avma
action against medical accidents

The charity for patient safety and justice

Lawyers Service Newsletter

November 2016

Contents

Editorial

Lisa O'Dwyer
Director, Medico-Legal Services

- Fixed Recoverable Costs
- Rapid Resolution and Redress
- Providing a "safe space" in healthcare safety investigations

Fixed Recoverable Costs

Although the Fixed Recoverable Costs (FRC) Consultation has still not been published, the government appears to have lost none of its apparent enthusiasm for changing the way clinical negligence cases are run.

Jackson LJ has previously been clear that he believes FRC should be introduced for claims up to £250,000. However, earlier this month it was announced that he was to lead a new review of FRC to take forward the government's commitment to "Transforming Our Justice System" - link to this paper below:

www.gov.uk/government/uploads/system/uploads/attachment_data/file/553261/joint-vision-statement.pdf

We understand that he will be considering how high the FRC threshold should be, as well as what category of case FRC should apply to. Jackson LJ has also stated that he is mindful of the need to consider how disbursements are dealt with including barristers and experts fees. Submissions to assist the review should be sent to: fixed.costs@judiciary.gsi.gov.uk **by 23rd January 2017**. See also:

www.judiciary.gov.uk/publications/review-of-fixed-recoverable-costs

AvMA has been advised by the Department of Health (DH) that Jackson LJ's new review will not stop them consulting on its clinical negligence proposals. We understand that these proposals are to be published "soon".

continued on page 2

continued from page 1

Rapid Resolution and Redress

Not content to leave matters there, on 17th October the DH advised that they intend to consult on a new scheme, Rapid Resolution and Redress (RRR). RRR is intended to be an alternative to litigation for cases that involve babies who have sustained a brain injury "during or soon after birth". The complex nature of these claims is such that they do necessarily tend to result in huge awards of damages being made; they are difficult cases and expensive to run. The DH sees RRR as a potential "alternative to costly legal processes"

RRR is loosely based on a "no fault" compensation scheme. AvMA believes that a scheme that offers an alternative to litigation and provides swift acknowledgement of injury caused, full and prompt compensation and care packages as well as learning lessons would be a very positive step in the right direction. However, for such a scheme to be effective it must have regard to the child's needs and cannot therefore be subject to a financial cap. AvMA is very clear that families electing to go through the RRR scheme should have access to independent specialist advice. The DH has not announced when the consultation on RRR is to be published.

Providing a "safe space" in healthcare safety investigations

The DH has now published a consultation document on "Providing a "safe space" in healthcare safety investigations". This is an open consultation which closes on 16th December 2016; it is important reading and for your ease we have provided a link: **https://consultations.dh.gov.uk/safety/safe-space-healthcare-safety-investigations**.

A safe space is intended to enable clinicians to speak openly about things that go wrong without fear that information they disclose will be used against them in court or professional misconduct hearings. It was first introduced by the Secretary of State in July 2015 as one of the principles underpinning the powers of the Healthcare Safety Investigation Branch (HSIB), those powers are set out in the National Health Service Trust Development Authority (Healthcare Safety Investigation Branch) Directions 2016, and Regulation 6 of those directions creates a statutory "safe space". The Directions can be viewed here:

www.gov.uk/government/uploads/system/uploads/attachment_data/file/514217/HSIB_directions.pdf

Paragraph 5.2 and 5.3 of the consultation envisages extending the reach of the safe space principle so that it covers serious incident reporting; if this happens the contents of serious incident reports will not be available for consideration in inquests and civil claims. If successful this will mean that disclosure of material obtained during health service investigations will be restricted unless the High Court makes an order permitting disclosure.

The safe space principle is modelled on the investigation process used in the airline industry. The recent case of:

R (on the application of SECRETARY OF STATE FOR TRANSPORT) (Claimant) v HM SENIOR CORONER FOR NORFOLK (Defendant) & BRITISH AIRLINE PILOTS ASSOCIATION (Intervener) (2016)

demonstrates how the Air Accident Investigation Branch's (AAIB) authority over safe space trumped that of the Norfolk coroner. If the statutory safe space principle is extended this scenario is likely to become common place in healthcare cases.

When talking in terms of a safe space, we need to be clear about what it is that clinicians feel they need to be safe from. This means looking carefully at the factors that prevent clinicians from coming forward. It probably over simplifies a clinician's concerns to say they don't come forward for fear of litigation. It will remain to be seen whether providing a safe space will on its own, address the cultural difficulties that exist in healthcare, including fear of reprisals from a clinician's employer; it will probably do little to instil trust in injured patients, particularly those who continue to need ongoing healthcare services from the trust that provided the negligent treatment. The safe space principle does not sit comfortably with the NHS policy on being open and honest, or the statutory duty of candour.

The potential ramifications of extending the safe space principle are such that I have included AvMA's full briefing on extending safe space arrangements to all patient safety investigations in this edition of the Newsletter. **We are appealing to you** to send in examples of cases where disclosure has shed a very different light on the facts of the case as represented by the trust. For example, do you have any cases where disclosure of documents used to prepare an SIR have identified serious issues that were omitted to be mentioned in the SIR itself? Perhaps you have cases where disclosure has changed the complexion of the facts of the case as recited in the SIR or equivalent reporting document? These examples are potentially powerful weapons in arguing against a "safe space" principle being extended further.

Please send any examples (redacted if necessary) to norika@avma.org.uk.

AvMA has continued to meet with the NHS LA, DH, politicians and other interested parties to keep concerns about the effect of FRC on clinical negligence claims in the forefront. We will continue to seek engagement where we can to raise concerns and draw attention to the likely effect these proposals will have on access to justice. We are taking every opportunity to engage on the issues around RRR and safe space.

In September 2015 we raised numerous Freedom of Information requests of the NHS LA, the more interesting responses are now on the **Lawyers Service section of the website**. You may find the **NHS LA Framework agreement** of particular interest as this details the hourly rates and fixed fees payable by the NHS LA to defendant lawyers in cases up to £25,000, £25,001 - £50,000; £50,001 - £100,000. For your further ease we have set out those rates in a more user friendly **two page document**, also available on the Lawyer Service section of the AvMA website.

