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Lawyers Service Newsletter

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Contents

Editorial

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2020 has undoubtedly been a year of firsts. The first national lockdown in response to a pandemic. A UK first for furlough schemes and the first government incentive to dine out to help out. It is also a first for the Care Quality Commission (CQC) who successfully prosecuted University Hospitals Plymouth NHS Trust under Regulation 20 of the Health and Social Care Act (Regulated Activities) Regulations 2014, more commonly known as the statutory duty of candour. This edition of the Newsletter carries an article "**Duty of Candour**" by Elizabeth Boulden and Megan Griffiths, both barristers practising at 12 Kings Bench Walk where they take a closer look at the duty and what it requires health professionals to do when things go wrong.

AvMA, SCIL and NHS Resolution have come together to produce a Clinical Negligence protocol to help claimant and defendant lawyers to work together during the COVID 19 pandemic. Paragraph 4 of the protocol recognises that medical examinations may now be difficult to carry out and recommends that in the case of condition and prognosis reports ***"Both parties should consider and promote the use of remote/virtual examinations wherever possible to ensure cases proceed."*** Questions around whether these sessions should be recorded or not will perhaps be raised more frequently, there is currently no formal guidance on this but you may find Paul Sankey's article "**Recording Consultations with Medical Experts**" a helpful read. Paul is a Partner at Enable Law and frequently writes and speaks on matters relating to medico-legal experts. In May 2019, the Academy of Medical Royal Colleges came together to produce guidance for medical experts "Acting as an expert or professional witness" which highlights the importance of reports based on reasoned opinion. The article "**Expert Evidence and breach of duty**" also by Paul Sankey, addresses this very point with specific reference to the recent case of *Bradfield-Kay v Cope [2020] EWHC 1351 (QB)*.

The much-anticipated judgment in **Swift v Carpenter** *[2020]* EWCA Civ 1295 was handed down on 9th October, AvMA is delighted to include an article of the same name, by Richard Baker, barrister at 7 Bedford Row in this newsletter. Richard is extremely experienced in issues concerning

accommodation claims having represented claimants at trial in both *Manna V Central Manchester University Hospitals Foundation Trust [2017] EWCA Civ 12 and JR V Sheffield Teaching Hospitals [2017] EWHC 1245 (QB).* Richard looks at what the decision means in practice, explains how to value the reversionary interest and what the decision might mean for claimants with short life expectancies. Richard has also produced a webinar on the subject for AvMA which is available free of charge to all LS members. If you haven't seen the webinar yet but would like to, please email: **Norika@avma.org.uk**.

Two articles aimed at helping busy practitioners recover costs for their injured client are: "**Recovering Private Healthcare Costs in a personal injury claim"** by Shilpa Shah, barrister at Ropewalk Chambers, Shilpa looks at Section 2 (4) Law Reform (Personal Injuries) Act 1948 and encourages lawyers to think more broadly about the range of treatments which may be shown to benefit their client and recovering the cost of the same. Chris Hough, barrister at Serjeants' Inn asks: "**How do we assess gratuitous care?**" and importantly reminds us, with direct reference to the case law, of the principles behind an award of damages for gratuitous care, and what rates might be recoverable.

Laurence Vick, Consultant Solicitor with a special interest in patient safety draws on the findings from the "Report of the Independent Inquiry into the issues raised by Paterson" Chaired by the Right Reverend Graham James and published in February 2020. Laurence's article: "**Lessons from Paterson: the need for private healthcare providers to have skin the game**" looks at the need for reform to prevent private care providers from escaping legal liability and responsibility for poor patient care.

At the time of writing we are halfway through a second national lockdown, it may not be the last. Neil Shastri-Hurst and Chris Bright, both barristers practising at No 5 Chambers ask: "**Will COVID reshape how we look at standard of care during crises?**" Neil and Chris consider how the courts might approach the appropriate standard of care with careful reference to Bolam and more recent decisions to help inform our thinking.

Fixed Recoverable Costs (FRC) have not been introduced for clinical negligence work, for months now we have been assured that government is ready to launch a consultation, but we are still waiting. With FRC in mind, I have included Sarah Stocker, Clinical Negligence solicitor at Tees article "**Why defendant's actions and attitudes need to change prior to any implementation of fixed recoverable costs**". Sarah's experience will no doubt resonate with many of our readers, on its own a FRC scheme is unlikely to do much to discourage this sort of behaviour, sadly there appears to be little appetite to put patient safety and learning at the centre of the scheme, an approach which would go some way to potentially encouraging a reduction in the number of incidences that give rise to claims and with it a reduction in both legal costs and compensation that has to be paid.

Ged Courtney from Kain Knight article on **Belsner v CAM Legal services**, looks at how this case provides some security for lay clients by ensuring that their lawyers give far greater detail in their advice at the outset in relation to deductions made from their client's damages to cover the shortfall created by costs actually incurred by the solicitor and those recoverable under the FRC scheme. It does however impose a significant additional burden on lawyers, who must show that they had their client's "informed consent" when agreeing their retainer, if they wish to rely on their client's agreement to the terms. Whilst on the face of it, the need for informed consent is seen as a victory for claimants potentially preserving their damages, it also increases the risk that if a FRC scheme is introduced in low value clinical negligence claims there will be little or no incentive for lawyers to take on the lower value claims. The time required to obtain "informed consent" to solicitors charging arrangements will undoubtedly eat into tight margins, with the added risk that a significant contribution from the client to cover unrecovered costs might not be achieved, it makes work at the lower end of the spectrum even less attractive.

Over recent years we have seen several scandals related to maternity care, Shrewsbury and Telford Hospital NHS Trust, looks set to be the largest maternity care scandal in NHS history. The Ockenden report has not yet been published but inevitably the human cost of maternal deaths and brain damaged babies will be incalculable and the failure to learn lessons startling. Marcus Coates-Walker is a barrister practising at St John's Chambers in Bristol his article **"The NHS maternity care scandal: What to expect from the Ockenden Inquiry and beyond?**" considers some of the issues likely to come out of this report. Our last article is a case report **"Inquest touching the death of Jonnie Meek"**, counsel Rajkiran Barhey from 1 Crown Office Row was instructed by Fleur Hallet of AvMA. This was a second inquest for the family who were determined to have a proper investigation into their young, vulnerable and much loved son's death, they were only able to achieve this through AvMA's pro bono inquest service albeit more than five years after his death.

If you are interested in volunteering for the helpline please see Gill's video footage at: **https://www.avma.org.uk/get-involved/** We are also interested in receiving any

expressions of interest from trainee solicitors or newly qualified solicitors who might be able to help us for one day a week with our written services, we are particularly interested in hearing from you if you think you may be able to do this between January and early March 2021, please let Norika know by emailing her: **Norika@avma.org.uk** On behalf of everyone here at AvMA we wish you all the best for the forthcoming holidays and a very happy and prosperous 2021.

Best wishes

The duty of candour and recent prosecution of an NHS Trust by the CQC

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In this article, Elizabeth Boulden and Megan Griffiths of 12 King's Bench Walk discuss the duty of candour in response to the news that the University Hospitals Plymouth NHS Trust is the first to have been prosecuted and convicted for breaching the statutory duty of candour.

The Care Quality Commission (CQC) recently brought a successful prosecution against the University Hospitals Plymouth NHS Trust for breaching the statutory duty of candour, following the death of 91-year-old Elsie Woodfield [1]. It was the first prosecution of its kind and resulted in a conviction, with a fine of £1,600, a victim surcharge of £120 and court costs of £10,845.43.

Mrs Woodfield had undergone an endoscopy at Derriford Hospital in December 2017. During the procedure, she suffered a perforated oesophagus, and, accordingly, the procedure was abandoned. Mrs Woodfield was transferred to the ward for observations, where she collapsed and sadly later died. The CQC then brought the prosecution after finding out that the Trust had not been open or transparent with Mrs Woodfield's family about what had happened or given an apology in good time.

In light of this news, we shall look at the duty of candour in more detail: what it is, where it originates from, and what it means in practice.

What is the duty of candour?

The duty of candour is often something that does not get much discussion when considering the legal aspects of clinical negligence cases. However, such a duty is fixed in English law, by virtue of Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014/2936 ("the Regulations"), as modified by the Health and Social Care Act 2008 (Regulated Activities) (Amendment) Regulations 2015/64. The Regulations have effect until 31 March 2022 [2]. In Wales, a statutory duty of candour is due to be introduced by Part 3 of the Health and Social Care (Quality and Engagement) (Wales) Act 2020, which is not yet in force.

Regulation 20(1) states: *"Registered persons must act in an open and transparent way with relevant persons in relation to care and treatment provided to service users in carrying on a regulated activity"*.

Regulation 2(1) defines a "registered person" as the service provider or registered manager in respect of a regulated activity. Such identities are further explained within regulation 2(1) and broadly amount to registered health or social care providers. According to regulation 20(7), a relevant person is the patient/service user, or, alternatively, the person acting lawfully on their behalf if the patient/service user a) has died, b) is over 16 and lacks capacity, or c) is under 16 and not competent to make a decision about their care or treatment. The meaning of "regulated activity" is elaborated in regulation 3(1), regulation 8 and Schedule 1 of the Regulations, and encompasses almost all types of medical and nursing treatment that would occur in a hospital setting. There are exceptions to regulated activities set out in Schedule 2 to the Regulations; however, it is submitted that it is good practice for all medical professionals to take heed of and adhere to the duty of candour.

The duty of openness and transparency referred to in regulation 20 relates not only to information provided to patients (or their representatives or advocates), but also to the culture within organisations. Such a duty encourages staff to be open and honest with their colleagues and employers, as well as with investigations and reviews, regulatory bodies, and the public. This is not to say that such openness and transparency does not already happen within many healthcare organisations; it is simply that there is a legal framework to enforce and support this requirement.

The formation of the duty of candour arose from the recommendations of the Francis report [3], a report setting out the findings of the Mid Staffordshire NHS Foundation Trust Public Inquiry chaired by Robert Francis QC ("the inquiry"). The inquiry looked into serious failings at the Trust regarding "conditions of appalling care" [4] between 2005 and 2008. It discovered failures in the system which

meant that legitimate concerns were not addressed and that there was "[t]oo great a degree of tolerance of poor standards and of risk to patients" [5]. It also noted failures in "a system which ought to have picked up and dealt with a deficiency of this scale" [6]. The inquiry identified negative aspects of the organisation's culture, including defensiveness in response to criticism and a lack of openness with patients, with the public and with external agencies.

Accordingly, one of the aims of the inquiry's recommendations was to "[e]nsure openness, transparency and candour throughout the system about matters of concern" [7]. Indeed, the inquiry's findings included the recommendation of a statutory obligation on "healthcare providers, registered medical and nursing practitioners to observe the duty of candour" [8] and on "directors of healthcare organisations to be truthful in any information given to a regulator or commissioner". There was also a recommendation for it to be a criminal offence for various organisations and healthcare professionals to "obstruct the performance of these duties or dishonestly or recklessly to make an untruthful statement to a regulator" [9].

The Francis report gave a definition of the duty of candour as follows [10]:

"For a common culture to be shared throughout the system, these three characteristics are required:

- Openness: enabling concerns to be raised and disclosed freely without fear, and for questions to be answered;
- Transparency: allowing true information about performance and outcomes to be shared with staff, patients and the public;
- Candour: ensuring that patients harmed by a healthcare service are informed of the fact and that an appropriate remedy is offered, whether or not a complaint has been made or a question asked about it."

The report's summary further elaborated that all organisations and those working in them should be "honest, open and truthful in all their dealings with patients and the public" [11] and that organisations and their leaders should be "completely truthful when making statements to regulators, and they must not be misleading by omission" [12] and that "[p]ublic statements must also be truthful and not misleading" [13].

What does the duty of candour require healthcare professionals to do?

Put simply, those providing medical treatment to a patient must be open and transparent about the treatment given when talking to the patient and their family. The NMC and GMC have issued helpful guidance about what the duty of candour entails. In particular, the guidance on the NMC website [14] sets out, inter alia, the following:

Pre-treatment [15]

- Patients should be fully informed about their care.
- When discussing care options with patients, both risks and benefits should be discussed.
- The patient should be given clear, accurate information about the risks of the proposed care or treatment plan, as well as the risks of any reasonable alternative treatment options.
- Practitioners should check that the patient understands.
- The risks that should be discussed are those that occur often, those that are serious even if very unlikely, and those that the patient is likely to consider to be important.

When something goes wrong with a patient's care [16]

- After doing what they can to put things right, healthcare professionals should speak to the patient as soon as possible (which, most appropriately, would be done by the lead or accountable clinician).
- The patient should have someone available to support them.
- The clinician informing the patient should share all they know to be true about what went wrong and why, and what the consequences are likely to be, and should make clear what has and what has not been established so far.
- The clinician should be honest in response to any questions and should apologise to the patient.
- The patient should be given the option of not knowing every detail, but, if this is the case, clinicians should try to find out why, and, if the patient does not change their mind, this should be recorded and the patient's wishes respected, with the patient being offered the option of being given more information at another time.
- If the patient has died, or is unlikely to regain consciousness or capacity, then those close to the

patient should be informed in lieu of informing the patient.

Encouraging a learning culture [17]

- When things go wrong with a patient's care, reporting should occur at an early stage so lessons can be learnt rapidly and future harm be prevented.
- Professionals should follow their organisation's policy on reporting adverse incidents and near misses.
- There are also national reporting schemes for various types of incidents, which professionals should adhere to.
- If a professional's organisation does not have a reporting system, the professional should report this to their manager, and, if necessary, raise a concern in line with the guidance.
- Professionals should not try to prevent colleagues or former colleagues from raising concerns.
- Equally, professionals should be supported by their organisation in routinely reporting adverse incidents and near misses, and, if professionals are discouraged or prevented from reporting, concerns should be raised in line with the guidance
- Professionals must participate in regular reviews and audits of their team's standards and performance

Senior/high-profile clinicians or those with management responsibilities [18]

- Senior clinicians should set an example and encourage a culture of openness and honesty in reporting adverse incidents and near misses, and should actively foster a culture of learning and improvement.
- Those with management responsibilities should ensure that systems are in place to give early warnings of failures or potential failures in clinical performance by individuals or teams.
- Such systems should include those for conducting audits and systems for patient feedback to be considered.
- Any concerns about individuals or teams should be investigated, and, if appropriate, addressed, quickly and effectively.
- There should be systems in place to review, monitor and improve the quality of a team's work.
- Those with management responsibilities should ensure that the teams they manage are appropriately trained in patient safety and supported to openly report adverse incidents.

Near misses [19]

- Professionals should use their professional judgement when considering whether to tell patients about near misses.
- Sometimes there will be information that the patient needs to/would want to know and sometimes the information could aid the patient's recovery.
- Also, sometimes not being open with a patient about a near miss could damage their trust and confidence in the healthcare team.
- However, in some circumstances, patients might not need to know and speaking to them about it may distress or confuse them unnecessarily.
- Near misses do not include adverse incidents which may result in harm but have not yet done so – on these occasions patients must be told and these incidents must be reported in line with the guidance.

What do the Regulations require when things go wrong?

When aspects of a patient's care do go wrong, there is explanation in the Regulations as to what, in law, needs to be done by healthcare professionals/the healthcare provider. Regulations 20(2) to 20(6) set out the mandatory steps that must be taken if a notifiable safety incident has occurred.

A "notifiable safety incident" is defined in regulations 20(7)-(9) as any unintended or unexpected incident that occurred in respect of a service user during the provision of a regulated activity that, in the reasonable opinion of a healthcare professional, could result in/appears to have resulted in death, or one of a number of listed types of harm. For a health service body, that harm is severe harm, moderate harm, or prolonged psychological harm, such terms being defined in regulation 20(7). For other registered persons, that harm is i) an impairment of the sensory, motor or intellectual functions of the service user which has lasted, or is likely to last, for a continuous period of at least 28 days, (ii) changes to the structure of the service user's body, (iii) the service user experiencing prolonged pain or prolonged psychological harm (as per the definitions in regulation 20(7)), (iv) the shortening of the life expectancy of the service user, or (v) a need for treatment by a healthcare professional in order to prevent death or any injury to the service user which, if

left untreated, would lead to death or one or more of (i)-(iv) above.

