services changed and improved.

Bringing medical negligence claims involving suicides is therefore much more than just bringing a claim for compensation – it is about supporting bereaved families to obtain the answers and accountability they are looking for.

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

Medico-Legal Issues in Surgery

16 September 2020, Outer Temple Chambers, London (rearranged from 18 March)

This one day conference has been designed for solicitors and barristers to illustrate the key medico-legal issues in surgery, and is an excellent opportunity to learn from leading surgeons and develop your understanding to assist you in cases. The medico-legal issues in cholecystectomy, gynaecological, ENT and colorectal surgery will all be examined, along with hospital acquired infection and consent and causation. A day not to be missed and essential for your clinical negligence caseload.

Court of Protection conference

30 September 2020, Hilton Leeds City Hotel (rearranged from 26 March)

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.

Medico-Legal Issues in the Care of Older People

22 October 2020, 39 Essex Chambers, London (rearranged from 19 May)

Join the 'Medico-Legal Issues in Older People Care' conference to recognise the issues impacting on older people's care, differentiate expected complications from negligent treatment and understand the legal and costs implications for bringing a claim. This is a must-attend conference for clinical negligence solicitors and barristers and healthcare professionals specialising in older people care and clinical governance and will provide the most up-to-date practical and legislative information to help ensure older people get the best care possible and are properly represented.

AvMA Annual Clinical Negligence Conference

29-30 April 2021, Bournemouth International Centre (rearranged from 25-26 June 2020)

Join us in Bournemouth 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. The programme this year will have a focus on **obstetrics**, whilst also covering many other key medico-legal topics at such an important time for clinical negligence practitioners.

Networking is also a big part of the ACNC experience. On the evening of Wednesday 28 April, we will be holding the conference Welcome Event at Level8ight The Sky Bar at the Hilton Hotel in Bournemouth, and the Mid-Conference Dinner will be held on the Thursday evening at the Bournemouth International Centre. Our **Charity Golf Day will take place on Wednesday 28 April at Meyrick Park Golf Club.**

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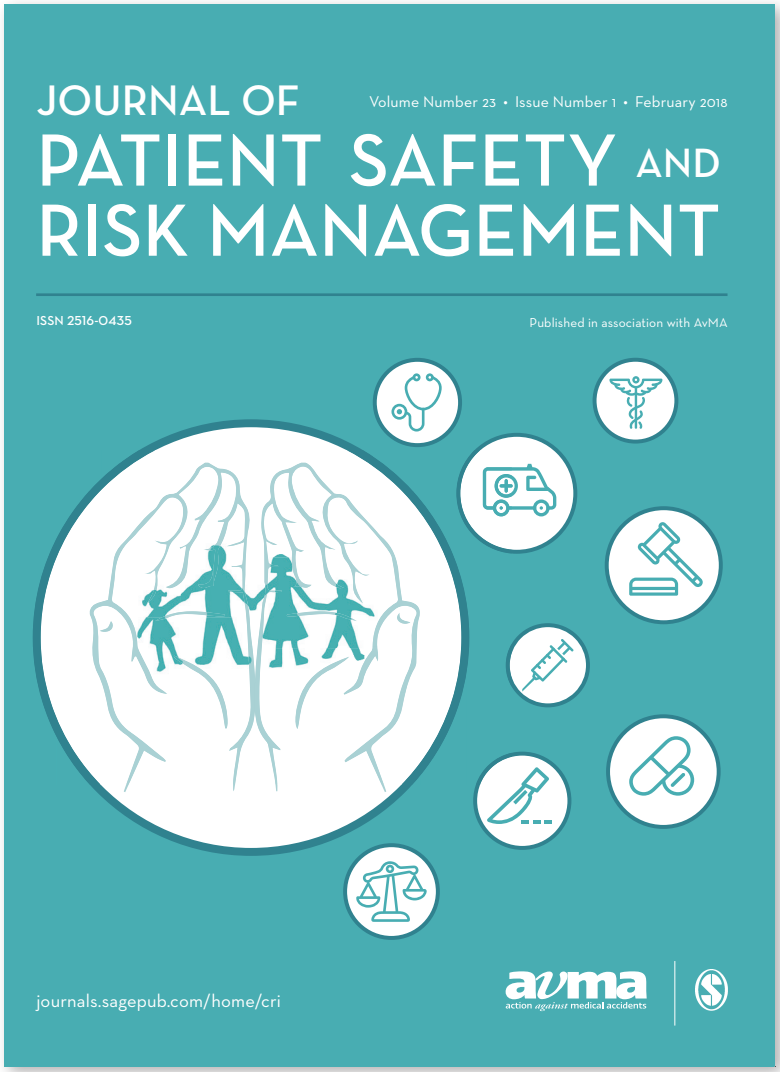