We hope you like the new style newsletter, the index will hopefully make it easier for you to quickly identify articles of interest In this edition several of AvMA's pro bono inquest cases have been written up, with thanks to Rhoderick Chalmers (One Crown Office Row), Thomas Banks (12 KBW) and Dr. Ruth O'Sullivan (AvMA). Ed Ramsay's (also at 12 KBW) article on *"Falls and avoidable deaths in hospital: when should the Coroner sit with a jury?"* will be of particular interest to many of you. Our thanks also go to Amy Milner of Penningtons, Dr Kevin Naylor of Exchange Chambers and William Chapman of 7 Bedford Row for their contributions.

In the dark days of winter, good news is particularly welcome; we extend our warm congratulations to two long standing and loyal supporters of AvMA, both well respected panel members, on their recent marriage. Richard Follis and Fiona Mills (now to be known as Fiona Follis) tied the knot in Scotland at the end of October and have kindly agreed to share a wedding photo to cheer everyone up; we wish them a long and happy life together with many more annual conferences to come! I look forward to catching up with many of you at the AvMA Panel Meeting and afterwards at drinks on Friday 2nd December.

Best wishes

We would like to hear from you with any examples (redacted if necessary) of cases where disclosure has shed a very different light on the facts of the case as represented by the trust.

Please contact:

norika@avma.org.uk

Policy update

Clamp down on legal costs in clinical negligence would leave many with no chance of legally challenging NHS denials

The long awaited consultation on controversial Department of Health proposals to impose a 'fixed recoverable costs regime' on clinical negligence cases is expected before the end of the year. The proposal would impose absolute limits on what legal costs can be recovered by claimant lawyers who win clinical negligence cases. It will be proposed that the amount of legal costs recoverable should never be more than the amount of compensation won for the injured patient/their family – regardless of how unreasonable and drawn out the denials and defence of a claim have been. AvMA believe that the proposals would create a perverse incentive for NHS trusts and other health providers to deny and defend claims rather than learn from mistakes and settle claims with minimal legal costs. The cap on legal costs would mean, particularly in cases involving smaller amounts of compensation (including child deaths, stillbirths, and elderly people's treatment) would not be able to find lawyers able to take on their case, if it is defended. For more information see AvMA's briefing on what is known about the proposals so far.

AvMA chief executive Peter Walsh said:

"We are all for saving unnecessary legal costs. However the way to do that is for the NHS to investigate incidents better, identify where it has made mistakes, and settle cases without the need even to litigate. The proposals as we understand them would both take away many people's ability to get access to justice and create a deny and defend culture rather than the learning culture which the NHS needs so much."

"We do not condone any excessive or inappropriate claiming of costs by lawyers, but if and when that does happen the courts and the NHS already have the ability to challenge this and clamp down on it."

Department of Health proposal to apply 'safe space' arrangements to all safety investigations could legitimise cover-ups

AvMA are calling on everyone who shares its concerns about the **DH consultation on legislating for 'safe space' arrangements in NHS investigations**, which could see relevant information being withheld from patients/families harmed by lapses in patient safety, to respond to the consultation. The closing date is December 16th.

The proposal is to extend arrangements in place for the new HSIB to withhold information from patients/families - even when it directly relates to what happened in their treatment – to all NHS safety investigations. The consultation asks whether this should be phased in, potentially starting with maternity cases. Whether phased in or not, this would mean that local NHS trusts investigating their own serious incidents would be able to withhold relevant information from patients/families if they believed this was important for providing a 'safe space' for health professionals, so that they could provide evidence without fear of blame or serious consequences.

See next page for AvMA's briefing.

AvMA chief executive Peter Walsh said:

"This proposal is misguided and very dangerous. We fully support initiatives to protect all staff including whistleblowers from inappropriate or disproportionate blame from employers or regulators, which is what they tell us they most fear. However, allowing the covering up of the full truth about what happens in patients' treatment from them or their family is unethical and in direct contradiction to the NHS Constitution and the statutory Duty of Candour brought in just two years ago."

Giving evidence to the Public Administration and Constitutional Affairs select committee on 8th November both Keith Conradi, the chief investigator of the HSIB, and Scott Morrish, father of Sam Morrish, spoke out against the idea of extending the provisions made for the HSIB. AvMA are also in discussion with Mr Conradi and the Department of Health about the possibility of amending the existing statutory directions for HSIB itself to reflect the original Expert Advisory Group recommendation that notwithstanding other elements of the 'safe space' arrangements, all relevant information "must" be shared with the patient or family.

Briefing on Department of Health proposal to extend "safe space" arrangements to all patient safety investigations

1. Introduction

In October 2016 the Department of Health launched a consultation *"Providing a 'safe space' in healthcare safety investigations"*. See **www.gov.uk/government/consultations/providing-a-safe-space-in-healthcare-safety-investigations**

This briefing explains the concerns of Action against Medical Accidents (AvMA) about the proposals and offers alternative suggestions. It focuses in particular with the proposal to legislate for a 'safe space' approach to all NHS patient safety investigations (see pages 30-32 of the consultation), which would allow the withholding of information found by investigations from patients/families - even when that information is directly relevant to what happened in their or a loved one's treatment. The aim of this briefing is to help patients and families and other stakeholders gain an informed view of different perspectives and encourage them to make their own response to the consultation. The deadline for responding is 16th December.

AvMA is the independent charity for patient safety and justice. We provide specialist advice to people who have been affected by 'medical accidents' – things that go wrong in healthcare that are believed to have caused harm. We support around 3,000 such people a year and have 35 years' experience. We work with the NHS, Government departments, regulators and other public bodies to improve systems for improving patient safety and how medical accidents are dealt with. The needs to improve the quality of NHS investigations and develop a genuinely 'just culture' are long held priorities for the charity.

2. 'Safe Space' and 'Just Culture'

There is widespread agreement amongst most stakeholders, including AvMA that more needs to be done to address the 'fear of blame', and protect staff from unfair or disproportionate treatment as a result of honest mistakes, providing evidence to investigations, or indeed sharing information with patients. However, we have strong concerns about the way that the 'safe space' has been provided for with respect to the Healthcare Safety Investigation Branch (HSIB), and even stronger concerns about proposals to extend the same or similar approach to all serious incident investigations.