The mandatory steps listed in regulations 20(2)-(6) must be taken as soon as reasonably practicable after becoming aware that a notifiable safety incident has occurred, and include:

- As per regulation 20(2)(a), the registered person's representative(s) notifying the relevant person that a notifiable safety incident has occurred.
- Providing reasonable support to the relevant person regarding the incident, including when being notified of the incident (regulation 20(2)(b)).
- When notifying the relevant person of the incident, doing so in person (regulation 20(3)(a)), providing an account of all the facts known by the registered person at the time which must be true to the best of the registered person's knowledge (regulation 20(3)(b)), as well as providing advice as to what further enquiries into the incident the registered person believes are appropriate (regulation 20(3)(c)).
- Providing an apology when notifying the relevant person of the incident (regulation 20(3)(d)).
- Keeping a written record of the notification to the relevant person of the incident, which must be kept securely by the registered person (as per regulation 20(3)(e)).
- Providing a written notification as a follow-up to the initial notification (either written or sent to the relevant person), which contains the account of all the facts known by the registered person at the time (which must be true to the best of the registered person's knowledge), details of any enquiries into the incident the registered person believes are appropriate, the results of any further enquiries into the incident, and an apology (regulation 20(4)).
- The registered person keeping a copy of all correspondence with the relevant person made under regulation 20(4) (regulation 20(6)).

If the relevant person cannot be contacted or refuses to be contacted, a record must be kept of the attempts made to communicate with them (regulation 20(5)).

Regulation 22(3) states that failure by a registered person to comply with regulation 20(2)(a) or regulation 20(3) is an offence. However, regulation 22(4) indicates that it is a defence for a registered person to prove that they took all reasonable steps and exercised all due diligence to prevent the breach of any of those regulations that has occurred.

Apologising when things go wrong

One of the most crucial aspects of the duty of candour is the apology. This is defined in regulation 20(7) of the Regulations as "an expression of sorrow or regret in respect of a notifiable safety incident".

There is further helpful guidance on the NMC website, which states, *inter alia,* that [20]:

- As part of an apology, patients normally expect to be told what happened, what can be done to deal with any harm caused, and what will be done to prevent harm to others.
- The apology should occur at a time and place where the patient is best able to understand and retain information, and the information should be given in a way that they can understand.
- An apology only has value if it is genuine, hence a formulaic approach to apologising should not be encouraged.
- An apology is not an admission of legal liability.
- The NHS Litigation Authority (currently NHS Resolution) advises that apologising is the right thing to do, and fitness to practise panels might view apologies as a sign of insight.
- There is no need for professionals to take personal responsibility for things that were not their fault.
- Professionals should ensure that the patient knows who to contact if they have any further questions of if they wish to raise concerns.
- Professionals should also give patients information regarding independent advocacy, counselling or other support services.

It is important to reiterate that an apology would not amount to an admission of liability for the purposes of Part 14 of the CPR. In particular, the NMC guidance referred to above contains a link to the Compensation Act 2006. Section 2 of the Compensation Act 2006, entitled "Apologies, offers of treatment or other redress", states that "[a]n apology, an offer of treatment or other redress, shall not of itself amount to an admission of negligence or breach of statutory duty."

Comment

Unfortunately, things do sometimes go wrong in a healthcare setting. At this point it is crucial for healthcare professionals to have open discussions with patients and/or their families about what has happened.

For patients and their families, one of the issues of key importance is understanding what went wrong and why. Often there is difficulty in getting information, which sometimes only starts to materialise following pursuit of a civil claim or during the process of an inquest (if the patient has died). This, unsurprisingly, feels unsatisfactory to those involved, who can feel that they are intentionally being left "in the dark" about what happened.

From the perspective of healthcare organisations and healthcare professionals, there is concern that apologies or comments by members of staff can be taken as admissions, or that such might prejudice subsequent legal proceedings. This is not the intention of the duty of candour, and it is worth reiterating that an apology or discussion of what happened would not, in and of itself, amount to an admission of civil liability. It is also sometimes the case that there is difficulty in providing full information due to investigations being incomplete; in these instances, it is suggested that the situation is explained to the patient and their family, with what has been established so far being imparted.

In the context of civil claims, swift clarification of what happened and what went wrong can aid early narrowing of the issues. Indeed, paragraph 2.2(a) of the Pre-Action Protocol for the Resolution of Clinical Disputes encourages openness, transparency and early communication of the perceived problem between patients and healthcare providers. Such communication and clarification can further assist in enabling claims to be concluded at an earlier stage: from the patient's (or family's) perspective, this prevents prolongation of stressful legal proceedings; from the healthcare provider's perspective, swift resolution of claims can avoid legal costs continuing to accrue over several months or years.

In general, an early apology and discussion of what went wrong can assist in maintaining trust and communication between healthcare professionals and patients, or their families and representatives. Not only does this promote continuation of the relationship, which is beneficial if there is still ongoing treatment with the same provider, but also it should serve to reduce the level of stress of any ensuing litigation. Finally, on a more pragmatic note, timeous investigation and discussion of an incident enables early collation and preservation of evidence, which thereby avoids the risk of memories having faded when matters are inevitably revisited at a later date.

References

https://www.cqc.org.uk/news/releases/care-quality-commission-prosecutes-university-hospitals-plymouth-nhs-trust-breaching

Regulation 1(6) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014/2936

https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/279124/0947.pdf

supra at page 7 paragraph 1

supra at page 4

supra at page 4

supra at page 4

supra at page 75 paragraph 1.181

supra at page 75 paragraph 1.181

supra at page 75 paragraph 1.176

supra at page 75 paragraph 1.177

supra at page 75 paragraph 1.178

supra at page 75 paragraph 1.178

https://www.nmc.org.uk/standards/guidance/the-professional-duty-of-candour/read-the-professional-duty-of-candour

supra at paragraphs 6-7

supra at paragraphs 8-12

supra at paragraphs 22-28

supra at paragraphs 29-31

supra at paragraphs 20-21

supra at paragraphs 13-16

Recording Consultations with Medical Experts

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Claimants may want to record consultations with medical experts and mobile phones make it relatively easy to do. Should they do this and how? What view do the courts take?

Whilst many doctors may be reluctant for patients to record appointments, the GMC recognises that there may be advantages in doing so although it encourages patients to seek the doctor's prior agreement. It may enable patients to remember and reflect on advice, process information, include families in decision-making and there may be particular benefits where a patient is vulnerable. In the legal context, claimants may want to safeguard themselves against their comments being misreported and tests being carried out incorrectly. There have now been several reported cases where the question has arisen. The cases relate to brain-injured claimants.

Williams v Jervis [2008] EWHC 2346 (QB

The issue arose in Williams v Jervis. The claimant succeeded in establishing that a relatively low velocity road traffic accident was sufficient to cause a subtle brain injury and that she in fact had such an injury. The defendant had disputed whether she in fact suffered post-traumatic amnesia, a factor increasing the likelihood of a brain injury. Her evidence on the point was significant.

The trial judge accepted her evidence although he commented that she had a complex and difficult personality and that her memory was at times selective. This was therefore a case where there were vulnerabilities in the claimant's evidence. However, she was helped by having recorded her consultation with the defendant's neurologist. The transcript demonstrated that the neurologist's account of what she said during the consultation was inaccurate in particular as concerned various facts relevant to whether she had suffered post-traumatic amnesia. The expert had also wrongly said that she had been unwilling to answer certain questions. The judge criticised the expert's evidence for not being thorough, adequate in its analysis or reliable.

The case demonstrates how claimants can be vulnerable to an expert who fails to record their evidence correctly. Although the judge had accepted the claimant's evidence in the face of some quite adverse comments about her personality and reliability, it is easy to imagine how he might have rejected it had the expert's evidence as to her account not been shown to be wrong.

Mustard v Flower [2019] EWHC 2623

Mustard v Flower concerned another low speed road traffic accident alleged to have caused a subtle brain injury. The speed of impact and nature of the injury were contested.

The claimant covertly recorded consultations with 2 of the defendant's experts. At a consultation with the defendant's neuropsychologist it was agreed she could record the examination but not the testing. In fact, she failed to turn off her device after the examination (on her evidence inadvertently) and therefore recorded the testing.

The neuropsychology expert instructed on her behalf, Prof Morris, was asked to review the transcript. Whilst clearly uncomfortable about the recording having been made covertly, he felt constrained to produce a further report commenting on an incorrect administration of the tests, rendering the results unreliable.

At an application to consider whether the transcript and Prof Morris' further report should be admitted, Master Davison described covert recording as 'reprehensible' but accepted for the purpose to the application that recording the testing was inadvertent. He permitted admission of both the transcript and the report. Their probative value was a factor outweighing the court's disapproval of covert recording. He heard arguments (apparently supported by the British Psychological Society) that making a recording changed the dynamic of the assessment, failed to meet the standardised conditions under which testing should take place and potentially prevented claimants from being re-tested in the future. However, he thought there was a

greater risk of impairment of results from failing to carry out the tests correctly than by recording changing the dynamic of the assessment. He also thought that it was now impossible for the experts to disregard the evidence of the transcript. In effect, the genie was out of the bottle.

McDonald v Burton [2020] EWHC 906 (QB)

A similar issue arose in McDonald v Burton, which concerned another road traffic accident, this time causing what was clearly a very serious injury to a man now lacking capacity. The claimant has already obtained evidence from a neuropsychologist and that assessment had not been recorded. The parties had agreed that consultations with 7 experts instructed by the defendant would be recorded but the defendant objected to any recording of an assessment by Prof Kemp, its neuropsychologist.

The claimant argued that a recording could provide an aide memoire, protect a vulnerable and suggestible claimant against errors and avoid the risk of his answers being misinterpreted.

Martin Spencer J was asked to give directions and invited by the claimant to make observations of general application. The arguments were much the same as those in Mustard v Flower. The defendant also argued the allowing the consultation to be recorded would create an inequality of arms between the parties: the claimant would have the benefit of a transcript of the appointment with the defendant's expert but the defendant would not have a transcript of the appointment with the claimant's expert.

The judge appeared sympathetic to the claimant's wish to protect his position, not least because of the 2 previous cases cited above. However, he ruled that to allow the recording would create an uneven playing field and ordered that the consultation should not be recorded. This suggests that if the appointment with the claimant's expert had been recorded, he would have permitted recording the appointment with the defendant's expert.

He declined to make any general observations for future cases, noting that a working party of APIL and FOIL was trying to formulate an agreed approach. He also noted that the British Psychological Society was working on its own guidelines, of which the defendant's expert was in fact and author, and expressed the hope that these would reflect the concerns apparent from cases such as Williams v Jervis and Mustard v Flower.

He also considered whether privilege would to the recordings. He thought that a recording by a claimant of the defendant's expert's consultation was not privileged. A recording of a consultation by his own expert would be but privileged would be waived when the report was disclosed.

Conclusions

There is a risk of experts inadequately recording information or carrying out testing and of claimants being prejudiced as a result as Williams v Jervis and Mustard v Flower show. The risk may be more acute for vulnerable patients. Recording consultations is a way of providing evidence of what in fact took place during a consultation.

The practice is acceptable in general but should be done openly and by agreement. To record covertly is 'reprehensible'. Faced with the evidence of a covert recording, its probative value may nevertheless outweigh disapproval of the conduct of the person making the recording, as happened in Mustard v Flower. It is also difficult to disregard evidence once it is known to the experts and the court. However, the need for a level playing field means that either both sides' experts' appointment or neither should be recorded.

There are potential problems with recording neuropsychology assessments which may not arise with other disciplines. Neuropsychologists argue that recordings prevent assessments being carried out in standard conditions although whether the evidence justifies this concern and to what extend is unclear. There is a risk of prejudicing the ability to re-test claimants and of confidential testing material entering the public domain. It may also be necessary for neuropsychologists to consider whether there is a risk of breaching licence conditions under which the tests are used and it would be prudent to obtain the licensor's agreement to any recording. This means that requesting agreement to record an assessment should not be done at the last minute.

It would be helpful if the APIL and FOIL working party can reach an agreed position because the issue of recording consultations is likely to arise more frequently in the future.

Expert Evidence and Breach of Duty: Logical Analysis Outweighs Experience Bradfield-Kay v Cope

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The judgment in Bradfield-Kay v Cope[1] is raises 2 issues of interest in relation to expert medical evidence. The first is the weight of a reasoned opinion with logic on its side may outweigh the weight of an expert's impressive background. The second is that, although it is unusual, an action regarded as reasonable by a responsible body may still be negligent is it lacks a logical basis. In judge appeared to be approaching the Bolam test through the lens of Bolitho, despite rather oddly saying he was not.

The facts

The claimant had undergone a left total hip replacement operation carried out privately by Mr Cope in December 2009. He was unhappy with the outcome and experienced painful clicking. He consulted another surgeon, Mr Hemmady, who performed revision surgery. At surgery Mr Hemmady found that the cup was retroverted. Its anterium[2] was said to be prominent and was 'catching on the anterior structures'.

The claim

The claimant brought proceedings against Mr Cope. The allegation of negligence of significance for this article was in incorrectly positioning the acetabular component (cup) such that the iliopsoas tendon was catching on it, causing tendonitis. The other allegations were of using the wrong size of femoral component and then failing to record and act upon reports of groin pain at a subsequent appointment. The first of these succeeded and the second failed.

The expert evidence

The parties called expert evidence from orthopaedic surgeons, Mr Chatterji for the claimant and Mr Manktelow for the defendant. The judgment comments that the primary focus of Mr Chatterji's practice was knee replacement surgery but he also conducted total hip replacements. Mr Manktelow, on the other hand, had a specialist practice in primary and revision hip arthroplasties. He had performed 103 revisions in 3 years. He had also published extensively on hip arthroplasty and been president of the British Hip Society. The judge commented that on his ability to 'speak to the practice of hip specialists in England'. That might have suggested that his evidence was likely to be the more persuasive than that of his opponent.

On most issues the experts were in agreement. They agreed on what was a satisfactory position for the acetabular component and that it should be positioned such as to avoid interference with the iliopsoas tendon. They agreed that the cause of the claimant's pain was a prominent acetabular component irritating the iliopsoas tendon. Neither thought the orientation of the acetabular component was satisfactory. They also agreed that a surgeon should be able to detect and correct any such prominence. Where they disagreed was on whether it was positioned outside the range of what was reasonable and therefore whether there had been a breach of duty. So the issue was whether was clearly a poor result fell below an acceptable standard or not.

Mr Manktelow's said that in his own practice he came across similar situations where the acetabular component had been left prominent. He regarded this as an error and disapproved of it. However, there was a body of surgeons who would achieve a similar poor result. He did not give any explanation as to why or as to why they would fail to correct it.

Mr Chatterji thought this was an unacceptable error which fell outside the scope of reasonable surgery. It

1 *[2020] EWHC 1351 (QB)*
2 *I have been unable to find a medical definition of anterium. Google is redirecting me to a garden centre.*

was entirely avoidable. Surgery competently performed would identify and avoid the problem.

The judge preferred Mr Chatterji's evidence over that of Mr Manktelow in particular because Mr Manktelow had not been able to give any rationale for positioning the component unsatisfactorily. In the judge's words, 'I was left with the impression that Mr Manktelow's justification for asserting that there was no breach of duty was because he said so'.

This raises 2 issues about expert evidence.

First, it is often an advantage to be relying on the more experienced and specialist expert. There are exceptions where it is best to avoid asking a specialist to report on breach of duty by a generalist: the risk is that the specialist will apply too high a standard. However, in this case the surgeon with the greater degree of specialism actually set the bar too low, regarding an avoidably bad result as falling within the acceptable range.