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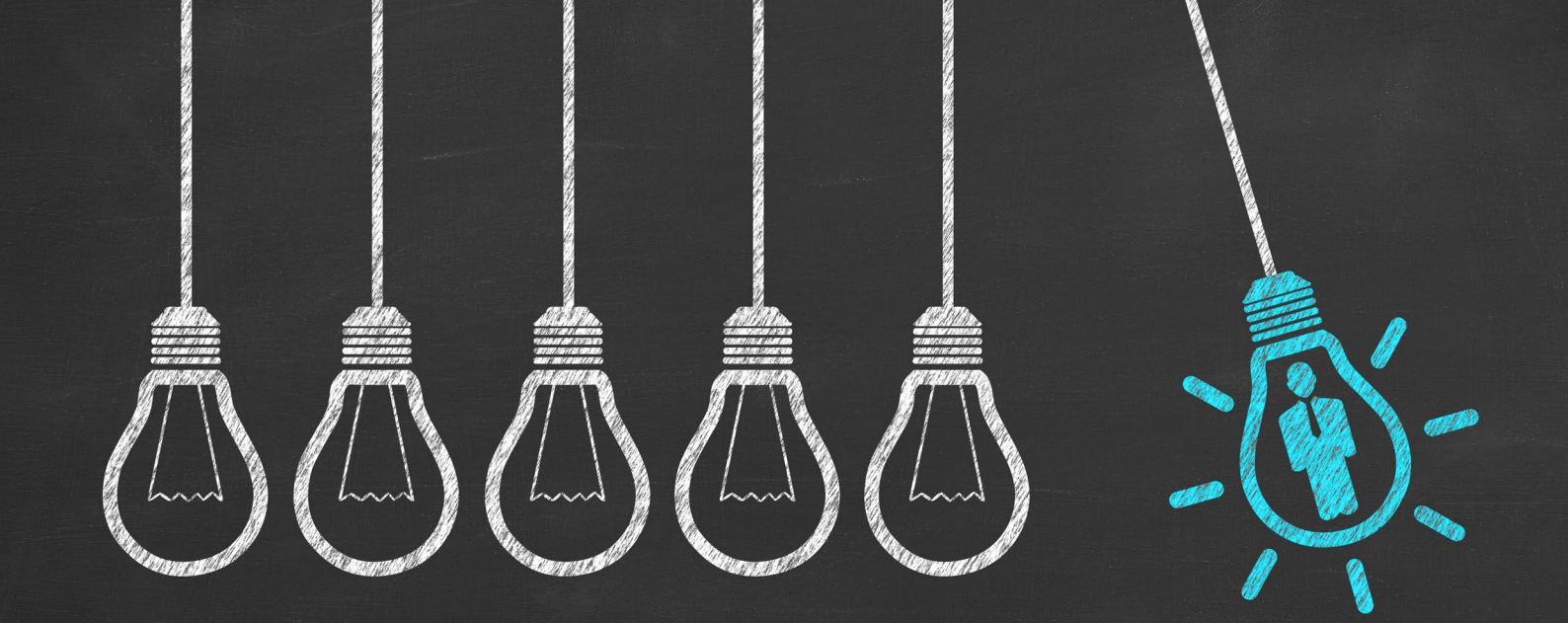

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