The key challenge is how to create a 'just culture' which both addresses the fear of blame and stays true to the principle that patients (or their families) should be guaranteed full openness and honesty about what happens with respect to their own treatment. We would question whether a culture which deliberately allowed for the withholding of such information from patients / families could possibly be called a 'just culture'.

We believe that there is a real prospect that the way that HSIB has been designed, and the way that it is purposed to extend the 'safe space' provisions to all healthcare safety investigations would undermine public confidence in the NHS and undo the good work that has been done so far in creating a duty of candour and working towards an open and fair culture.

The Expert Advisory Group for HSIB recommended that a 'just culture taskforce' be established to consider the complex issues that are involved in creating a genuinely just culture. We agree, and think that initiatives which potentially impact on just culture should be informed by that work rather than policies which may have unintended consequences being brought in in a piecemeal fashion.

3. HSIB

The Expert Advisory Group advising the Secretary of State on HSIB, gave long and careful consideration to these issues. It concluded that whilst supporting the general 'safe space' principle, that all relevant information about a patient's treatment uncovered by an investigation *'must'* be shared with the patient / family.

Notwithstanding the EAG recommendation, the Department of Health's Directions created for HSIB say that the Chief Investigator *'may, when requested'* disclose such information *'but such disclosure may only be made... to such an extent that the Chief Investigator judges... to be consistent with the safe space principle'*. It is clear from this that there is a distinct possibility that patients / families will have information relevant to their treatment

continued on page 6

continued from page 5

withheld from them. Indeed, they would have to ask for it for the Chief Investigator to be able to disclose it to them and even then he has discretion to keep it from them, even if it directly relates to what happened in their treatment.

AvMA welcomes the creation of HSIB and also the broader principles of 'safe space' as qualified by the EAG. However, we fear that public confidence in HSIB and therefore its effectiveness if it starts off under a cloud of controversy and suspicion that it will withhold relevant information from patients/families. The Chief Investigator of the HSIB, Keith Conradi, agrees that HSIB's Directions should be amended to address this issue and that relevant information should be shared with patients/families.

We understand it is relatively quick and easy for the Secretary of State to amend Directions, and recommend that he does so to reflect the recommendation of the EAG.

4. Local Investigations

We think that it is already worrying and contrary to the spirit of the NHS constitution and duty of candour even if the above approach was restricted to HSIB. However, the recently published consultation on safe space envisages it being extended to all NHS safety investigations. This has even more serious and far reaching implications.

For example, if the current HSIB 'safe space' approach was extended to all local safety investigation in England it would apply to around 30,000 serious investigations a year.

Applying the current 'safe space' approach would directly cut across the statutory Duty of Candour adopted following the Mid-Staffordshire public inquiry. Under the duty of candour, any NHS provider is under a statutory obligation to be open and honest with patients or their families when something goes wrong that appears to have caused harm. This applies equally to new information gleaned from investigations as it does to incidents that are recognised at the time of treatment. The 'safe space' arrangements as currently framed would mean that relevant information could be withheld and patients / families might not get to hear the full truth about what happened in their treatment. The current approach to 'safe space' is also at odds with the well-established professional standards for doctors and other health professionals. They all have an absolute duty of candour.

There is a huge difference between an independent organisation like HSIB, with no conflict of interest, having the discretion to withhold information and NHS organisations who are investigating themselves being allowed to. The conflict of interest is obvious.

We would also urge the Department of Health and others to look at evidence from overseas about what effect applying the safe space principle by making information found from investigations legally privileged. We are not aware that this has been found to have a beneficial effect where it has been applied in parts of the USA, Australia and Canada. On the other hand, ironically, Sweden makes everything obtained in investigations available to patients/families. The Department of Health holds Sweden out as a model of good practice when it comes to learning from mistakes (see the recently announced Rapid Resolution and Redress proposals).

The NHS currently faces huge challenges – not least in improving the quality of investigations. Now is not the time to bring in such a radical change even if the issues of principle can be addressed. HSIB should be given time to prove itself and the approach should be evaluated. The NHS should not be forced to run before it can walk with respect to investigations.

Keith Conradi, chief investigator of HSIB agrees that the 'safe space' provisions should be restricted to the HSIB and is not appropriate for local NHS organisations.

5. What do professionals want protection from?

The concept of a 'safe space' is based on the understanding that fear of unfair or disproportionate consequences which might be applied to individuals providing evidence to investigations might deter them from giving full, honest evidence. However, it is worth looking more closely at what health professionals most fear and want protection from. In our own conversations with many health professionals, it is invariably fear of unfair treatment by their employers or regulators that is top of their list. Few if any self-respecting health professionals would condone

the deliberate withholding of information relevant to a patient's treatment from the patient or their family.

6. Conclusion

AvMA will, subject to final agreement by its trustees, be responding to the consultation asking for the proposal to extend the safe space approach to local investigations to be dropped; for amendment of the HSIB Directions to reflect the need to share all relevant information with families; and for establishment of the 'just culture taskforce' recommended by the HSIB Expert Advisory Group. We urge all like-minded individuals and organisations to do likewise.

AvMA wholeheartedly supports appropriate steps to ensure that staff are not unfairly blamed or punished for unintentional mistakes or system failures, or for giving evidence or speaking out. However, denying patients / families the full information relevant to what happened in their treatment is not what health professionals want and can never be the right thing to do. The 'safe space' proposals as currently framed would undo the progress that has been made since Mid-Staffordshire on moving towards an open and just culture and introducing a statutory duty of candour.

Of course, a balance needs to be struck, and we believe that the broad church of patient safety experts represented on the Expert Advisory Group for HSIB did just that. The broad principle of 'safe space' can be adopted and much more could be done to protect staff from unfair or disproportionate treatment by employers or regulators. However, the ethical imperative to require full openness and honesty with patients / families about what happens in their care must be preserved. All relevant information an investigation finds concerning a patient's treatment should be shared with them.