Secondly, the quality of an expert's evidence is not necessarily determined by the experience of the expert. However impressive an expert's cv, the expert needs to be able to explain the rationale for their view. Persuasive expert evidence is grounded in transparent and logical reasoning. The quality of reasoning is key to good expert evidence. As was said in another case, 'Experts' opinions, if they are to be accorded any weight, need to be supported by a transparent process of reasoning'[3] .

Breach of duty

The Bolam test provides the definition of breach of duty in relation to the conduct of orthopaedic surgery. The test assumes a lack of reasonable skill and care where conduct falls below that of a responsible body of orthopaedic surgeons. In Bolam[4] McNair J defined negligence by reference to what is not negligent: 'a man is not negligent, if he is acting in accordance with such a practice, merely because there is a body of opinion who would take a contrary view'.

The test makes most sense where there is a fine balancing of risks and benefits which may lead practitioners adopt different schools of thought and take different approaches. However, a test defined by reference to a responsible body makes little sense where there is a surgical error, in this case failing to position an acetabular component correctly. There is no responsible body who would advocate such a practice. The issue is really whether the result is consistent with the exercise of reasonable skill and care.

In Bradfield-Kay v Cope, the disagreement between the experts could be said to reflect alternative schools of thought but only as to whether the poor result was consistent with the exercise of reasonable care. The defendant's expert thought it was. On the face of it the Bolam defence was made out and the error fell short of negligence.

However, the Bolam test was qualified in Bolitho[5] , a case which determined that for a body of the thought to be reasonable or responsible, it must have a basis in logic. In this case the defendant's expert did not set out any logical basis for failing to take steps which would identify and correct the prominent placement of the acetabular component. There was no fine balancing of risks. There was simply an avoidable error. The judge therefore found that, although a body of surgeons may consider the poor result within a reasonable range, that could not be a reasonable and responsible body. The claimant succeeded in establishing a breach of duty.

Oddly the judge specifically rejected the defendant's leading counsel's submission that to reject the defendant's expert evidence entailed relying on Bolitho. The judge said, 'In my view, both Bolam and Bolitho require the court to examine the different schools of thought and to ask itself whether the school of thought relied on by the defendant can demonstrate that its exponents' opinion has a logical basis'. That is true of the Bolam test but as qualified by Bolitho and it is hard to see why the judge thought Bolitho was not playing a role. The reality is that the case succeeded because the body of thought on which the defendant relied was found not to stand up to logical scrutiny and this is therefore an example of the Bolitho qualification at work.

3 *Hirtenstein and Il Sole Ltd v Hill Dickenson [2014] EWHC 2711 (Comm)*

4 *Bolam v Friern Hospital Management Committee [1957] 1 WLR 583*

5 *Bolitho v City and Hackney Health Authority [1996] 4 All ER 771*

Swift v Carpenter

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The Court of Appeal's decision in *Swift v. Carpenter*[1] contains both a welcome reassertion of the guiding principles behind the assessment of damages in personal injury cases and the adoption of a potentially flawed mechanism. By its own admission it does not provide the final answer to the problem of valuing special accommodation claims but it does at least provide clarity and compensation for a large number of injured claimants. This article will go some way towards looking at how the approach in Roberts v. Johnstone failed and the approach that the courts will now adopt. It will explore the problems that persist and how the courts might seek to resolve those.

The problem of how the court should value a claim for accommodation was first addressed in *George v. Pinnock [1973] 1 WLR 118*. The claimant advanced a claim for the capital cost of purchasing special accommodation, that is to say the additional cost that she had incurred in purchasing a bungalow over and above the expense that they would have incurred in purchasing property had they been uninjured. A review of the facts of that case discloses that the claimant purchased a bungalow for £14,500 out of an interim payment of damages made before the trial. The trial judge awarded the claimant £48,682, which included an award of £19,000 for general damages for pain, suffering and loss of amenity, but declined to make any award in respect of the cost of purchasing accommodation. The Court of Appeal upheld that decision, confirming that the claimant could not recover the capital cost of purchasing the accommodation as she had not incurred a loss as: "The plaintiff still has the capital in question in the form of the bungalow"[2]. The court formulated the claimant's loss in a different way by observing that in purchasing accommodation a claimant would be involved in greater expense than would otherwise have been the case, either because the claimant had to take out a mortgage and would incur interest charges, or they would have to use damages that could otherwise have been invested for profit to purchase accommodation. The claimant could therefore categorise their loss either by reference to an annual interest rate expended or the loss of a rate of return on capital that would have been invested if it had not been spent on accommodation.

The circumstances that had informed the Court of Appeal's decision in *George v. Pinnock* had altered by the time that court considered the case of *Roberts v. Johnstone*. As with the claimant in the previous case, the claimant in *Roberts v. Johstone* had sustained serious injuries and required special accommodation in the form of a bungalow. Taking into account a notional sum of £18,000 that she would have spent on accommodation in any event, the court determined that she would have to spend an additional £58,500. Since *George v. Pinnock* mortgage interest rates had risen, and buyers no longer obtained the benefit of tax relief on interest payments. This led to the claimant advancing a claim for mortgage interest of 9.1% per annum, an approach that produced the following calculation:

£58,500 x 9.1% x 16 = £85,176

The product of the mortgage interest rate approach therefore provided the claimant with a sum that not only exceeded her claim for accommodation but significantly exceeded the total purchase price of the accommodation that she had already purchased by the date of trial. The justification for the Court of Appeal's rejection of that approach was therefore obvious. The Court of Appeal categorised the claimant's loss by reference to the second limb of *George v. Pinnock*, namely that the claimant's loss could instead be described as the loss of a rate of return on investment of capital. The notional rate of return on that investment was said to be 2%, a rate that was later tied to the discount rate. This approach led to the claimant recovering £18,720 for accommodation a shortfall that was comfortably met by the £78,300 awarded for general damages for pain, suffering and loss of amenity.

When properly contextualised, both decisions are therefore essentially pragmatic and in the interval between *George v. Pinnock* and *Roberts v. Johnstone*, reactive to changing circumstances. It is a common feature in

1 *[2020] EWCA Civ 1295*
2 *Per Orr L.J. at page 125*

both cases that neither claimant needed to purchase accommodation utilising any fund other than their award of general damages and so their loss could be seen as the loss that would be suffered by investing unallocated capital into domestic property rather than an investment that provided a steady rate of return. Alternative ways of categorising their loss resulted in obvious and unjustifiable overcompensation.

The practical use of the *Roberts v. Johnstone* formula soon revealed problems with the formula. The calculation was unfavourable for claimants with shorter life-expectancies and as the value of property increased, outstripping any inflation of awards for general damages, claimants soon found that they were unable to make up the shortfall from unallocated damages. As Tomlinson L.J. observed in *Manna v. Central Manchester University Hospitals NHS Foundation Trust [2017] EWCA Civ 12* (at paragraph 17):

"The exercise in which the court is thus engaged is in modern conditions increasingly artificial. The assumption underlying the approach is that the claimant will be able to fund the capital acquisition out of the sums awarded under rubrics other than accommodation. But in modern times residential property prices have increased rapidly while general awards for pain, suffering and loss of amenity have remained at traditional levels. Whilst Peter is no doubt robbed to pay Paul, it must often be the case that the accommodation assessed by the court as suitable is simply not purchased. A further problem confronts the claimant with immediate and pressing needs but a relatively short life-expectancy"

The formula reached breaking point with the introduction of a negative discount rate on 20 March 2017. Whilst it was understood that a change in the discount rate below +2% would render the calculation unfavourable it became unworkable with a negative discount rate.

JR v. Sheffield Teaching Hospitals NHS Trust [2017] EWHC 1245 (QB) was the first case to consider the *Roberts v. Johnstone* formula following the introduction of a negative discount rate. In that case William Davis J observed that whilst: "a fair and proper solution should be found to the conundrum of providing a claimant with the means to purchase special accommodation"[3] the court was nonetheless bound to apply *Roberts v. Johnstone* even if doing so produced a nil award. That case was appealed to the Court of Appeal, but the defendant compromised the claim based on the full capital value of the special accommodation before the case could be heard.

The issue arose again before Lambert J in *Swift v. Carpenter* [4]at first instance. Her approach to the conundrum created by *Roberts v. Johnstone* presupposed that the principle of avoiding over-compensation took precedence over the potential harm that could be done to the claimant by receiving a nil award in respect of accommodation (per Lambert J at paragraph 137):

"But as the Court observed in Manna the formula is the product of 'imperfect principles which have held sway since George v. Pinnock' and I have no doubt that I am bound by Roberts v. Johnstone. It cannot be sensibly argued otherwise. Each alternative formulation advanced by the Claimant in this case would produce, if capitalised, a final figure greater than the loss which the formula is intended to address. Each formulation would produce the 'windfall' which the Court in Roberts considered to amount to over-compensation. As I have said, so far as I am concerned, that must be the end of the matter…"

The impression created by this extracted is however ameliorated by Mrs Justice Lambert's comments in granting the claimant permission to appeal:

"I granted permission as there exists an, in my view, important point of principle which the CA needs to resolve. That is, whether the *Roberts v Johnstone* formula remains consistent with the principle of full restitution. Even though the current discount rate may increase such as to produce some relatively modest damages in respect of additional capital costs of accommodation in this case, the application of the formula produced anomalous results event when the discount rate was 2.5%".

In considering the appeal in *Swift v. Carpenter* the Court of Appeal were thus faced with the question of whether *Roberts v. Johnstone* did offend the principle of full compensation, by leaving a claimant who purchased accommodation undercompensated; whether the Court of Appeal were bound by the decision nonetheless; and, if not bound by it, how the Court of Appeal should categorise the loss suffered by the claimant.

The respondent addressed the first question by contending that the claimant who purchased accommodation would not suffer a loss as funds invested in accommodation following trial could be realised to fund care in later life by using an equity release arrangement. The responded submitted that the award of damages would therefore permit the claimant to meet her needs as defined by the court but would still meet the stated objective of the Court of Appeal in *Roberts v Johnstone*, namely to: "avoid

3 *Paragraph 48*

4 *[2018] EWHC 2060 (QB)*

leaving in the hands of the plaintiff's estate a capital asset not eroded by the passage of time…".

This argument, whilst ingenious, placed the burden of risk firmly on the claimant's shoulders. It relied upon a buoyant property market and a suitable equity release product existing at a time in the distant future. The absence of either would put the claimant at risk of not being able to raise the necessary capital to fund her needs in later life. These elements rendered the approach unacceptable, as Nicola Davies LJ observed (at paragraph 214):

"The effect of the negative discount rate is such that even the respondent acknowledges that the damages awarded to this appellant in the High Court proceedings will be insufficient to allow her to purchase, from existing funds, appropriate accommodation and thereafter meet all necessary costs resulting from her injury. What is envisaged by the Responded is that when the Appellant is approaching the age of 80, she will undertake a form of equity release on the property, or by some other means release capital, in order to provide necessary funding. In my judgment, this proposed course undermines the principle of full and fair compensation. Further, it will do so at a time of particular vulnerability for this Appellant, but reason of her age and disability"

The question therefore remained as to whether the Court of Appeal was bound by *Roberts v. Johnstone*. In answering that question, Irwin LJ noted that in *Knauer v Ministry of Justice* [2016] UKSC9, the Supreme Court had drawn a distinction between decision based on principle, which should be subject to the usual rules of precedent, and decisions that provide practice and guidance. In his view the underlying and immutable principle behind the quantification of damages in personal injury claims is the desire to provide fair and reasonable compensation but not overcompensation. Decisions of the courts, including the decision in *Roberts v. Johnstone* might provide practical guidance on how that principle might be achieved in a given situation but: "are explicitly based on the conditions of the day". It follows that: "the reasoning in *Roberts v. Johnstone* was a means to an end rather than a principle, or end in itself. If there is a justified call to alter the means by which that end (fair compensation but not overcompensation) is reached, and another means is available, it appears to me this court should be ready to contemplate a change in the guidance to be given".

Underhill LJ agreed with this approach but observed that revision of guidance offered by the court in personal injury claims should only be revisited in response to "really significant changes" and will rarely if ever be revisited by a first-instance court.

The interpretation of *George v. Pinnock* and *Roberts v. Johnstone* as pragmatic solutions to the overall problem of understanding and compensating a claimant's loss is undoubtedly correct. *Roberts v Johnstone* itself demonstrates that the authorities were capable of adapting, at least in circumstances where an existing formula provided over-compensation. The corollary should also be true and the fact that both cases provided a fair balance between the claimant and defendant's interests at the time that they were decided, did not mean that they should be upheld if changing landscapes shifted that balance against the claimant so as to provide under-compensation.

Having determined that the *Roberts v. Johnstone* formula was inadequate, the Court was left with the question of what should replace it. Various alternatives had been reviewed in the lead up to the appeal in *JR* and had been found to be inadequate, leaving the award of the full capital value of the accommodation as the only apparent solution. The new development during the course of the appeal in *Swift* was the suggestion that justice as between the parties might be balanced by seeking to value the reversionary interest in the property, in other words to define what it would cost to acquire the right to own the claimant's property after their death. Unusually, and possibly uniquely, the Court of Appeal heard oral evidence from expert witnesses, amongst other things, as to the process of valuing reversionary interests. That evidence was of limited practical assistance, with Underhill L.J. noting that the evidence called during the Appeal falling short of establishing that there was an active market upon which an assessment of an established rate could be based[5] . A review of the evidence heard by the Court of Appeal supports this conclusion, with it being evident that there was a very niche market for reversionary interests in practice, with only a few sales occurring every year and the valuation of those interests being relatively unpredictable and essentially speculative. Faced with a lack of cogent evidence upon which to base a standardised calculation the Court of Appeal therefore chose a rate of its own. They elected to base this upon a discount rate of 5% to which table 28 of the Odgen tables should be applied.

In Mrs Swift's case the calculation revealed that she had a recoverable claim for £801,913:

1.05 xy -45.43 = 0.1089

£900,000 x 0.1089 - £98,087.00

£900,000 - £98,087.00 = £801,913.00

5 *Paragraph 230*

This calculation adopted the agreed figure of £900,000 for special accommodation. This figure was reached by Lambert J and involved deducting the value of the claimant's existing (but for) property from the value of the property that she now needed due to her disability. The need to make this reduction was made clear in *Thomas v. Brighton Health Authority* [1996] PIQR 30; and *Evans v. Pontypridd Roofing Ltd* [2001] EWCA Civ 1657. The reduction applies not only to the capital cost of the accommodation that the claimant owned or would have owned but also to rental payments, if they rented rather than owned property. The reduction also applies in respect of property that the claimant would hypothetically have owned or rented had they been uninjured and in the case of a child claimant it will be necessary to consider what type of property they would have lived in in the future and what the costs associated with that would have been. In most cases it is reasonable to assume that the claimant in the hypothetical scenario would have shared accommodation costs with another person, a partner or spouse, and should therefore only give credit for half of the notional rent or purchase price. In the case of a child it is reasonable to assume that they would not have incurred accommodation costs until they reached adulthood and lived independently.

Another important practice point is that the decision in *Swift v. Carpenter* does not displace the conclusions of the Court of Appeal in *Manna* that the costs of purchasing a second property could be recovered in cases where the parents of a disabled child had separated. Based upon that case, it is arguable that the reversionary interest should be valued based upon the claimant's life-expectancy and not that of the parent who would be living in the other property.