The word 'relevant' is very significant. Neither the Expert Advisory Group nor AvMA have argued that *all* information uncovered by an investigation should have to be shared with patients / families - only information relevant to their own or family member's treatment.

We recommend that the HSIB Directions be amended to reflect the recommendations of the Expert Advisory Group.

We recommend that the proposal to extend the safe space approach to local investigations (whether amended or not) be dropped, the just culture taskforce be established, and HSIB be given time to prove it can work and for lessons to be learnt from its approach.

In discussing 'safe space' the Department of Health has often suggested it is not intended to withhold relevant information from patients / families. However, the Directions for HSIB specifically give HSIB the power to do just that.

In considering the notion of 'safe space' we suggest that respondents to the consultation and the Department of Health ask themselves:

Should application of a 'safe space' arrangement ever be allowed to trump the ethical, statutory and professional duty to share all relevant information discovered about their treatment with patients / families?

The NHS Constitution pledges that the NHS will: *"ensure that when mistakes happen or if you are harmed while receiving health care you receive an appropriate explanation and apology"*. In the light of how of the 'safe space' is currently being framed, this would need the words *"unless the safe space principle applies"* added.

November 2016

Medico-legal aspects of bariatric and metabolic surgery

KHALEEL R FAREED DM FRCS
AMY MILNER LLB
BRUNO LORENZI MD PHD

PENNINGTONS MANCHES

The prevalence of obesity among adults increased sharply during the 1990s and early 2000s. According to the Health Survey for England, the proportion of the population categorised as obese {BMI 30kg/m2 or over) increased from 13.2% of men in 1993 to 24.3% in 2014 and from 16.4% of women in 1993 to 26.8% in 2014.

Obesity is associated with a range of health problems including type 2 diabetes, cardiovascular disease, high blood pressure, obstructive sleep apnoea and cancer. The resulting NHS costs attributable to patients being overweight and obese are projected to

reach £9.7 billion by 2050, with wider costs to society estimated to reach £49.9 billion per year.1

When combined with a comprehensive treatment plan, bariatric surgery can be an effective tool to achieve sustained weight loss and significant improvement in an obese patient's quality of life. Surgery has been shown to help improve or resolve many of the obesity related conditions described above and to be cost-effective in the medium and long term.2

Despite the obvious benefits of surgery, there seems to be an increase in litigation after bariatric surgery, which is reflected in the high medical insurance premiums. In fact, in the UK, bariatric surgery and cosmetic surgery appear to have the highest insurance premiums amongst surgical specialities. There may be many factors underlying this. Patients undergoing surgery tend to have high expectations and, if surgery does not go to plan, the consequences can be potentially devastating for the patient and those around them.

There may be many reasons for this. The population of patients undergoing bariatric surgery for morbid obesity tends to be young and often relatively active. They are undergoing surgery to prevent future medical complications rather than to deal with immediate life threatening conditions. They therefore feel particularly aggrieved when complications arise .

In addition, the use of bariatric surgery is dramatically expanding. For example, in the US, laparoscopic gastric bypass surgery is now one of the most commonly performed operations and, as a result of this increase in the number of surgeries being performed, there has been an increase in the number of potential complaints.

In highly cash-strapped health care systems such as the NHS, there is strict regulation of publicly funded bariatric surgery . Patients therefore often fund surgery themselves in the private sector and are more likely to complain. The nature of bariatric surgery is such that patients who have undergone surgery may develop complications many years down the line. Patients who have had gastric bands fitted may develop band slippages, band erosions or obstruction. Patients who have had a gastric bypass may suffer internal hernias, adhesions and possible bowel obstruction. Often, due to 'package' deals on their surgery in the private sector, these complications may develop after the package has expired. A delay in

diagnosing these problems by non-specialists and the morbidity or even mortality associated with this failure can lead to litigation claims.

Bariatric surgery is a relatively new sub-speciality and formal higher-level training opportunities are few and far between. Upper gastro-intestinal tract surgeons who may have not undergone formal specialist training often perform private sector bariatric surgery . Although they may be good general gastro-intestinal surgeons, they may not appreciate the particular nuances of bariatric surgery.

Bariatric surgery - particularly the gastric bypass - is a technically challenging operation and a lack of a period of supervised training can lead to difficulties post-operatively and open a surgeon to litigation based on the grounds of lack of specialism .

The Medical Defence Union {MDU) indicates that the most common problems encountered following this type of surgery include:

- Post-operative infection
- Gastric bands slipping or leaking
- Delay in diagnosing these problems
- Difficulties and complications in adjusting bands

- Failure to obtain consent from patients, for example not consulting them about the risks involved.

It is important to note that not all of the problems highlighted by the MDU represent negligent care and some are simply recognised complications of the procedure. It is, however, imperative that the patients are appropriately counselled about the risks involved with this type of surgery (as with any type of surgery) before they make their decision to proceed.

The importance of patients being appropriately counselled is particularly important following the Supreme Court decision in the case of Montgomery v Lanarkshire Health Board. This decision changed the historic consent position where a doctor only needed to discuss risks which other doctors felt should be discussed.

The Supreme Court decided that a doctor must make sure that the patient knows about the material risks of treatment and that reasonable alternatives have been discussed. In deciding whether a risk is material, the court will now consider the question from the patient's rather than the doctor's perspective.

Another aspect that must be taken into consideration when counselling patients pre operatively is whether or not they are suitable candidates for bariatric surgery. The current debate is whether people electing to undergo elective cosmetic surgery (including bariatric surgery) or bariatric surgery for medical reasons should be psychologically assessed to determine both whether they are suitable and will benefit from the surgery.

The clinical negligence team at Penningtons Manches receive many enquiries from people who have not been appropriately counselled as to their suitability for surgery and who have not tolerated the effects of surgery as a result.