Whilst pragmatic and fair in the case of Charlotte Swift, the decision in *Swift v. Carpenter* suffers from the same limitations as *Roberts v. Johnstone*. As with the earlier case, the formula may be prone to changing circumstances and fails to provide full compensation when applied to claimants with short life-expectancies. If Mrs Swift's life multiplier had been 10 rather than 45.43, her reversionary interest would have been valued at £552,521.93, far higher than her award of general damages and leaving her with a shortfall in damages that could only be met by utilising damages awarded under other rubrics. Unlike its predecessor in *Roberts v. Johnstone*, though, the Court of Appeal built a safety mechanism into their judgment. Part of that solution can be found in Underhill LJ's comments at paragraph 224

…On the face of it the most straightforward approach would be simply to award the claimant the full amount of the cost of the additional accommodation attributable to the injury ('the additional element'). But of course that fails to take into account the fact that at the point where the claimant ceases to need the additional element (typically though not necessarily, when they die) they or their estate will continue to benefit from its capital value and to that extent will be over-compensated – or, to use a term which is convenient if not wholly apt, receive a windfall. If there is a fair and workable means of avoiding that windfall it should be adopted. As appears from paras 8-11 and 33-35 of Irwin LJ's judgment, various ways of addressing the problem which might seem superficially attractive have proved flawed or unworkable on closer examination. The only workable candidate now in play, at least in a case of the present kind where there is a long-term need for the additional element, is the 'value of the reversion' approach, in which the award is reduced by the amount of the present value of a notional right to receive the windfall amount at the assumed date of the claimant's death. I agree with Irwin LJ that this is in principle an appropriate way of avoiding over-compensation, at least in a case of the present kind where the claimant has a long life expectancy…"

What is the solution for a claimant with a short life-expectancy then? The words of Irwin LJ at paragraph 205 and 206 of the judgment appear to mirror the concerns of Underhill LJ above:

"The principles of law by which this court is bound can be summarised in two propositions: firstly, that a claimant injured by the fault of another is entitled to fair and reasonable, but not excessive compensation. Secondly, as a corollary of that fundamental principle, in relation to the head of claim with which we are concerned, the award of damages should seek so far as possible to avoid a 'windfall' to a claimant… If it were impossible here to award a claimant full compensation without a degree of over-compensation, then it seems to me likely that the principle of fair and reasonable compensation for injury would be thought to take precedence…"

Following this, it is arguable that in the absence of a fair solution that avoids overcompensation, the claimant is entitled to recover the capital cost of accommodation. As it appears to be accepted that the *Swift* formulation does not provide a reasonable solution for claimants with short life-expectancies does it follow not only that the formula does not apply to them but also that they are entitled to recovery of the full capital value of the accommodation as the only alternative? This solution appears arbitrary and would undoubtedly create an imbalance between

different classes of claimant, which would be perceived as unfair by those claimants with longer life-expectancies who are required to give up their general damages to make up the shortfall. There seems however no other workable solution by which claimants with short life-expectancies could be provided with adequate funds to purchase their accommodation other than by an award of full capital value; it seems almost inevitable therefore that the next battleground for accommodation claims will focus on them.

Practice points:

- A calculation based upon valuing the reversionary interest in special accommodation will now represent the means by which accommodation claims are calculated;
- That calculation should be applied to the value placed upon the accommodation that the claimant will need after deducting the cost of purchasing or renting accommodation had they been uninjured;
- Claimants should only give credit for 50% of notional in any event accommodation
- Betterment should be deducted from the adaptation costs and not from the purchase price;
- The reversionary interest approach will not function for claimants with short life-expectancies and alternatives should be considered. In the absence of a workable alternative the full capital value approach should be regarded as the default position.

Recovering Private Healthcare Costs in a Personal Injury claim

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The Principle

Within their claim for financial loss, a successful claimant is entitled to recover all expenses reasonably incurred in their attempt to mitigate their loss. This may often include the cost of medical treatment regardless of the availability of state-funded care. This was codified by the Law reform (Personal Injuries) Act 1948, s2(4):

> *"In an action for damages for personal injuries ... there shall be disregarded, in determining the reasonableness of any expenses the possibility of avoiding those expenses or part of them by taking advantage of facilities available under the National Health Service."*

Of course, the claimant is only entitled to claim and recover their actual losses. It is therefore open to a defendant to challenge a claim for future treatment costs by establishing that

i. the treatments are available free of charge on the NHS or through Social Services and

ii. that the Claimant is likely to make use of that free provision of treatment and not incur any expenditure privately, Eagle v Chambers No2 [2004] EWCA Civ 1033.

The point was tested in *Woodrup v Nicol* [1993] PIQR Q104, where the claimant sought damages in respect of the cost of future check-ups and physiotherapy. The court found that whilst the claimant would be likely to have to fund half of his required medical treatments privately, he would be likely to rely on the NHS to provide 'the other half'. On that basis, the Court of Appeal held that the claimant could recover only the 'private' half of those expenses, Russell LJ summarising:

> *"If, on the balance of probabilities, the claimant is going to use private medicine in the future as a matter of choice, the defendant cannot contend that the claim should be disallowed because National Health Services facilities are available. On the other hand, if, on the balance of probabilities, private facilities are not going to be used, for whatever reason, the Claimant is not entitled to claim for an expense which he is not going to incur"*

Causation and reasonableness

The issue of causation will need to be satisfied and credit will need to be given for medical costs and expenses that would have been incurred in any event. In *Giles v Dr Chambers* [2017] EWHC, HHJ Graham Wood QC considered an apportionment argument and awarded 60% of the claimed past psychiatric treatment costs, holding that 40% was due to unrelated causes for which the claimant would have been likely to require treatment in any event. In determining whether the cost of the treatment should be recoverable from the defendant, the court will assess first whether it was reasonable for the claimant to undertake such treatment and then whether it was reasonable in amount.

Still the subject of much debate, is the issue of complimentary or alternative therapies. Challenges are often raised as to whether 'unconventional' treatment costs should be recovered, such as for acupuncture, heat therapy, herbal medicine, spa treatments, head massage and Reiki.

It is clear that there are no absolute bars to the recovery of such treatment costs – provided the court can be persuaded that it was reasonable for the claimant to try such alternative treatment. Indeed, it may be that the physiotherapist or those working within a multi-disciplinary approach, such as in pain management, have themselves recommended some form of 'complimentary' therapy alongside, or even following the exhaustion of, conventional treatments. Documentary evidence that such a recommendation was made by a treating medic will go a long way to supporting and justifying the costs of such treatment.

Proving the claims

Where the claimant can speak about the benefit or pain relief that such treatment has given them, this should be carefully detailed in their own words within their witness statement. It is most likely that a court would be prepared to accept that any treatment which has in fact benefitted the claimant is self-evidentially reasonable, not least because the success of that treatment would in some way have limited the general damages a defendant would otherwise be liable for, or keep down the potential financial loss. In *McMahon v Robert Brett & Sons* [2003] EWHC 2706 (QB), Cox J awarded the claimant her cost for aromatherapy treatment, accepting her evidence that it had helped to overcome her pain.

It is not the case that the treatment needs to be 'scientifically proven' to produce benefit and in *Sadler v Filipiak & anr* [2011] EWCA Civ 1728, the Court of Appeal dismissed the defendant's objections to the claim for the cost of private bio-oil purchases which the claimant had been applying to her scars. Pitchford LJ said:

> *"I reject the argument that scientific evidence or something like it was required before the judge was entitled to accept the evidence of the claimant herself … he was perfectly entitled to accept the evidence of the claimant's personal experience".*

Claims for the cost of treatments which, with the benefit of hindsight, were found to be unhelpful to the claimant's condition, or even those that aggravated it, are not necessarily doomed to failure. They may be recoverable where it can be established that it was reasonable for the claimant to have undergone the particular treatment at the time the decision was made. To support this, an account should be taken of what was known about the treatment at the time and why it was expected to provide some benefit to that particular claimant.

Costings will also need to be carefully detailed and proven. A defendant might well take issue with the fact that such treatment claimed is more expensive than other available treatments, relying on the principle that a claimant is under a duty to mitigate their loss. Whilst medical treatment costs may be found to have been reasonably incurred even if there is a less expensive alternative available, see *Rialis v Mitchell* (1984) Times, 17 July, there is some risk of the claimant losing the difference if a defendant is able to establish that lower cost treatment was available to the claimant and that it was not reasonable for them to have incurred a greater cost.

Insurance providers and subrogation

There may be cases in which the claimant has had the benefit of a private healthcare policy, travel or holiday insurance. The claimant may have elected to use that insurance to obtain treatment whilst abroad, or to be repatriated, or simply to obtain urgent treatment not immediately available on the NHS. The insurer has therefore suffered a 'loss' in having to cover those expenses or costs, which otherwise the claimant would have paid and then recovered from a tortfeasor. The issue which then arises is whether the claimant can recover within their claim, such outlay.

To protect against the usual rule that a claimant may not ordinarily recover damages for the loss suffered by a third party, the contract between the claimant as policy holder and the insurer, would have to contain a provision so as to enable a claim to be made on behalf of that provider for its outlay.

Generally, the obligation is imposed directly on the policy holder, requiring them to seek to recover the outlay and costs of such medical treatment as funded through the policy, cemented with a 'reimbursement' clause. In other contracts, the right to reimbursement may be coupled with the subrogation clause drafted so as to entitle the insurer to bring the claim, usually in the name of the policy holder.

In practice, it was not always easy to engage the co-operation of the policy holder in recovering expenses, which they may not feel they had any direct interest in doing. In consequence, such clauses have somewhat 'tightened' over the years and may now stipulate a requirement on the part of the policy holder to co-operate with the bringing of such claims. Such contracts often state that any failure to do so would amount to a breach of the contract, entitling the insurer to terminate the policy and recover the whole of its outlay and costs directly from the policyholder.

Anecdotally and from experience, there appears to be a growing prevalence for insurers who have an outlay to recover, to insist that the claimant provides for this within their clinical negligence claim. Whilst practitioners in this field are well versed in ensuring that any medical treatment costs already paid for by an insurer are included within the claim, it may not appear obvious to check whether there are any additional subrogated claims to be made, for example from any travel insurance policy, or earnings protection policy. Of course, the issue of causation must be satisfied, namely that the loss sought to be recovered arose out of the defendant's negligence, but the wording on the policy often requires the client to notify the insurer

at the outset and to keep them involved from the moment a claim is intimated.

A more concerning trend within such policies is the inclusion of a 'priority' term in favour of the insurer, imposing a requirement to first and fully reimburse the insurer from the proceeds when either a full or partial settlement is achieved.

Terms in policies currently in circulation include provisions that might appear far-reaching, if not somewhat draconian, including terms dictating that the policy holder may not enter into any settlement without written approval of the insurer and, in the case of the negligence leading to death, that the terms as to reimbursement survive and apply to the estate, beneficiaries or any other interested party to the estate. Whether such term is enforceable, is beyond the subject matter of this paper, but one can see straightway the potential of some risk of a conflict between the client's interests and those of the insurer seeking to enforce their rights under the policy. It may be that but for the obligation to recover medical or other subrogated costs, the claim would have more prospects of reaching a pragmatic settlement. It may even be the case that a settlement of a claim at a value less than the full amount the insurer might be contractually entitled to recover from the claimant, would expose them to a liability and a 'loss' despite the otherwise 'successful' conclusion of the claim.

The House of Lords in the case of *Lord Napier and Ettrick v Hunter* [1993] AC 713 summarised the principles with regards to an insurer's right when there has been some recovery from the insured in respect of the same loss and determined that the right of subrogation is fortified by the 'equitable lien' over the proceeds of the claim. It might therefore require a return to the Higher Courts to review the principles of an 'equitable lien' in order to argue that damages recovered by a claimant in respect of losses other than the insurers' outlay ought to be ringfenced from monies the claimant might otherwise need to use to repay his insurance provider.

Conclusions

- There is reasonable scope for the claimant to recover their costs and expenses arising out of private medical treatment, including appropriate complimentary or alternative therapies;
- Care should be taken to ensure that all properly recoverable private treatment costs are investigated and carefully set out within the claim;
- Except in the clearest of cases, evidence should be obtained to establish a causative link between the injuries sustained and treatment;
- The Claimant should address how they came to undergo such treatment, especially if it was recommended to them by a treating medic, and the benefits they actually derived from such treatment;
- Advisers are under a duty to check for any policies to ensure that any relevant outlay is included as part of the claim. Failure to do so may be deemed to be a potential breach of contract and subject the client to exposure to a personal liability;
- In most cases, it might be expected that the insurer with an outlay to recover would be keen to work 'with the policy holder' and an early dialogue might better set an agenda with the spirit of co-operation so that the insurer sits better as an allay than an enemy in such cases.

How Do We Assess Gratuitous Care?

SERJEANTS' INN

CHRISTOPHER HOUGH
SERJEANTS' INN

One of the forces behind this series of articles is the realisation that Counter Schedules have been introducing arguments which have been rejected by the courts, often many years ago, or were inconsistent with the courts' rationale.

I have found that there are renewed challenges to the assessment of gratuitous care. To give some recent examples:

– that visiting someone in Hospital isn't to be compensated (as the care is provided by the Hospital staff),

- the re-introduction of a "stopwatch" to calculate care provided,

- that night-time care should not be compensated at an aggregate rate (which is said not to be a concept paid in the private sector),

- that the care provided is not sufficiently serious to justify an award (relying on some obiter remarks in Mills v British Rail Engineering, a case decided in 1992).

These arguments have little merit. Even allowing for the games Defendants will play, and the principle that "nothing ventured, nothing gained", these are really aimed at achieving an undeserved discount on the appropriate level of damages. With that in mind, this article looks at how gratuitous care is assessed, and points to the very wide range of activities and support which have been held should be compensated.

Principles

The object of an award for gratuitous care is 'to enable the voluntary carer to receive proper recompense for his or her services' (*Hunt v Severs* 2004 AC). It is normally agreed that there is a "ceiling" on such awards, set by the commercial cost of providing care (*Housecroft v Burnett* 1986 1 ALLER 332). This sets a ceiling in the very unusual case of a person giving up a well paid job to care for a relative – they cannot recover their loss of earnings, but will be subject to a ceiling of the cost of commercial care (see *Woodrup v Nicol* [1993] PIQR).

But this article looks at what can be claimed. A good starting point is Brooke LJ's judgment in *Giambrone v JMC Holidays Ltd* [2004] EWCA Civ 2158 (a case involving food poisoning). Brooke LJ established the principle that the care to be compensated should include care which goes distinctly beyond that which is part of the ordinary regime of family life.

The court had been asked to conclude that cases of food poisoning were not serious enough to justify an award for care, relyiing upon the old case of *Mills v British Rail Engineering* (1992). Brooke LJ said (supported by his colleagues):

> *'I reject the contention that Mills presents any binding authority for the proposition that such awards are reserved for "very serious cases". This was not a point which had to be decided in Mills, which was on any showing a very serious case, and a proposition like this would be very difficult to police. Where is the borderline between the case in which no award is made at all (unless, for example, a working mother incurs actual cost in hiring someone to look after her sick child when she was at work) and the case in which a full award of reasonable recompense is made? An arbitrary dividing line, which would be likely to differ from case to case, and from judge to judge, would be likely to bring the law into disrepute ...*
>
> *In my judgment the judge was correct in principle to make an award for the cost of care in each of these cases. Anyone who has had responsibility for the care of a child with gastro-enteritis of the severity experienced by these children will know that they require care which goes distinctly beyond that which is part of the ordinary regime of family life. The fact that one of these mothers had a child who had suffered in this way on previous occasions provides no good reason for concluding that an award of some sort is not appropriate if there is an identifiable tortfeasor to blame'.*

In assessing what goes beyond the ordinary regime of family life, is that limited to the periods when actual care/ support is being offered (the "stopwatch" approach), or a more generous assessment of an availability to provide such care.

In *Evans v Pontypridd* Roofing Ltd [2001] EWCA 1657 the court rejected the stopwatch argument. Mr Evans needed not just physical care and physical assistance, but emotional support (for a very severe depression). The trial judge assessed the care at 24 hours per day. Those acting for the Defendant roofers went to the Court of Appeal arguing that the care claim should not include the emotional support, and that there should be no compensation for the periods when Mrs Evans was not providing support (for example, when she was asleep).

The key passages are in the judgement of May LJ who stated (paragraph 30):

> *'Any determination of the services for which the court has to assess proper recompense will obviously depend on the circumstances of each case. There will be many cases in which the care services provided will be limited to a few hours each day. The services should not exceed those which are properly determined to be care services consequent upon the claimant's injuries, but they do not, in my view, have to be limited in every case to a stop-watch calculation of actual nursing or physical assistance. Nor ... must they be limited in every case to care which is the subject of medical prescription. Persons, who need physical assistance for everything they do, do not literally receive that assistance during every minute of the day. But their condition may be so severe that the presence of a full time carer really is necessary to provide whatever assistance is necessary at whatever time unpredictably it is required. It is obviously necessary for judges to ensure that awards on this basis are properly justified on the facts, and not to be misled into findings that a gratuitous carer is undertaking full time care simply because they are for other reasons there all or most of the time.'*

This passage is very helpful in advising many partners/ spouses who feel trapped by their role as carer – unable to get on with their own lives, go out, maintain social interests and activities because they have to be "on hand just in case" the injured person needs their help. Such time can be compensated.

Specific Activities

Unless there is some pre-injury medical history indicating that such care was required in any event, it is usually agreed that actual physical care (helping with dressing, washing, bathing, transfers, cutting up food/feeding and so on), and support such as cooking, shopping and cleaning will be recovered.

What is clear (and not always agreed) is that the care to be compensated can go beyond these physical acts.

a. As the case of Evans shows, it can include offering emotional support, so frequently needed as the injured person comes to terms with their disability.

b. Painting, decorating, DIY, gardening and looking after the car (see for example Smith v East and North Hertfordshire Hospitals NHS Trust [2008] EWHC 2234.

c. Prompting and encouraging a brain-injured Claimant, and helping them to organise their affairs (appointments and finances).

d. Helping with the organisation of carers and treatment ("Case management") Massey v Tameside & Glossop Acute Services NHS Trust [2007] EWHC 317.

e. Providing care for others which would have been provided by the injured person Froggatt v Chesterfield & North Derbyshire Royal Hospital NHS Trust [2002] All ER (D) 218.

f. Attending at Hospital – see O'Brien v Harris (22 February 2001 QBD Pitchford J; Warrilow v Warrilow [2006] EWHC 801 Langstaff J, but not the conflicting case of Huntley v Simmonds [2009] EWHC 405 Underhill J.

The Hourly Rate

It has become conventional to use the Spine Point 8 of the National Joint Council rates. In many cases, the family member provides care during the night, at weekends, on Bank Holidays and so on. The court usually allow an enhanced "aggregate rate" rather than the flat rate to reflect this. For example, in a case called **Whiten v St George's Healthcare Trust** 2011 EWHC 2016, Mrs Justice Swift held:

> *From the beginning, the claimant has required a very high level of care by comparison with an uninjured child. That care has been required at all hours of the day and night. The levels of stress and exhaustion experienced by the claimant's parents as a result of the demands placed upon them are well documented*

in the evidence. When paid care was first introduced, it was available only on weekdays. It was not until April 2009 that the claimant's parents 2obtained some assistance with overnight and weekend care. Up to that time, they had been solely responsible for his care at those periods. Moreover, the claimant has always required one to one care. His needs are such that it is not possible to care for him whilst at the same time carrying out any other activity. I am quite satisfied therefore that, in the circumstances of this case, it is appropriate to value the gratuitous care given by the claimant's parents throughout the relevant period at the aggregate NJC rates ..

Although there are the odd case where enhanced rates are provided for Case Management (see, for example, Massey cited above), the courts have not looked at the actual costs of some of the more skilled aspects of care: it is obvious that one cannot find a competent counsellor/ therapist, or a builder at Spine Court 8 rates. One battle that has yet to be fought and won is for a much higher hourly rate for some of the more skilled caring activities.

Lessons From Paterson: The Need For Private Healthcare Providers to Have Skin in the Game

LAURENCE VICK
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The Paterson case highlighted multiple failures of governance, regulation and patient care at all levels in the NHS and private sector. In this article Consultant Solicitor Laurence Vick comments on the reaction to the Independent Inquiry report published on 4 February 2020 and the reforms needed in private healthcare if we are to avoid similar scandals in the future. There were crucial lessons for responsibility and accountability of private providers, with obvious implications for outsourcing of treatment by the NHS to the private sector.

I share the view of many commentators that the conventional contractual model - by which private hospitals and clinics provide what is effectively the package of care but escape legal liability and avoid responsibility if treatment fails – is flawed. Ultimately I don't believe we can be sure of our safety in the private sector until private hospitals are required to have 'skin in the game.' In short, as the Paterson scandal highlighted, they should have a stake in the outcome and be accountable for the care patients receive in their hospitals.

The background to the Paterson case.

Paterson was sentenced to 20 years imprisonment in 2017 on charges of wounding with intent and unlawful wounding. He had been allowed to perform unnecessary and inappropriate breast operations and other surgical procedures for at least 14 years until 2011, at Solihull Hospital (Heart of England NHS Foundation Trust) and in the private sector at Spire's Solihull Parkway and Little Aston hospitals which had granted him practising privileges. The numbers are substantial; he had carried out 6600 operations at the Spire hospitals and 4400 in the NHS, including 'procedures on children.

The James Review considered a wide range of issues including responsibility for the quality of care and the appraisal and validation of staff working in the private sector, information-sharing between the private sector and the NHS, the role of insurers of private providers and the level of medical indemnity cover doctors working in the independent sector are expected to hold.

The Rt. Reverend James in his hard-hitting report said patients had been "let down over many years" by the NHS and independent providers; there had been a "culture of avoidance and denial" in a "dysfunctional healthcare system that had failed patients at almost every level" and had allowed these operations to take place in "plain sight." This was yet another scandal in which whistleblowers had been silenced or suppressed, at great cost to the patients whose terrible suffering might have been avoided or significantly reduced had colleagues in the NHS and at the Spire hospitals felt able to raise concerns without fear of retribution.

Spire and other private provides carry out a significant amount of work for the NHS. There have long been concerns over the lack of transparency in the private health sector and the culture of secrecy that seems to prevail when the NHS outsources treatment to can often turn out to be inadequately vetted private hospitals and clinics and gaps in the supervision and monitoring of those contracts when in progress. Much of the care provided by private providers is of the highest standard but as they are beyond the reach of a Freedom of Information request and have relied in the past on commercial confidentiality to refuse to disclose information and data how do we assess this and compare outcomes and safety standards in the two sectors? How do we check whether the private hospital has appropriate facilities and resources for the treatment we are to undergo and the ability to cope with complications that can occur with any kind of medical procedure?

These issues need to be addressed otherwise we will lose the advances of recent years in the consent process before treatment and the duty of candour required if treatment has failed and the patient has suffered harm. Paterson's NHS and private operations pre-dated the introduction of the duty of candour but what could patients expect from

this obligation on healthcare providers if the treatment had taken place today?

In their response to the report, AvMA welcomed the findings of the review but warned that it did not go far enough in providing clarity over responsibility and accountability for failed treatment in the sector. AvMA wish to see a number of checks and balances: regular audits and the same level of supervision of staff as occurs in the NHS, a single robust complaints procedure for patients receiving private treatment with the right to appeal to an ombudsman or equivalent and a funded independent advice service, and a statutory requirement for private health organisations to take responsibility and provide indemnity for patients receiving negligent treatment in their hospitals.

Lack of liaison between the NHS and private sector

The emerging scandal revealed a worrying lack of liaison between the two sectors. Large numbers of both NHS and private Paterson patients had not been contacted and followed up by the Trust or Spire. The report found that the number of patients subjected to unnecessary treatment could run to more than 1000 and no less than 11,000 patients in both sectors are to be recalled and have their treatment assessed. These investigations will involve significant input from medical experts and lawyers for the NHS and together with claims brought by patients found to have been harmed by Paterson will result in enormous expense – expense which could have been avoided had steps been taken to halt Paterson and his dangerous activities. It was also announced that West Midlands Police had referred 23 fatal cases of Paterson patients who had since died of breast cancer to the Coroner in Birmingham.

Although NHS Resolution paid out £17 million to settle the claims of Paterson's known NHS victims, many obstacles were placed in the way of his private patients in their battle for compensation. Spire maintained in the separate court proceedings brought by his private surgery victims that they had relied on the NHS to vet his competence and warn them of any concerns over his abilities. Prior to the eventual settlement of the court action Spire were reported to have sued the NHS Trust for failing to warn them of his dangerous practices: a tactical move to blur lines of responsibility perhaps but surely a damaging position for a private health care provider to adopt.

Implications for outsourcing by the NHS to the private sector

Of the 211 patients who gave evidence to the Inquiry, 92 were private patients treated at the two Spire hospitals and 5 were NHS patients treated by Spire at those hospitals. Although only a small proportion of Paterson's private operations were funded by the NHS, the scandal provides a window into the private sector to which the NHS is currently proposing a substantial increase in outsourcing, particularly of elective procedures.

Prior to this year's COVID-19 outbreak the data indicated that a third of all hip replacements, cataract and other ophthalmic procedures are carried out in the private sector. The NHS was contracting out a fifth of its total healthcare budget, equivalent to more than £20 billion a year. Spire's NHS referrals nationally accounted for a third of its annual revenues. Nearly a quarter of their activity at the Solihull and Little Aston hospitals is funded by the NHS.

I don't personally believe that we are heading for full-scale privatisation of the NHS. There must be a doubt over the private sector's appetite for taking over and accepting the operating risk and indemnity cost of running a full-service hospital, maternity unit or A & E department after Circle's experience of running Hinchingbrooke NHS hospital for 3 years up to 2015. Leaving aside the long-term political considerations of this increasing trend to outsource treatment, the result is a blurring of lines of responsibility and accountability which in some places leads to concerns over gaps in safety where the two sectors overlap.

There is no national system for monitoring the care provided to NHS patients treated in the private sector. My concern, on which I've written articles published by CHPI and other journals, relates to the safety issues and the fear that private providers are not adequately vetted and NHS contracts are not adequately monitored when in progress. Local NHS management may not be in a position to intervene swiftly if problems occur and it can be difficult to establish who within the NHS has overall responsibility at the highest level for the safety of outsourced care. It is reasonable to assume that standards will be at least as good as those which the patient can expect in the NHS.

Whereas NHS hospitals treat patients of all ages with the full range of medical conditions, illnesses and diseases, private hospitals carrying out outsourced work for the NHS can effectively 'cherry pick' the most profitable, usually low-risk, forms of treatment that can be delivered at a predictable cost. This should present no difficulty

for surgeons and their teams but problems can and do occur. There should be few if any complications, so the 50% complication rate – attributed in a subsequent investigation to not one but to a 'constellation' of failures – only four days in to the outsourcing contract for cataract procedures carried out by Vanguard Health in 2014 for the Musgrove NHS Trust in Taunton was alarming. One of my clients lost his sight. The investigation also exposed a complex chain of sub-contracting whereby three companies provided various elements of the outsourced service: Vanguard as main contractor, The Practice PLC supplying the surgeons, and Kestrel Ltd the equipment. Unless each organisation in the chain of care providers is checked there is an inevitable risk of patient harm and expense to the NHS (which they never seem to be able to recover).

The "flawed" legal structure

The contract for undertaking private treatment in the private sector (with no element of outsourcing) is between the patient and the consultant or surgeon, with a separate contract between the patient and the hospital for the use of the hospital's facilities and services. Spire refused to accept responsibility for compensating Paterson's private patients, relying on the limited scope of a private hospital's liability in line with this traditional formulation of the private hospital/surgeon/patient relationship.

Paterson's private patients had been unable to recover compensation from Paterson personally and his professional indemnity insurers had refused to meet claims on his behalf maintaining that cover is discretionary and there was no requirement to indemnify him by reason of his criminal acts.

The liability position of private hospitals would have been tested and no doubt clarified had the trial listed for hearing in 2017 gone ahead. It is entirely possible that Spire and their insurers bowed to the inevitable and agreed to pay £27.2m into a fund to compensate 750 of Paterson's private patients, simply to avoid a precedent being set. The total compensation paid to patients as a consequence of Paterson's treatment is equivalent to an average of £49,600 for each private patient – this takes into account the £27.2M paid by Spire, a further £10m provided by Paterson's insurers and the total cost of the compensation paid by the NHS. His NHS patients had already received an average £62,815 per patient. Neither the NHS nor Spire have admitted liability.

Is it such a stretch for a court to find that private providers owe a duty of care to the patient? The claim against Spire had been put in terms of vicarious liability and breach of a non-delegable duty of care to their private hospital patients, such that they were liable for Paterson's acts and omissions.

Many patients are drawn to private healthcare providers through their on-line advertising. The review confirmed that as at 2019 the information on Spire's website was misleading as it gave the impression the treating consultants are employed by Spire and that Spire were therefore responsible for those consultants and their actions. Spire's advertising stated that they ***"employ the best and brightest consultants"*** whereas the patient terms and conditions stated that consultants were independent contractors and not employees.

Looking at the on-line advertising after publication of the report, patients are asked to give feedback on the experience Spire has provided. The website stated ***"we're a trusted healthcare provider delivering outstanding patient care" "Our consultants: find out about our experts and the treatments we provide at a Spire hospital near you" "You can expect outstanding care from our expert consultants and dedicated nurses" (to GPs) "Your patient will see the same consultant at every appointment"***

Does the caselaw on vicarious liability help us?

The judgments of the Supreme Court in Barclays Bank Plc v Various Claimants and WM Morrisons Supermarkets Plc v Various Claimants were handed down on 1 April 2020; the decisions may initially be viewed as a set-back in establishing whether a private hospital might be liable for negligent care caused by a healthcare profession authorised to provide treatment there. However, it is important to note that these two supreme court cases were decided on their own particular facts and those facts are not directly analogous to the Paterson case.

Barclays Bank plc v Various Claimants [2020] UKSC 13

The case concerned the activities of a doctor and the extent to which he was acting an "independent contractor" when carrying out medical examinations of existing and future Barclays employees. The examinations took place at the doctor's home and he was paid a set fee by the bank for each examination. He was also employed on a part time basis by the NHS and held his own indemnity cover. The doctor died in 2009 but a police enquiry in

2013 revealed evidence of sexual assaults during these examinations, and no less than 126 victims brought claims against the bank.

The Court of Appeal upheld the original decision which found Barclays to be vicariously liable for the sexual assaults committed by the doctor, an independent contractor. The examinations were for the benefit of the bank and were an integral part of their business activity. The arrangements made by the bank exposed employees to the risk of harm and employees had no choice but to agree to the examinations.

The Supreme Court overturned the Court of Appeal decision and found that Barclays were not vicariously liable for the actions of the doctor who had been carrying out an independent business as an independent contractor. The Supreme Court had to consider whether the relationship between the bank and the doctor was such that it would be proper for the law to impose a duty on the bank to bear responsibility for the doctor's actions.

A number of recent cases demonstrate that where certain "incidents" are present non-employment relationships may give rise to vicarious liability on the basis that the relationship is ***"akin to that between an employer and an employee"*** Not all factors carry the same weight and it is open to the court to give different weight to each incident depending on the facts of the case. Vicarious liability does not extend to those running recognisably independent businesses of their own. This was the approach taken by the Supreme Court which emphasised that what is required is a careful consideration of the details of the relationship. An examination has to be undertaken to establish whether the contractor is *"effectively part and parcel of the employer's business"*.

Having regard to the case law and the principles by which vicarious liability for contractors can be established, Lady Hale said: **"the question therefore is, as it has always been, whether the tortfeasor is carrying on business on his own account or whether he is in a relationship akin to employment with the defendant."**

A detailed examination of the true nature of the relationship is required. Is the doctor (in the context with which we are concerned) truly carrying on a business on his or her own account or is the relationship more truly akin to an employment contract?

VM Morrisons Supermarkets Plc v Various Claimants (2020)

The Morrisons case involved a disgruntled senior IT employee who leaked personal data of a large number of employees on the internet after he had been reprimanded by the company. He was prosecuted for his criminal acts. A group of employees sued Morrisons for breach of data protection laws, misuse of private information and breach of confidence. The Court of Appeal upheld the first instance decision that the company was liable for the employee's actions on the basis there was sufficient connection between the wrongdoing and the nature of his employment, regardless of motive.