From a medicolegal perspective, the following issues are examples which may be regarded as substandard or negligent care that result in claims:

- The band is put on the wrong part of the stomach or at the wrong angle during the operation leading to a complete blockage requiring emergency surgery. A failure to spot the situation developing post-operatively can often, in itself, be negligent.
- Failure to perform the anastomoses properly in gastric bypass surgery or to fire the mechanical stapler correctly in a sleeve gastrectomy can cause a leak. Again, a failure to recognise the development of a leak post-operatively can often be open to criticism.
- Sometimes the wrong type of bariatric procedure has been performed.
- Surgeons performing the procedure without sufficient expertise and making unacceptable technical errors.
- There can be issues with the quality of the gastric band itself which may result in a product liability claim against the manufacturer rather than the surgeon.

It is important from both a clinic and medicolegal perspective that anyone undergoing weight loss surgery is given sufficient information about what the surgery entails and any problems that may arise and that the surgery is only undertaken by those who are experienced in this field. A high standard of post-operative care and quick recognition of developing complications appears to be key.

The clinical negligence team at Penningtons Manches is currently dealing with claims for patients with a range of unexpected problems arising from gastric band surgery . These range from faulty band and incorrect insertion to suffering significant bleeding as a result of arterial damage during the procedure. All of these clients have suffered very significant problems and are evidence of the importance of patients being properly advised before their surgery is undertaken by a suitably experienced practitioner.

A further consideration from a medicolegal perspective is that this type of surgery is often carried out at a private clinic. This is perfectly acceptable if the patient fully understands the procedure, it goes smoothly and there are no complications . However, the Penningtons Manches clinical negligence team has experience of patients who have had surgery privately, have suffered complications and the clinic has not been equipped to deal with emergency care, resulting in emergency hospital transfer and, potentially, further surgery.

As an example, the clinical negligence team has recently settled a claim against a private surgeon who, it was alleged, had failed to warn a patient of the recognised complications of gastric banding surgery. In this case, the client suffered a significant bleed during surgery and required transfer as an emergency to a hospital with full

facilities to manage the bleeding. Post-operatively, it became apparent that the surgeon had damaged the aorta and had failed to identify the source of bleeding. This led to the client requiring further emergency surgery, a prolonged recovery and an adverse psychological reaction.

continued on page 10

continued from page 9

It was the client's case that, had she been appropriately advised of the risks of surgery, she would not have undergone the procedure at all.

Now more than ever, it appears evident that bariatric surgery must be offered and performed safely. Surgeons must have undertaken specialist training and remain up-to date on national and international guidelines. Surgery should be only offered to patients who are suitable candidates who have shown adequate comprehension of the procedure and its related consequences and risks.

Patients who demonstrate poor understanding of the information supplied or show poor compliance with medical advices should be discouraged from undergoing surgery. Hospitals offering bariatric surgery should be equipped to deal with emergency complications and adequate follow-up should be planned and offered by a team of professionals with experience in the field.

In the private sector with its increasingly competitive market, advertising is often used to promote surgery. It is important that promotional material is thoroughly reviewed and tailored to avoid suggesting unrealistic outcomes. Material should refrain from suggesting a frequency or percentage of success, because this is often secondary to patient selection, rather than the proficiency of the staff or facility and it can be misleading. The potential benefits of the operation could be detailed but should not be presented in a categorical manner and should not be exaggerated. ■

Reference:

1. McPherson K, Marsh T, Brown M. 2007. *Modelling future trends in obesity and the impact on health*. Foresight Tackling Obesities: Future Choices (**http://foresight.gov.uk**)
2. Douglas IJ, Bhaskaran K, Batterham RL, Smeeth L. 2015. *Bariatric Surgery in the United Kingdom: A Cohort Study of Weight Loss and Clinical Outcomes in Routine Clinical Care*. PLoS Med 12(12)

Consent: the new landscape

DR KEVIN MT NAYLOR, EXCHANGE CHAMBERS

EXCHANGE CHAMBERS

Most practitioners will be familiar with the decision of the Supreme Court in *Montgomery v. Lanarkshire Health Board*[1] which concerned a pregnant diabetic patient of short stature who was not warned, by her obstetrician, Dr McLellan of the risk of shoulder dystocia (7 – 10%). The evidence suggested that approximately 70% of cases of shoulder dystocia are reduced using the McRobert's manoeuvre. The risk of unresolved shoulder dystocia was therefore between 2 – 3%. Mrs Montgomery had raised concerns about vaginal delivery but Dr McLellan's policy was not routinely to advise diabetic women about shoulder dystocia as, in her view, the risk of a grave problem for the baby was very small, but if advised of the risks of shoulder dystocia women would opt for a caesarean section, which, in Dr McLellan's view, was not in the maternal interest.

Lord Kerr described the risks to the baby of shoulder dystocia as follows:

> *"Shoulder dystocia also presents risks to the baby. The physical manoeuvres and manipulations required to free the baby can cause it to suffer a broken shoulder or an avulsion of the brachial plexus – the nerve roots which connect the baby's arm to the spinal cord. An injury of the latter type may be transient or it may, as in the present case, result in permanent disability, leaving the child with a useless arm. The risk of a brachial plexus injury, in cases of shoulder dystocia involving diabetic mothers, is about 0.2%. In a very small percentage of cases of shoulder dystocia, the umbilical cord becomes trapped against the mother's pelvis. If, in consequence, the cord becomes occluded this can cause the baby to suffer from prolonged hypoxia, resulting in cerebral palsy or death. The risk of this happening is less than 0.1%"*

The option of caesarean section was not discussed with Mrs Montgomery and she proceeded to a vaginal delivery. The baby's shoulder became impacted during an attempted forceps delivery. During the 12 minutes between the baby's head emerging and delivery, the umbilical cord was occluded which caused oxygen starvation resulting in dyskinetic cerebral palsy. He also suffered a brachial plexus injury. If Mrs Montgomery had undergone elective caesarean section her son would have been born uninjured.

In evidence Dr McLellan had stated that she did not routinely warn of shoulder dystocia as nearly all women would chose caesarean section if such a warning was given.

The Supreme Court determined that if Mrs Montgomery had been warned, she would have chosen caesarean section and there would have been no attempt at vaginal delivery. The issue was whether she should have been warned.

The decision of the Supreme Court, abandoning the *Bolam* test and overruling the view of the majority in *Sidaway v Board of Governors of the Bethlem Royal Hospital*[2] takes account of recent social and legal developments, substituting a different test, the doctrine of fully informed consent, endorsing the views of Lord Scarman in *Sidaway* and Lord Woolfe MR in *Pearce v United Bristol Healthcare NHS Trust*[3].