The Supreme Court overturned the decision and found that the company was not vicariously liable for the employee's actions. The relevant principle in establishing vicarious liability is whether the employee (however misguided) is furthering his or her employer's business or is engaged solely in pursuing his or her own interests. The employee in this case had not been authorised to make these disclosures.

Although both Supreme Court decisions show that the courts currently have little appetite to expand the concept of vicarious liability, the circumstances that arose and were allowed to continue in the Paterson case suggest that a court may well arrive at a different conclusion. The existence of a non-delegable duty of care owed to a private patient needs to be tested and hopefully it will not be long before the right case emerges.

Concerns over transparency and governance

The President of the Royal College of Surgeons Derek Alderson commented in a BBC Panorama interview on 16 October 2017 that private hospitals are not reporting enough data on patient outcomes: ***'We don't know exactly what's going on in the private sector... It cannot be as robust or as safe as the NHS at the moment for the simple reason that you do not have complete reporting of all patients who are treated... It's not good enough. Things have to change.'*** The RCS recommended that private hospitals must be required to participate in clinical audits as a condition of registration by the CQC and forced to report similar patient safety data including 'never events,' unexpected deaths and serious injuries as required of NHS hospitals.

Facilities and safety in the private sector

In October 2017, Centre for Health and the Public Interest (CHPI) published their report **'No safety without liability: reforming private hospitals in England after the Ian Paterson scandal'** the CHPI thinktank made a number of key recommendations: private providers should directly employ the surgeons and other consultants who work in their hospitals; private hospitals will not be safe unless

they have adequate intensive care facilities to deal with post-operative emergencies, avoiding what can be the hazardous transfer of patients to NHS hospitals. CHPI had previously noted in their 2016 report '**Privatisation and independent sector provision of NHS healthcare'** that private providers without the necessary facilities rely on the NHS as a safety net – reducing expense for the private hospital but at substantial cost to the NHS.

In the interests of transparency and the need for a valid consent, patients should surely be informed of any shortcomings in the facilities available to a private hospital or clinic so they can make an informed choice between NHS or private care.

The report called on the government to address the safety and governance issues: patients should be ***"made aware of the risks of private hospital treatment."*** The problem is that with a private sector adept at marketing but not noted for its transparency or openness obtaining meaningful information about those risks, and being in a position to understand and evaluate them can be extremely difficult. Some of the risks patients face in the private sector are much greater than the risks they would encounter if they were undergoing the same procedure in the NHS.

The report's recommendation that individual surgeons should publish their record and experience on a website is too simplistic. The patient needs to be warned of any shortcomings in the hospital's facilities, or the support available to the surgeon, and how this might impact on any complications he might suffer.

Whistleblowing

It was impossible to believe when the scandal was first reported that there would not have been employees at Spire as well as in the NHS hospital who knew of Paterson's dangerous practices and who either raised concerns which were suppressed or ignored by senior colleagues and managers or were prevented from doing so or worse, who turned a blind eye to his activities. The review found that Paterson's NHS colleagues were ***"genuinely fearful of the consequences"***. Concerns had been raised by medical staff at Solihull Hospital in 2003 and it transpired that a number of those staff reported having been subjected to bullying and aggression after voicing concerns. Difficulties with acting on those concerns were compounded when the NHS Trust decided they needed to prioritise Paterson's right to confidentiality as an employee and therefore dealt with those concerns ***"under HR processes and not as a patient safety issue,"*** The report found that this was a key failing which allowed Paterson to ***"hide in plain sight"*** for more than two decades until his eventual suspension in 2011.

Although the report found clear failings in the way the NHS managed complaints about Paterson, it is worth remembering that by contrast we don't have a full picture of what attempts if any, were made by Paterson's colleagues at the private hospitals to raise the alarm.

Continuing concerns over governance

Shortly after the Paterson Inquiry report was published in February 2020, Spire announced that they had launched another investigation into another surgeon, Mr Michael Walsh who had undertaken surgery at their hospital in Leeds between 2012 and 2018. Mr Walsh, a specialist shoulder surgeon, was suspended and had been reported to the GMC by Spire in April 2018. Lightning had struck twice in the same place for Spire with reports in January 2020 that they had already been forced to launch yet another review, this time involving care received by 217 patients of orthopaedic consultant Mr Habib Rahman. The review into Mr Rahman's care concerned ***"unnecessary or inappropriate"*** shoulder operations performed at the Spire Parkway, Solihull hospital – the same hospital where Paterson had operated. Spire said they had restricted Rahman from practising at their hospital in September 2018 and suspended him in January 2019; Spire had asked the Royal College of Surgeons to review his practice and they were liaising with the CQC and the GMC over the RCS' findings. Meanwhile Mr Rahman is still employed by his NHS Trust which says they have not been required to recall any of his patients but they have subjected him to "interim conditions."

Spire commented in the press that the financial impact of the Rahman review on their business would be immaterial as any claims would be met by Rahman and his insurers. This reliance on the traditional private health model again demonstrates how it is too easy for the private sector to avoid responsibility. The Investors Chronicle reported on 6 March 2020 under the heading "Spire haunted by clinical issues" however that Spire had suffered reputational damage "which could stunt (their) ability to benefit from capacity constraints in the NHS."

Concerns were also reported in the press over a shoulder procedure carried out at the same Solihull Parkway Hospital by consultant orthopaedic surgeon Amir Salama. A letter in July 2019 from the Spire hospital director to the patient said independent specialists had found ***"very little clinical or radiological justification"*** for the operation.

A Spire spokesman said: "As part of our robust oversight and governance, we continuously review consultants' practice and occasionally contact individual patients about their care if there is a concern." The company said that as "a responsible healthcare business", there would "inevitably be reviews... In this instance, following a complaint by one patient, we undertook a wider review of this consultant's practice and have been in contact with one further patient to follow-up their care." "We can confirm that we have not undertaken a recall involving this consultant's patients and that we have no reason to do so at this time"

This appears to have been dealt with appropriately by Spire but this does beg the question: If a private provider such as Spire is in a position to grant and if necessary withdraw a Consultant's practising privileges and conduct full reviews into the care a patient/patients has received from a particular consultant, might this action alone be interpreted as assuming a measure of responsibility for that treatment?

Conclusion

If private providers are able to avoid legal responsibility for the actions of doctors working on their premises, alongside their staff and using their equipment the risk is they will continue to regard themselves as untouchable and will lack the incentive to monitor the activities going on in their hospitals. The reputation and profile of the individual doctor or surgeon carrying out the treatment inevitably play a key part in enabling a private hospital to make a profit. A further point is that private hospitals often provide treatment carried out by doctors who also work as NHS doctors - surely they should not be able to argue, as appears to have been Spire's reported intention, that it is the responsibility of the NHS and not the private hospital to vet those doctors. Public policy dictates that the private sector should be accountable directly to the patient for the treatment carried out in their hospitals. Private hospitals can readily obtain insurance to cover their liabilities. It cannot be acceptable for an injured patient to be exposed to the vagaries of a doctor's defence organisation who have a discretion to refuse to meet a claim, as occurred in Paterson. If a private provider has a remedy against the surgeon carrying out treatment in their hospital, let them pursue it. Where treatment has been outsourced by the NHS to the private sector, similarly the NHS should not be out of pocket if patients receive negligent care.

Inquiries in one form or another have proliferated and have become the inevitable and entirely understandable response from the government to the many scandals that have emerged in recent years. Patients and families, though, want more than catharsis. As well as the opportunity to tell their stories and be heard, they want to be reassured that issues will be fully investigated, with all relevant individuals and organisations called to give evidence and account for their actions or inactions. Above all, they want to see that positive changes will made and that lessons really will have been learned to ensure that their experiences and suffering will not be repeated. The government's response to the Paterson review with, if necessary, legislation to address the fundamental flaws in the private health care model cannot come too soon.

Will COVID reshape how we look at standard of care during crises?

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On 23 March 2020 the UK entered into uncharted waters. The Prime Minister addressed the nation in sombre tones, as he announced that we would be entering into a period of unprecedented lockdown. The use of the adjective "unprecedented" went into overdrive. These were, and remain, unprecedented times. We continue to have unprecedented restrictions on our day-to-day lives. The National Health Service faced unprecedented demands in, what now appears to have been, the first wave. Whilst arguably in better preparedness, winter pressures and rising case numbers will stretch the NHS's capacity and resources even further in the months to come.

A necessary response to the COVID-19 pandemic has been the NHS putting in place a plethora of new processes in order to cope with a surge in demand. Whilst some, for example the Nightingale Hospitals, have not been fully utilised, they remain an important reserve should the number of cases reach a tipping point.

However, one commonplace measure during the first wave was the redeployment of clinicians outside their normal scope of practice. In addition, retired practitioners returned to the workforce and final year medical students were fast tracked through the end of their studies. Such re-enforcement of troops is likely to be required again if a significant second wave occurs.

In 2018/19, 10,678 new clinical negligence claims were received by NHS Resolution. The value of those claims totalled £4.9 billion. It is inevitable that, during this crisis, clinicians will continue to be stretched and mistakes will be made. T**he Coronavirus Act 2020** evidently has this in mind, and addresses the issue of indemnity for health service activity at sections 11 to 13.

Given the unique nature of this crisis, as and when such claims come before the courts, a fundamental question is whether or not the current situation gives rise to a lower standard of care.

The law as it stands excludes the experience of a clinician when establishing the legal standard of care. The test is an objective one. The individual medical practitioner is judged by the standard of a reasonable doctor, skilled in that particular specialty. Thus, for example, a general practitioner must act as a reasonable GP, and a neurosurgeon as a reasonable neurosurgeon.

This principle was underscored in the case of **FB (Suing by Her Mother and Litigation Friend (WAC) v Princess Alexandra Hospital NHS Trust [2017] EWCA Civ 334**. The one year old FB was brought by ambulance, accompanied by her mother, to the Emergency Department of Princess Alexandra Hospital suffering with a high temperature, erratic breathing and eye rolling. She was assessed by a Senior House Officer ("SHO"), Dr R, who diagnosed her with a respiratory tract infection and discharged her home. Dr R did not specifically ask why FB's mother had brought her to hospital nor whether there were any signs of eye rolling. FB's condition continued to deteriorate at home. She was re-admitted under the Trust's Paediatric Service, and antibiotic therapy commenced. A fortnight later FB was transferred to Great Ormond Street London and diagnosed with pneumococcal meningitis causing multiple cerebral infarcts and, sadly, permanent brain damage. A claim was brought against both FB's GP and the Defendant Trust.

At first instance, Jay J dismissed both claims. He found that, whilst a Consultant Emergency Physician or Paediatrician would have detected the subtle signs of abnormal state variation exhibited by FB and/or elicited further information as to the reason for FB's hospital attendance, Dr R had not failed in her duty of care by not adducing such a history.

The case against the Defendant Trust was appealed in relation to whether Dr R had failed to take an adequate history or conduct an adequate examination. It was argued that Jay J had erred in his application of the standard of care when addressing the issue of obtaining a satisfactory history and had conflated the distinct issues of clinical examination and history taking. Whilst in the case of the former the clinical signs were subtle and the ability to identify them required experience, the ability to ask pertinent questions when obtaining a history was not

predicated upon having a vast number of years of clinical experience and was well within the purview of an SHO.

Thirwell LJ gave the Court of Appeal's main judgment, with which King LJ and Jackson LJ agreed. The key question was whether Dr R's failure to elicit why FB's mother had brought her to hospital was a breach of duty. On this, Jay J had erred in the first instance judgment, as the reason for a child to attend the Emergency Department was a basic tenet of history taking. Unlike detecting subtle clinical signs, which required greater experience, Jay J was wrong to conclude that there was a lower standard of care for an SHO taking a history than a consultant or registrar.

In adding to Thirwell LJ's judgment, Jackson LJ reminded the Court of the foundational cases of *Bolam v Friern Hospital Management Committee* [1957] 1 WLR 582 and **Wilsher v Essex AHA [1987] 1 QB 730**. It was incumbent upon Dr R to exercise the skill and care of a reasonably competent doctor working as a SHO in the Emergency Department. The Lord Justices were unanimous in their decision that Dr R had failed in her duty of care when taking a history from FB's parents. It was insufficient for Dr R to assume FB's parents would volunteer information and it was a basic requirement of history taking to clarify why the hospital attendance had occurred.

The case of *Pope v NHS Commissioning Board* [2015] (unreported), which concerned a clinical negligence claim arising out of the H1N1 (Swine Flu) pandemic, provides some guidance as to how courts may consider claims arising in exceptional times. A patient attended her local health centre concerned that she had contracted H1N1. She was reassured and advised to return home and rest. The experienced member of nursing staff who saw her did not follow the national guidance on the management of potential H1N1 cases. The patient was subsequently admitted to the Emergency Department, and sadly suffered a cardiac pulmonary arrest resulting in profound brain damage. The Court found that the defendant, through its employee nurse, had breached their duty of care resulting in the claimant's catastrophic brain injury.

Conversely however, the case of **Mullholland v Medway NHS Foundation Trust [2015] EWHC 268 (QB)** suggests an alternative judicial approach in determining the appropriate standard of care. The claimant, subsequently diagnosed with a cerebral tumour, had not been assessed by the Emergency Department clinicians as meriting an immediate CT scan, such that the tumour was not diagnosed until 7 months later. However, taking into consideration the pressures and manner of work, the High Court found that there was no breach of duty of care by the Emergency Department physicians. The judgment noted that the standard of care "*must be calibrated in a manner reflecting reality*".

The reality now is that clinical challenges brought about by the COVID-19 pandemic are clearly not confined to those related to its treatment alone. A real challenge for the courts will be tackling the issue of specialist clinicians, normally practising in areas entirely unrelated to respiratory disorders, who are placed on the coronavirus front line. Take a consultant surgeon, whose operating lists have been suspended in light of the pandemic, who is asked to oversee a COVID-19 ward. What then of the objective standard?

Proceedings arising out of alleged negligence, whether directly or indirectly as a result of COVID-19, where care has been adversely affected by organisational restructuring and redeployment of staff and resources, have already started to emerge. Only time will reveal the precise approach that the courts will adopt. Each case will of course be fact specific and the importance of adhering to clinical protocols will be an important element. It would appear that, as set out in Pope, the starting point will remain whether a reasonable body of medical practitioners would have acted in the same way. However, the judgment in *Mulholland* will inevitably influence the analysis of the factual matrix when assessing the realities of the clinical working environment.

Indeed, from a regulatory perspective, the General Medical Council has already given express reassurances that the exceptionally challenging clinical environment will be taken into account when concerns are raised regarding a medical practitioner. Looking towards the clinical negligence field, the medical defence organisations are gearing up to deal with the aftermath of this pandemic. Once the dust has settled, it will be important also to have a clear steer from the judiciary as to how these cases will be approached and determined.

Dr Neil Shastri-Hurst is a member of the Clinical Negligence Group at No5 Chambers, of which Chris Bright QC is Head. Neil, like many others, returned to the clinical coalface during the pandemic.

Why defendant's actions and attitudes need to change prior to any implementation of fixed recoverable costs.

SARAH STOCKER
TEES

The Department of Health are seeking to implement fixed recoverable costs in lower value clinical negligence claims. Lower value is currently understood to be cases where compensation awarded is less than £25,000. The Department of Health is looking to bring in fixed recoverable costs citing the argument that "a significant (36%) part of the cost of clinical negligence claims against the NHS relates directly to the cost of litigation in claimant and defence costs. For claims under £25,000, claimant recoverable legal costs are on average 220% of damages awarded."

As a Clinical Negligence Solicitor, I am acutely aware of the concept of proportionality and that costs recovered should be in line with the level of damages recovered. However, I find it frustrating that so few cases are resolved during the Pre-Action Protocol phase and we are forced into unnecessarily issuing proceedings in order to resolve a case.

I want to highlight a case from my own caseload, where the Defendant's conduct and actions were directly responsible for both disproportionate and unnecessary costs.