> *[87]...An adult person of sound mind is entitled to decide which, if any, of the available forms of treatment to undergo, and her consent must be obtained before treatment interfering with her bodily integrity is undertaken. The doctor is therefore under a duty to take reasonable care to ensure that the patient is aware of any material risks involved in any recommended treatment, and of any reasonable alternative or variant treatments. The test of materiality is whether, in the circumstances of the particular case, a reasonable person in the patient's position would be likely to attach significance to the risk, or the doctor is or should reasonably be aware that the particular patient would be likely to attach significance to it."*

This passage from the judgment in *Montgomery* should be at the forefront of the mind of all clinicians advising a patient of the risk of any proposed treatment.

The patient is no longer to be considered as a passive recipient of medical treatment. The Supreme Court

continued on page 12

[1] [2015] UKSC 11
[2] [1985] 2 WLR 480
[3] [1999] PIQR 53, CA

continued from page 11

indicated that the clinician can only withhold information relating to risk in very limited circumstances. Firstly, if she reasonably concludes that its disclosure would be severely detrimental to the patient's health and secondly, in circumstances of necessity where, for example, the patient requires urgent treatment or is unconscious or otherwise unable to make a decision.

The Supreme Court went on to describe the practical consequences of the re-formulated test, in the clinical setting:

> *"89. Three further points should be made. First, it follows from this approach that the assessment of whether a risk is material cannot be reduced to percentages. The significance of a given risk is likely to reflect a variety of factors besides its magnitude: for example, the nature of the risk, the effect which its occurrence would have upon the life of the patient, the importance to the patient of the benefits sought to be achieved by the treatment, the alternatives available, and the risks involved in those alternatives. The assessment is therefore fact-sensitive, and sensitive also to the characteristics of the patient.*
>
> *90. Secondly, the doctor's advisory role involves dialogue, the aim of which is to ensure that the patient understands the seriousness of her condition, and the anticipated benefits and risks of the proposed treatment and any reasonable alternatives, so that she is then in a position to make an informed decision. This role will only be performed effectively if the information provided is comprehensible. The doctor's duty is not therefore fulfilled by bombarding the patient with technical information which she cannot reasonably be expected to grasps, let alone by routinely demanding her signature on a consent form.*
>
> *91. Thirdly, it is important that the therapeutic exception should not be abused. It is a limited exception to the general principle that the patient should make the decision whether to undergo a proposed course of treatment: it is not intended to subvert that principle by enabling the doctor to prevent the patient from making an informed choice where she is liable to make a choice which the doctor considers to be contrary to her best interests."*

Some branches of the medical profession have already embraced the judgment in *Montgomery* by re-drafting treatment guidelines relating to consent.

One example is the British Society of Gastroenterology (BSG). The recently published "Guideline for obtaining valid consent for gastrointestinal endoscopy procedures"[4] quotes the relevant part of the judgment in Montgomery and incorporates all of the recent guidance from the GMC and the Department of Health. The document is a detailed practical guide for the clinician seeking to obtain informed consent for endoscopy procedures.

It is fair to say that the Guideline, if followed, reflects a very high standard of clinical practice. Equally, however, the Guideline places a very heavy burden on those responsible for organising and working within a busy endoscopy unit.

Other branches of the medical profession will no doubt follow the lead offered by the BSG, when updating and re-drafting their guidelines. The Royal College of Surgeons published revised guidelines on 27.10.16 "Consent: Supported Decision-Making".

From a practical point of view the decision in *Montgomery* opens the door to a large number of claims based upon a lack of informed consent.

Very many treatment decisions are concerned with risk. The risk of the proposed treatment; the risk of alternative treatment; the risk of no treatment. *Montgomery* requires the clinician to enter a dialogue with the patient and to participate in a collaborative approach to decision making.

One can imagine very many scenarios where claims arise out of an alleged failure to provide valid consent. By way of example:

- The obstetrician advising on mode of delivery, either electively or when the patient is in labour.
- The surgeon advising a patient before an operation.
- The GP who is deciding whether to admit a patient for assessment or treat conservatively at home (eg. acute low back pain with some positive neurology; headache; acute asthma; abdominal pain suggestive of diverticulitis; chest pain; the elderly diabetic patient with diarrhoea and vomiting (where there is a risk of dehydration and acute kidney injury)).
- Any treatment where there are reasonable alternatives available, whether conservative treatment or interventional treatment.

It remains to be seen whether *Bolam* re-emerges in claims arising out of inadequate consent. How will the courts decide whether a clinician has taken reasonable care to ensure that a patient is aware of a material risk or whether the clinician acted reasonably in deciding that certain information about risk fell within the therapeutic exception? ■

[4] www.bsg.org.uk/clinical-guidelines/endoscopy/index.html

Damages for Article 5 rights

WILLIAM CHAPMAN – 7 BEDFORD ROW

A Claimant's Article 5 rights in maximum severity cases looks like it will increase the level of damages way beyond what was immediately apparent in the recent judgement of Charles J. in *Staffordshire CC v SRK & others* [2016] EWCOP 27. The case highlights how astute the courts will be to ensure that the most vulnerable have their Article 5 rights protected and ensuring that the Claimant's care regime - whether in an institutional setting or out of it – is the "least restrictive available option to best promote [the Claimant's] best interests," paragraph 3, *Staffordshire*. The Supreme Court set out the principles in *Cheshire West and Chester Council v P* [2014] UKSC 19. The practical reality for incapacitated Claimant's placed in a non-institutional setting is now taking shape following *Staffordshire*.

The immediately apparent consequences of *Staffordshire* were:

1. Reviews on a frequent, at least an annual basis, by the Court of Protection in all cases where there is on objective deprivation of liberty as widely defined in *Cheshire*, and 'the State knows or ought to know of the situation on the ground';
2. The duties of the Deputy include considering whether a) there was a deprivation of liberty involved in the care regime on the ground b) alerting the local authorities with adult-safeguarding responsibilities c) taking the necessary steps to ensure the deprivation of liberty is authorised.
3. The extent of these duties means that, almost certainly, a professional Deputy would be needed.
4. The increased costs of a professional Deputy with more onerous duties need to form part of the Claimant's damages.

The less apparent consequences of *Staffordshire* are no less important. It means fine arguments about whether the care regime 'is the least restrictive available option' to best promote the Claimant's interests can and should be made. That includes protecting and enabling a Claimant to make what limited choices he/she can make. For example:

1. a Claimant may well be justified in having a second support worker to cover those times when, although the Claimant has not expressed a desire to leave the house, it would be an effective deprivation of liberty to make it impossible for him/her to do so.
2. Where a Claimant has been deprived of his/her liberty in one way, enabling technology to mitigate this deprivation could be extensive.

Indeed, every line of a schedule in a catastrophic injury claim should be scrutinised to see if it achieves the least restrictive option that best promotes the Claimant's best interests. The reasonableness of any claim should, on the authority of *Staffordshire*, give way to a Claimant's Article 5 rights.

A brief summary of the legal twists and turns that led to *Cheshire* and *Staffordshire* helps understand how far reaching these decisions might prove to be. For those who doubt the importance of the European Union legislature in influencing important aspects of our lives, these are signal cases. The Mental Capacity Act 2005 was necessarily amended by the Mental Health Act 2007 following *HL v United Kingdom* (2005) 40 EHRR 32 where it was held that the existing statutory regime did not protect the Article 5 right 'to security and liberty'. By s.64 of the amended Act the definition of 'deprivation of liberty' was expressly surrendered to European law. Charles J felt so bound by EU authority that he reached his conclusion in *Staffordshire* 'with real reluctance because it seems to me that in this and many other such cases a further independent check by the COP will add nothing other than unnecessary expense and diversion of private and public resources would be better focused elsewhere.'

Each case concerned people placed in a domestic setting whose freedom of action was not heavily curtailed by their carers and only so far as necessary to protect them from themselves. In *Cheshire*, one of the cases concerned a young woman with learning disabilities. She was placed with a foster mother who had to provide constant supervision when the woman went out. She had no desire to go out on her own but if she had tried to do so her foster mother would have physically stopped her. *Staffordshire* was concerned with a man who was severely injured in a road traffic accident. He received

continued on page 14

a large award in compensation that was paid to and administered by his Deputy. The award funded a 24 hour care package in a specially purchased bungalow. The care package was provided privately.

Both cases have increased the effective oversight of the Court of Protection. *Cheshire* extended the class of those for whom their care regime should be regarded as a 'deprivation of liberty' to include those where there has been no objection to the placement and the person was placed in a normal domestic setting. As Baroness Hale put it, 'A gilded cage is still a cage'. *Staffordshire* extended the responsibility of the state to include cases where 'the State knows or ought to know of the situation on the ground' even where no aspect of the care is provided by the State. That means many incapacitated claimants in catastrophic claims will need to factor into their calculation of damages the additional burden on a professional Deputy of making sure there is the necessary oversight. In Charles J. view, 'a welfare order needs to be made in such cases to provide a procedure that protects the relevant person from arbitrary detention and so avoids a violation of the State's positive obligations under and the spirit of Article 5.'

Charles J doubted the value of his own judgment in increasing the burden on the Court of Protection, local authorities, carers and Deputies. '...It is not easy to see what value will be added....by the making of a welfare order and its review by the COP.' Be that as it may, there is clear value to incapacitated Claimants in seeking to recover substantial additional damages to protect their Article 5 rights. Notwithstanding Brexit, there is little political appetite to repeal the Human Rights Act 1998. Article 5 will remain. The real threat to the approach in *Staffordshire* is if a contrary view of its application is taken by a higher court that, post-Brexit, is unlikely to be challenged in the European Court of Justice. ■

Falls and avoidable deaths in hospital: when should the Coroner sit with a jury?

EDWARD RAMSAY, BARRISTER, 12 KING'S BENCH WALK

Inquest juries – the background

The significant legislative changes to the coronial system are now three years old. Even before their implementation in 2013 the impact of Article 2 of the European Convention on Human Rights had left its mark. One cannot be left in any doubt that the Coroner's court is not what it used to be. As was observed by Moses LJ 10 years ago in ***R (Lin) v Secretary of State for Transport*** **[2006] EWHC 2575 (Admin)** [at 32]:

> *"Long gone are the days of travel to some dispiriting corner of St Pancras or Battersea only to be told peremptorily, when appearing on behalf of the bereaved, "Keep quiet and sit down." Coroners nowadays are more concerned to conduct full inquiries with ample opportunity for participation, even absent the obligation to conduct enhanced inquests. Many, I was told, seek to conduct a full and fair inquiry and do not believe in offering the bereaved what may be perceived as a second -class inquest. Thus, following Taskoushis, there will often be little difference in practice between an enhanced Middleton —type inquest and other inquests following deaths which give rise to concern both to those immediately involved and to their families".*

With these changes in mind it is something of an anomaly that the Coroners and Justice Act 2009, which sought not only to put bereaved families at the very heart of the coronial reforms but also converted the *power* to report (under old Rule 43 of the Coroner Rules 1984) into a statutory *duty* to do so (under the new Regulation 28 of the Coroners (Investigations) Regulations 2013), also removed the obligation on the coroner to sit with a jury where he had reason to suspect *"that the death occurred in circumstances the continuance or a possible recurrence of which is prejudicial to the health of safety of the public or any section of the public"* (Section 8(3)(d) Coroners Act 1988). It must not be forgotten that inquests have an important public function to ensure *"that the full facts are brought to light; that culpable and discreditable conduct is exposed; that suspicion of deliberate wrongdoing (if unjustified) is allayed; that dangerous practices and procedures are rectified; and that those who have lost their relative may at least have the satisfaction of knowing that lessons from his death may save the lives of others."* ***(R (Amin) v Secretary of State for the Home Department*** **[2004] 1 AC 653)**. A jury is very often a principal means of achieving these objectives because their presence will ensure that the relevant facts are exposed to a greater degree of public scrutiny.