Case Example: (Case and Costs Settled)

ZZ developed a maternal pressure ulcer on her buttock following the birth of her daughter by caesarean section at an NHS Trust in England. In order to save costs, a Letter of Claim was prepared without expert evidence based on the facts within the medical records and review of NHS Resolution's "did you know? Maternity pressure ulcers" which included statistics on frequency of sores types, the most common location of a sore was on the buttock[1] , and the common theme that all women had received an epidural. In the Letter of Response, the Defendant denied liability, citing that a pressure ulcer only develops at a bony prominence and therefore the Claimant could not have developed a pressure ulcer on her buttock.

A supplemental letter was sent by the Claimant to the Defendant with photographic evidence of the residual scarring and a Part 36 offer of £7,500. The Defendant rejected the Part 36 offer, refused to engage in ADR and refused a limitation extension.

The Claimant had to formally instruct a Tissue Viability Nurse Expert to report on liability. In an attempt to avoid the costs associated with issuing proceedings, the Claimant proposed mutual exchange of our liability evidence, however, the Defendant maintained their position.

The Claimant proceeded to have a conference with Counsel and the Tissue Viability Expert and arrange for a Condition and Prognosis report to be prepared for issue of proceedings. Proceedings were Issued and Served on the Defendant, including reference to NHS Resolution's paper on maternity pressure ulcers. The Defence denied liability.

When filing the parties' Directions Questionnaires, the Defendant finally agreed to seek instructions on ADR and a 1 month stay of proceedings was agreed. The Claimant duly proposed a mediator and obtained dates of availability from the Claimant. At the end of the month, the Defendant stated they were without instructions and so a further 2 month stay was agreed and Ordered. The Defendant failed to respond to subsequent communications regarding ADR and the Claimant wrote to the Court to lift the stay. The Defendant later advised that subject to their client's approval they would be making a Part 36 offer of £5,000 to settle the claim. The Part 36 offer from the Defendant never materialised and so the Claimant sought instructions and made the proposed offer on a Part 36 basis.

1 *"From 1 April 2000 to 31 March 2018 NHS Resolution received 96 claims relating to pressure ulcers suffered by women in maternity units. Of these, 87 claims were awarded compensation... Frequency of sores type: 84 buttocks, 8 sacral area, 9 heels, 2 thigh, 18 no site indicated."*

The Claim settled for £5,000.

At the time the Claimant had made their initial offer of £7,500, the costs were approximately £7,500, with no disbursements. When the claim eventually settled 22 months later, the costs were significantly higher.

The bill was served including a detailed narrative setting out the Defendant's conduct throughout the litigation. No points of dispute were received from the Defendant and costs were settled for £43,500 (including recoverable ATE insurance premium and costs draftsman's fees).

The Defendant's behaviour was not only frustrating for my client, but as a tax payer, I find it wholly unacceptable to see such waste of public funds.

I am concerned that if these are the actions of a Defendant who was faced with the prospect of paying the totality of the Claimant's costs, what stance will be taken when fixed fees are brought in? Will there be more of these tactics taken by Defendants to frustrate the process and potentially put Claimant Solicitors off accepting instructions on such claims in the first place?

It is the responsibility of both parties to act in a way that is proportionate, if Claimant's are to be subject to fixed costs, then I would suggest that the conduct of the Defendant should be considered following settlement of a case to see if there is a reason to depart from fixed costs.

Belsner v CAM Legal Services

GED COURTNEY
KAIN KNIGHT

On Friday 16th October, late in the afternoon the Court handed down judgment in a decision that we'd been waiting some time for. It was hoped that the appeal in *Belsner v CAM Legal Services Limited [2020] EWHC 2755 (QB)* would bring about a degree of certainty to firms of solicitors involved in disputes with their former clients, but in some ways it raises just as many questions as it answers.

Ms Belsner sustained injuries when she was knocked off a motorcycle on which she was a passenger. This sort of matter was fairly typical of the work undertaken by the Defendant and the matter proceeded through the RTA Portal. The claim settled following the submission of a stage two settlement pack for the sum of £1,916.98. At the conclusion of the case, the Defendant retained £385.50 of the Claimant's damages (just over 20%) towards the fees they'd incurred. Ordinarily this is where matters come to an end.

Sometime later, the Defendant received correspondence from the Claimant's new legal representative. The Claimant asked for a Final Statute Bill (one having not been sent) and one was provided. The Bill set out the work done on the case and the fees payable in line with the agreed retainer. Whilst the Defendant's retainer set out that their client was liable for all unrecovered basic charges, they set a bill that capped the shortfall and success fee to the £385.50 taken previously. This meant that the Defendant had accepted the sums recovered from the other side and £385.50 in full and final settlement of their Bill. The Claimant remained of the view the charges were unreasonably high and brought a challenge in the Sheffield District Registry.

An idiosyncrasy of the directions in such matters in Sheffield resulted in the Judge initially assessing the Bill on paper. On paper he agreed with the Claimant that the success fee was too high at 100% and reduced it down to 15%. He also accepted the submission of the Claimant, that the basic charges should be restricted to the sums recovered from the other side due to an absence of an express agreement to charge more. When arriving at this conclusion he referred to s. 74(3) of Solicitors Act 1974 and CPR 46.9(2). The effect of this was that the success fee was calculated at 15% of the £500.00 fixed profit costs recovered as opposed to the profit costs calculated on an hourly rate. The Judge ordered the Defendant to repay the majority of the sums deducted from the Claimant's damages. The Defendant was not content with the findings and asked the judge to revisit his decision with the benefit of oral submissions.

At the subsequent hearing, the Judge, with the benefit of the papers and further submissions, overturned his earlier paper decision. He found as follows:

"The next issue for the court to determine is what do the words "written agreement" mean in 46.9(2) and whether the court should import in that paragraph that there must be sufficient information given to the contracting non-legal party, in other words the potential Claimant, in order to make an informed decision. It is submitted on behalf of the solicitors, the Defendant in this case, that it is sufficient that there is a written agreement and that that written agreement is sufficiently clear giving the solicitors the right to recover more than the costs recovered from the other side, and that the words of the terms and conditions of business and CFA are sufficiently clear to allow this to happen. It is said on behalf of the Claimant that there must be more information given in terms really that the client in order to give express permission must have enough information in order to balance up and have knowledge of the likely liability, for example, between fixed costs that might be recoverable as against the estimate of costs. I think that is setting the bar too high and I think it is trying to read in to 46.9(2) something that is not there. I think the court is entitled to look at the agreement, to make sure that it contains sufficient certainty and sufficient clarity so that the Claimant entering into the agreement knows full well that there is a potential liability for further costs over and above those which are recovered by the solicitors from the other side. I was initially troubled by paragraph 19, which is page 3 of the bundle of the terms and conditions which simply reserve the right to charge actual costs, taking into account recoverable costs, and

in my view if that was all there was that might have been uncertain in relation to express terms of the agreement, but I am satisfied, because I have been referred to other contractual provisions, particularly at page 28 para 19, page 19 (inaudible) of recovery that it is clear enough that entering into this agreement the solicitors will seek to recover the shortfall between their costs and the costs recovered from the other side. I think to import informed consent places the burden too high. It simply has to be an express term and an express term is a term that is clearly set out in the agreement and about which there can be no doubt and I am satisfied that this documentation meets that test."

The Claimant appealed the Judge's decision. In the Grounds of Appeal the Claimant pointed to the fiduciary nature of the relationship between solicitors and lay clients and argued that in order to satisfy the requirement of CPR 46.9(2), it wasn't good enough for the materials to simply say that the Claimant was liable for unrecovered costs. To meet the threshold in the rule, the Claimant's legal representative said that the solicitor must have the informed consent of their client. Moreover, that informed consent could only be obtained where solicitors advise the client as to the likely recovery in costs from a third party.

The appeal was heard in May 2020 but for a variety of reasons judgement was not handed down until October 2020. In his judgement, Lavender J found for the Claimant. He was of the view that the Defendant had not done enough so as to meet the requirements of CPR 46.9(2). His reasons for arriving at this decision fall broadly into three categories:

Informed consent

Contrary to the findings of District Judge Bellamy at first instance, Lavender J felt that informed consent was a requirement if the Solicitor were to rely on CPR 46.9(2). He opined that this did not arise from the wording of the rules, but by virtue of the fiduciary relationship between the solicitor and their client. At para 68, he said;

"I do not consider that this appeal can be determined by a simple comparison between the wording of CPR 46.9(2) and (3). The requirement for informed consent which applies in cases under CPR 46.9(3) does not arise because of the use of the word "approval" rather than the word "agreement". The requirement for informed consent arises because of the fiduciary nature of the relationship."

Adequacy of Disclosure

Having found that informed consent was required, the Judge then put his mind to what would be required to obtain it. Three scenarios were considered at para 71;

"The key question in this case is therefore whether the Defendant made sufficient disclosure to the Claimant for the purposes of section 74(3) and CPR 46.9(2). There were, broadly, three possibilities which were given canvassed in argument. At one extreme, neither party suggested that a solicitor is obliged to give a detailed and comprehensive explanation of the provisions of the Civil Procedure Rules and the Protocol concerning fixed costs. On the other hand, the Defendant's position was, in effect, that it is sufficient for a solicitor to disclose to the client that the agreement permits payment to the solicitor of an amount of costs greater than that which the client could have recovered from another party to the proceedings, without giving any detail as to what the limits are on such recovery. In between was the position contended for by Mr Kirby, which was that the solicitor was obliged to give some indication of what the limit on recovery might be."

In the retainer documents the Court considered, the Defendant had made it clear that the Claimant was responsible for the shortfall in basic charges. What concerned the Judge, however, was the absence of any indication given to the Claimant as to likely recovery from the third party. He observed that if the Defendant had sought to enforce their entitlement to charge as set out in the retainer, the Claimant would have only been left with 31% of her damages. Without knowledge of the likely recovery, the Claimant was not able to protect their position by seeking to agree a cap with her lawyers, or seeking to instruct other lawyers who would cap their fees. At para 85 Lavender J said;

"If it had been pointed out to the Claimant that, while the Defendant's estimate of costs was £2,500 plus VAT, she might recover only £500 or £550 plus VAT from the Insurers, then that may have affected the Claimant's consent to the agreement between them insofar as it permitted payment to the Defendant of an amount of costs greater than that which the Claimant could have recovered from the Insurers. It may, for instance, have led the Claimant to ask whether her liability could be capped, or to approach a different firm of solicitors, who would cap her liability. Prima facie, therefore, it ought to have been disclosed."

The Judge found that the Solicitor had not given sufficient disclosure to Ms Belsner to demonstrate that they had her informed consent. Without informed consent they could

not rely upon their written agreement for the purposes CPR 46.9(2).

The decision reached is problematic for a number of reasons. The judge's view that informed consent was required by virtue of the fiduciary relationship, presumes the existence of such a relationship at the point the parties are agreeing the terms of the retainer. This notion in and of itself raises problems. When seeking to negotiate the terms of their own remuneration, it is difficult to see how a Solicitor can put their prospective client's financial interests first. Many feel that a fiduciary relationship does not arise until the terms of the agreement are reached, and it is through the lens of the agreement that subsequent performance should be viewed.

A further point, which seems at odds with the Judge's own findings, is the fact that he did go on to order the Claimant to pay a modest success fee of £90.00. Whether this was intentional is unclear, but his findings regarding informed consent under CPR 46.9(2), make it clear that where informed consent is not obtained, no costs over and above those recovered from the opponent would be payable. This would naturally lead to disallowing the success fee, as this had not been recovered from the third party. In allowing a success fee in principle, the final order seems to be inconsistent with the Judge's findings.

The Judge's decision to disregard the fact that the Solicitor did ultimately limit their billed costs is causing concern for practitioners and legal commentators. If the fiduciary duty exists at the point the agreement is being formed and there is a breach of that duty, the effect of the judgment is that a solicitor cannot seek to amend or rectify the situation by subsequently electing to limit their fees at the conclusion of the claim.

One striking feature of the retainer documents considered by the Court in Belsner, was the absence of a cap on the chargeable shortfall. It seems to have been a point of particular interest to the judge, who indicated that knowledge of the likely recovery might have motivated the Claimant to agree a cap. In matters involving CFAs which do cap the recovery of any shortfall as a term of the agreement, the decision can be read to suggest that capping the overall shortfall is enough to show informed consent.

It is important to note that currenty the judgement is less broadly applicable than suggested by some. In the matter of *Lynch v Paul Davidson Taylor (a firm) [2004] WLR 1753 Hughes J found that s.74(3)* would not operate to cap the costs payable by a client to the sums recovered from a third party. In an obiter comment he felt that the rule would "bite" in relation to matters where costs were fixed, but it would lead to absurd outcomes if it operated as a cap in cases where costs were to be assessed.

Whilst some fields of work are insulated from specific elements of the decision for now, the anticipated widening of the scope of Fixed Recoverable Costs into other areas such as clinical negligence and lower value Multi Track litigation generally, means it is not something that can simply be ignored. Taking the *Lynch* decision at face value, the costs limiting effect of CPR 46.9(2) could "bite" in a cases of significantly greater complexity and value. It is important for those practicing in all areas to consider the impact this may have on their retainers in future.

Permission to appeal to the Court of Appeal is currently being sought, so it may be some time before a definitive position can be established.

The NHS maternity care scandal: What to expect from the Ockenden Inquiry and beyond?

MARCUS COATES-WALKER
ST JOHN'S CHAMBERS

Shrewsbury and Telford Hospital NHS Trust ("the Trust") is at the centre of the largest maternity care scandal in NHS history.

In 2016, concerns were raised about the standard of maternity care in 23 cases at Telford Princess Royal and Royal Shrewsbury Hospitals (involving stillbirths, neonatal deaths, maternal deaths, brain damage and other significant errors not resulting in harm). This campaign was primarily led by the Stanton-Davies family (whose daughter Katie died shortly after birth in 2009) and the Griffiths family (whose daughter Pippa died shortly after birth in 2016).

As a result, the Trust was placed into special measures and Jeremy Hunt (the Secretary of State for Health at that time) set up an independent inquiry to be chaired by Donna Ockenden (an experienced midwife).

The terms of reference of the "Ockenden Inquiry" includes direction for the review team to:

- Review the quality of investigations and subsequent reports into the identified cohort of incidents.
- Identify whether the investigations appropriately addressed the relevant concerns and issues from those incidents.
- Establish if recommendations were accepted and appropriate actions implemented within the timescales identified in the associated action plan.
- Consider how the parents, patients and families of patients were engaged with during these investigations.
- Reserve the right to undertake a second-stage review of primary cases should the considerations above justify such action.
- Establish whether the Trust had in place, at the time of each incident, mechanisms for the governance and oversight of maternity incidents and whether it does now.
- Establish whether incidents and investigations were reported and conducted in line with national and Trust policies that were relevant at the time.
- Identify any evidence of learning from any of the identified incidents and the subsequent investigations.

After the launch of the inquiry, hundreds more families came forward. Further, an 'open book' review of electronic and hard copy medical records was carried out by the Inquiry which resulted in an additional 496 cases being included within the scope of the investigation. As it stands, the number of families affected and included within the scope of the Inquiry has now risen to an astonishing total of 1,862 going back to the 1970s.

The Inquiry has now capped this number and hopes to have its report with initial, emerging recommendations for maternity services published at the end of this year.

So, what do we know so far?

In 2019, The Independent obtained a leaked interim update report from the Ockenden Inquiry. This report highlighted the following: (a) a continued failure to obtain informed consent from mothers opting to deliver their babies in midwifery led units; (b) failure to recognise serious incidents and poorly carried out investigations without the proper involvement of families; (c) a failure to learn from previous lessons; (d) a lack of transparency, honesty and communication with families following incidents; and (e) a lack of kindness, support and respect for families involved. The report also revealed that there was an awareness of issues from as far back as 2007 but inadequate steps were taken due to 'misplaced optimism'. In terms of other issues, there are reports of failures to properly monitor foetal heart rates, delays in deliveries and the wrong use of forceps.

Further, The Independent has also reported a leaked letter from the CQC to NHS England, which showed that the Chief Inspector of Hospitals was worried about the worsening picture at the Trust beyond the maternity unit. He is reported to have warned of ongoing and escalating concerns regarding patient safety and that poor care was becoming normalised at the Trust.

The Trust's new Chief Executive has written an open letter to the community, which reads: *"... You have a right to expect the very best care every time you use our services. However, if things do go wrong, it is the role of the Trust and our staff to learn from any failings, so that we can provide answers to families and patients and improve our care now and in the future. You will be aware that our maternity services have been under the spotlight for some time. I know our standards of care have fallen short for many families and I apologise deeply for this... I recognise that this will be concerning, both for those families and everyone in our communities, who depend on us for their care. The review is being taken very seriously by our staff too, who are committed to providing our patients with the highest standards of care and making the necessary further improvements to our maternity services. There is no doubt that this continues to be a difficult and painful experience for many families and I am truly sorry for their distress. We should have provided far better care for these families at what was one of the most important times in their lives and we have let them down. An apology is not enough. What needs to be seen is evidence of real improvement at the Trust. This is why we are committed to listening to families, our community and working with Donna Ockenden's review to ensure lessons are learned and we have a service which the community and our patients can trust. We have made some progress in improving the standards of care for mother and babies and the CQC now rates our maternity services as 'good' across three of the five standards (caring, effective and responsive). However, we recognise we have further to go. One of the things we have learned is that we must be better at listening to everyone who uses our services.*

We will work harder at this and create more opportunities for families to tell us about their experiences, allowing us to make positive, clear and tangible improvements, based on what we learn..."

What can we expect from the Ockenden Inquiry and beyond?

The Inquiry's report is expected in the next couple of months. There is no doubt that the Inquiry is likely to find significant failings in the maternity care provided by the Trust. No matter what the finer level of detail states, I suspect this is likely to be of some comfort to the many families affected. However, it will be worth carefully analysing the conclusions of the report to ascertain: (a) the time period of any such failings and how far they stretch back; (b) the proportion of cases where causative harm was caused to baby and / or mother; (c) what was known about these failings by Senior Management during this period; and (d) whether such failings could be considered 'systemic' at Senior Management level.

The findings of the Inquiry's report will inevitably form an important basis for any future civil proceedings brought by affected families. However, such conclusions may also provide the platform for further measures to be taken. In June / July 2020, West Mercia Police commenced an investigation (Operation Lincoln) into the scale of the harm to see if there was sufficient evidence for criminal charges to be brought either against individuals or the Trust itself. It comes as no surprise that as part of their investigations, Police have met with the Ockenden Inquiry and officials from the Department of Health & Social Care and NHS Improvement. Therefore, it is worth considering what criminal charges might look like in due course.

First, an individual clinician could be prosecuted for gross negligence manslaughter.

Further or alternatively, the Trust itself may be charged with corporate manslaughter pursuant to the *Corporate Manslaughter and Corporate Homicide Act (CMCHA) 2007*. Since being enacted, this legislation has rarely been used in proceedings against an NHS Trust. The most helpful indicator of the difficulties that such a prosecution faces is outlined in the case brought against Maidstone and Tonbridge Wells NHS Trust in 2015 / 2016. In summary, the case concerned the actions of two anaesthetists following a caesarean section and alleged failings on behalf of the NHS Trust with regards to supervision and / or ensuring the clinicians had adequate qualification and experience. One of the anaesthetists was not in the UK at the time of the trial. However, with regards to the other anaesthetist, Coulson J held that this was *"as far removed from a case of gross negligence manslaughter as it is possible to be"*. Applications on behalf of the anaesthetist and the NHS Trust that there was no case to answer were granted.

In his judgment, Coulson J identified the following ingredients of corporate manslaughter:

- A relevant duty of care.

- Activities which were managed or organised by senior management in a way which comprised a breach of the NHS Trust's duty of care.

- In all the circumstances, that breach of duty was gross. The term 'gross' here means the same as it does for the purposes of gross negligence manslaughter. It is a very high bar.

- The gross breach of duty must have caused or made a significant contribution to the death.

It is worth noting that a corporate manslaughter charge will not necessarily stand or fall with individual gross negligence manslaughter charges. Different verdicts may legitimately be reached on each charge. However, the offence of corporate manslaughter is likely to require *systemic* breaches of duty. Individual 'one-off' breaches of duty, even if very serious, are unlikely to be sufficient.

Therefore, the prospects of any successful criminal prosecution will likely be informed by the findings of the Ockenden Inquiry. Only time will tell whether sufficient systemic failings will be identified at senior management level to constitute a gross breach of duty. Hopefully, we will find out in the next month or so. If the Inquiry comes to such a conclusion and if those failings are found to have caused the death of babies and / or mothers, the Trust may have to prepare themselves for the second substantive use of the corporate manslaughter legislation against an NHS Trust.

Failings in maternity care are not restricted to Shrewsbury and Telford alone. In February 2020, the Healthcare Safety Investigation Branch (HSIB) published its report into the maternity services provided by East Kent Hospitals University NHS Foundation Trust. The HSIB's report identified recurrent safety risks around several key themes of clinical care, including: CTG interpretation, neonatal resuscitation, recognition of deterioration and escalation of concerns and responses. Despite repeatedly raising these concerns with the Trust, HSIB investigators continued to see the reoccurrence of the same themes. As a result, the Trust was asked to self-refer itself to its CCG and the CQC.

Building on the Ockenden Inquiry, a further inquiry has been launched by the Health and Social Care Committee into the Safety of Maternity Services in England. This is intended to build upon the investigations into the concerning incidents at University Hospitals of Morecombe Bay NHS Trust (between 2004 and 2013), Shrewsbury and Telford Hospitals NHS Trust and East Kent Hospitals University Trust. MPs are also set to consider whether clinical negligence and litigation processes need to be changed to improve the safety of maternity services and the extent to which a "blame culture" affects medical advice and decision-making. There has been a call for evidence in respect of which families, campaigns, charities, solicitors' firms and various medical bodies have contributed to date. This includes AvMA who have formally responded as part of the ongoing Consultation. It is hoped that this further inquiry will draw together the key learning from other important work and investigations into ongoing concerns in order to improve the level of maternity care on a national scale.

Inquest touching the death of Jonnie Meek

RAJKIRAN BARHEY
1 CROWN OFFICE ROW

1 CROWN OFFICE ROW

Jonnie Meek died at Stafford Hospital on 11 August 2014, two days after his third birthday. After a journey of over 5 years and two inquests, the family's belief as to how Jonnie died was finally vindicated. In this article, we explain their extraordinary story.

Jonnie's background

Jonnie was born to John Meek and April Keeling on 9 August 2011 with a rare genetic condition, de Grouchy syndrome. He suffered from developmental delay as well as problems with feeding, eczema, eyesight, and breathing. At around 3 months of age, Jonnie was placed on a feed designed for children with an allergy to cow's milk protein. He had a suspected intolerance (not allergy) to cow's milk protein and tolerated this feed well.

Jonnie was not putting on enough weight and the clinicians wanted to trial a higher calorie feed. This new feed was less hypoallergenic. A feed was trialled at home in 2013 twice. Jonnie did not tolerate the feed either time, vomiting both times. In 2014, another feed was trialled and, according to his parents, soon after starting the feed Jonnie had a dusky episode, vomited and was taken to hospital. His parents therefore requested that the next trial of the same feed took place in hospital, where he could be monitored in case anything went wrong.

On 11 August 2014, Jonnie went into hospital to trial the new feed at around 1pm. He died just after 4pm.

The first inquest

An inquest was held in January 2015, lasting one day before an Assistant Coroner in Staffordshire. The inquest heard evidence from pathologist Dr Tamas Marton. His view was that the appearance of Jonnie's lungs was consistent with pneumonia which had been undetected but which had led to Jonnie's death. He did not identify any connection between Jonnie's death and the change of feed. The Coroner accepted his evidence and that of the clinicians involved in Jonnie's care, concluding that Jonnie's death was from natural causes.

Overturning the first inquest

Jonnie's family complained about Jonnie's care and the hospital complaints process to Cannock Chase Clinical Commissioning Group ("CCG") who took up their case. The CCG commissioned an independent review by a Consultant Paediatrician, Dr Martin Farrier. He looked at all the circumstances, and concluded that pneumonia was not the most likely cause of Jonnie's death.

Followed the report of Dr Farrier, the CCG commissioned a further post-mortem from Dr Marnerides and a report from a Paediatric Allergist, Dr Donald Hodge. Dr Marnerides concluded that Jonnie likely died from an anaphylactic reaction. Dr Hodge concluded that it was likely that Jonnie had an intolerance, but not an allergy, to the new feed.

The CCG applied for an Attorney General's fiat. This was granted in 2018 and the High Court quashed the first inquest and ordered a fresh inquest. At a PIR, the Senior Coroner for Staffordshire decided to transfer the proceedings to Shropshire to avoid any perception of bias. At a later PIR, the Coroner indicated that Article 2 was likely not engaged and thus the family struggled to get any further legal help. At this stage, AvMA became involved to provide support. The inquest was listed in early 2020, but due to the COVID-19 pandemic, was relisted for the week of 12 October 2020.

The second inquest

The inquest was listed for 5 days and 10 factual witnesses were called, including several who had not been called to attend the first inquest. The Interested Parties were the family, the CCG, and the Trust. Stafford Hospital was part of Mid-Staffordshire NHS Foundation Trust but, following the Trust's dissolution in 2014, was now part of University Hospital of North Midlands Foundation Trust.

Jonnie's mum gave evidence that, as soon as the feed started, at around 1:30pm, Jonnie started to change colour and seemed irritable and was scratching. She said she raised concerns with the nurse who was monitoring Jonnie, with the doctors and with the dietician. Jonnie started receiving supplemental oxygen. After about an hour and a half on the new feed, Jonnie vomited, and she recalled that he deteriorated further until crash team were called at around 15:40. Despite resuscitation attempts, he died just after 4pm.

Jonnie's mum's account was broadly corroborated by a care worker who was present throughout and helped the family with Jonnie. However, it was contradicted in parts by the nurse who was monitoring Jonnie. She gave evidence that she had no concerns about Jonnie until just before his rapid deterioration at around 15:30.

The inquest also heard extensive evidence as to Jonnie's previous trials of feeds and his reactions and also his general medical condition before the trial of feed.

The Coroner also called both pathologists, Dr Marton and Dr Marnerides, and the Paediatric Allergist, Dr Hodge. There was significant disagreement as to the cause of death between the pathologists, with Dr Marton maintaining his conclusion of pneumonia, and Dr Marnerides likewise maintaining his conclusion of anaphylaxis. Dr Hodge thought it was unlikely that Jonnie was allergic to the feed but that he could have been intolerant. The parties and the Coroner agreed to 'hot tub' all three witnesses, i.e. they sat in a panel formation and questions were put to each expert in turn. After much discussion, the experts all agreed that Jonnie's death was likely caused by an adverse reaction to the new feed. They could not agree as to the mechanism of Jonnie's death – potential options canvassed were anaphylaxis, aspiration of the feed, potentially due to intolerance leading to asphyxiation, or aspiration leading to pneumonia.

The Coroner's conclusions

The Coroner returned the following narrative conclusion: *"Jonnie William Meek died following and as a result of an adverse reaction to a change of feed."* His cause of death was recorded as: *"(1a) Adverse reaction to introduction of change of feed (II) De Grouchy Syndrome, severe developmental delay, chronic lung damage and pneumonia."*

In his findings of fact, he noted that *"The crucial conclusion from this medical cause of death is that as the parents have always believed, Jonnie's death was not an unrelated natural cause but occurred following the introduction of the feed."* However he did not criticise the introduction of the feed, accepting Dr Hodge's evidence that Jonnie needed more calories and there was no reason to suspect that he would have an allergic reaction to the feed.

Also crucially for the family, the Coroner found that, in so far as there was any conflict between Jonnie's mum's evidence of his deterioration and the nurse's, he believed his mother's evidence.

Conclusion

This complex case raised a range of interesting but difficult issues which may be instructive to readers. The role played by the CCG is particularly interesting, as was the approach taken by the Coroner to the expert evidence. Whilst they eventually achieved the outcome which they had sought, Jonnie's family should not have had to wait over 6 years since his death.

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3 December 2020, online

This year's AvMA Specialist Clinical Negligence Panel Meeting will take place online on the afternoon of Thursday 3rd December. As you will know, it is a condition of Panel membership that you attend the annual Panel meeting, and, whilst we cannot physically meet for this year's event, we look forward to welcoming you online. If, for any reason, you are not able to attend then it is encouraged that a representative from your office joins the event.

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24 February 2021, online

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

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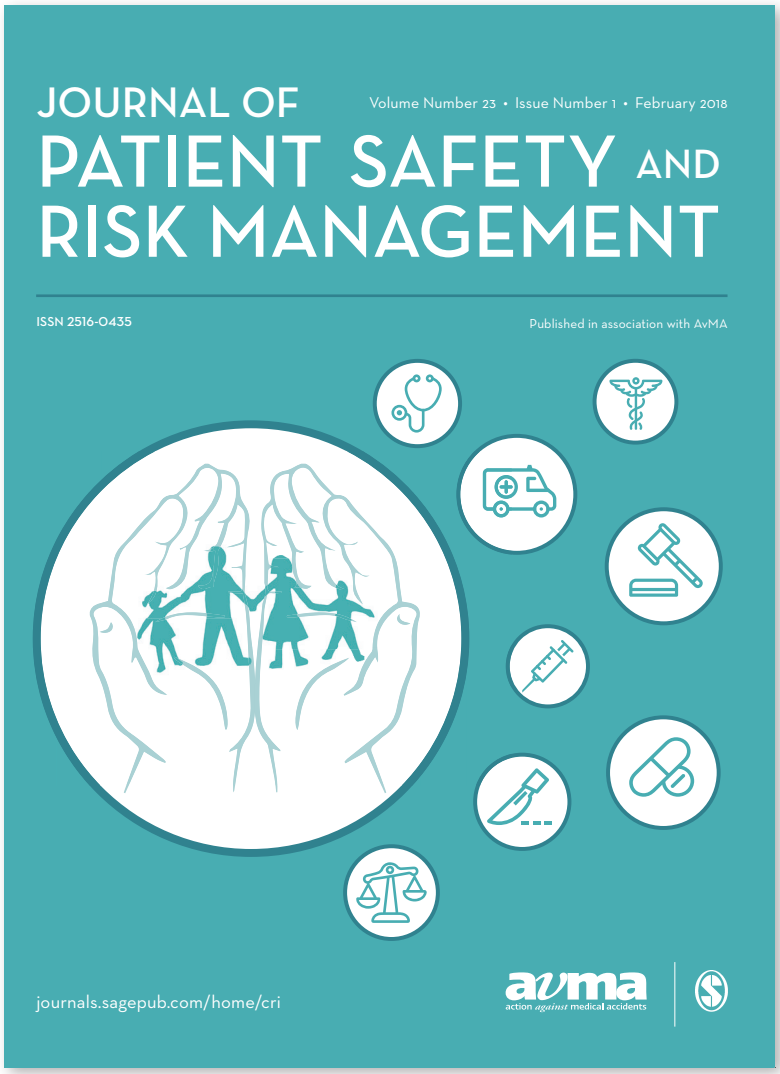
Journal of Patient Safety and Risk Management



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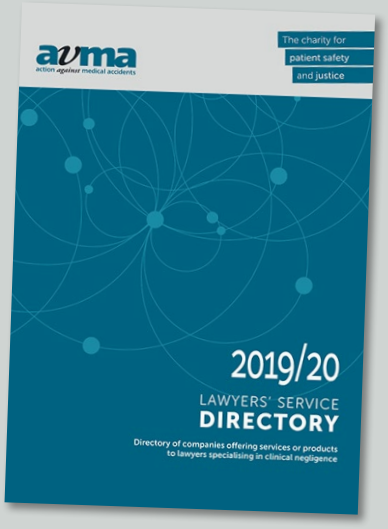

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