But the gradual trend has been to remove the role of the jury in all but the most serious of cases. The Coroners Act 1887 placed a requirement upon the Coroner to summon a jury of between 12 and 23 individuals; 12 would be required to deliver a verdict. The Coroners (Amendment) Act 1926 reduced the number of jurors to between 7 and 11. At the same time the 1926 Act began the process of whittling down the number of occasions when a jury would be required. The principles set out in the 1926 Act were later enshrined in the Coroners Act 1988. The 2009 Act is responsible for a further tightening.

Hospital cases

With the removal of the old Section 8(3)(d) of the 1988 Act, what provisions are left? And when do they apply in cases of deaths in hospital?

It must not be forgotten that the concern to conduct a full inquiry should in every case include careful consideration as to whether the Coroner should sit with a jury. The relevant provisions of the CJA 2009 are found in Section 7.

In hospital cases there are usually two categories of case when a jury will be mandated. One is well-recognised, namely when the deceased was in state detention and the cause of death is unnatural or unknown (s.7(2)(a) CJA 2009). These cases usually relate to Section 2 and Section 3 Mental Health Act 1983 patients; or those subject to a Deprivation of Liberty Safeguard (DoLS) under the Mental Capacity Act 2005.

The other less well-known category is where the Coroner has 'reason to suspect' that the death resulted from a notifiable accident (notifiable in this case to the Health

continued on page 16

continued from page 15

and Safety Executive (HSE) pursuant to the Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 2013, 'RIDDOR') (s.7(2)(c); s.7(4) CJA 2009).

Reason to suspect is a low threshold. It does not require positive proof. It is the same standard of proof required of the Coroner in initiating an investigation into death under Section 1 of the 2009 Act.

The third remaining category of case is where the Coroner has a residual discretion to sit with a jury where there is 'sufficient reason' for doing so (s.7(3) CJA 2009). As to this last category it is often assumed that in hospital death cases (where the medical and expert evidence may be complex) the jury will be unable to cope (see for instance the transcript of the discussion in ***Bloom v HM Senior Coroner for the Western District of London*** **[2014] EWHC 2698 (Admin)**. And that is even before considerations around listing and the additional expense of jury cases are factored-in. There is an ever present danger that the former is used as a fig leaf for the latter.

It is the second and third categories which are now discussed by reference to hospital falls and other avoidable deaths.

Hospital falls

The figures are staggering. There are, according to NHS England, over 250,000 inpatient falls in acute and community hospitals and mental health units in England reported each year[1].

NHS England is clear as to the scale and complexity of the problem.

> *"Falls prevention is a complex issue crossing the boundaries of health and social care, public health and accident prevention....*
>
> *Falls are a major concern for patient safety and a marker of care quality. A significant number of falls result in death or severe or moderate injury, at an estimated cost of £15 million per annum for immediate healthcare treatment alone (NPSA, 2007)"*[2].

Anyone with any experience of inquests will know that a significant number of hospital deaths reported to the coroner are directly or indirectly attributable to an earlier inpatient fall.

Many of the falls cases reported to the Coroner will already have been investigated internally (with varying quality) by way of a Serious Untoward Incident Report (SUI) or Root Cause Analysis Report (RCA).

In many instances the SUI or RCA will have identified shortcomings and failures in, for example, nursing supervision, inappropriate use of bedrails, lack of risk assessment and care planning documentation, and deficiencies in training and staff awareness. In other cases, similar failures will be obvious or suspected from review of the medical records and contemporaneous documents (or lack of them).

Consider the following example: an elderly patient with dementia is admitted to hospital as a result of a fall at home. He has a fracture to his clavicle. On admission to a general genterology ward a risk assessment puts him at high risk of falls and a high cot-side risk; but no falls care plan is initially completed. The patient is nursed in a cohorted bay with 4 other patients all at high risk of falls. The patient sustains a fall whilst getting out of bed in the early hours of the morning. There is some evidence the patient was trying to get to the toilet and had not been taken to the toilet for a number of hours. There are question marks about the levels of nursing care and supervision that morning. The cot sides were up when they should have been down. The patient injures his head and arm in the fall, sustaining fractures to both. There is a dispute as to whether the cot-sides had been negotiated or were instrumental in the severity of the injuries sustained. He is later discharged back to the care of a nursing home with a fracture to the humerus which has, by this stage, migrated through the skin and is covered with no more than a plastic stoma bag. The patient dies shortly after admission to the home. The fall is not reported internally at the Trust as having caused or contributed to the patient's death. The death is not reported by the Trust to the Coroner but by the care home GP who refuses to sign the death certificate and makes an Adult Safeguarding Referral. There is a police investigation which is subsequently discontinued. An internal investigation by the Trust is later conceded to have been unsatisfactory.

Many practitioners will have dealt with similar cases. This was a real case heard in Coventry this year in which the author represented the family. The Trust resisted the suggestion that the matter was or would have been reportable under RIDDOR thereby mandating the need for the Coroner to sit with a jury. The Coroner consulted the HSE and added them as a Properly Interested Person. The point was eventually conceded. A jury was sworn. A narrative conclusion was returned with a rider of neglect.

[1&2] www.england.nhs.uk/patientsafety/falls-prevention

In any hospital fall case where the patient has subsequently died it is necessary to consider whether there is a suspicion that the death was caused or contributed to as a result of a fall that is suspected to also have been reportable under RIDDOR.

In October 2014 the HSE issued Health Services Information Sheet No.1 (Revision 3) titled *"Reporting injuries, diseases and dangerous occurrences in health and social care"*. Reportable accidents (including falls) involving patients will include those that:

- *arise out of or in connection with a work activity* (including nursing care and supervision); and
- result in *death*; or
- a *specified injury* (including fractures, other than to fingers, thumbs and toes; amputations; any injury likely to lead to permanent loss of sight or reduction in sight; any crush injury to the head or torso causing damage to the brain or internal organs; serious burns (including scalding) which: cover more than 10% of the body; or cause significant damage to the eyes, respiratory system or other vital organs; any scalping requiring hospital treatment; any loss of consciousness caused by a head injury or asphyxia; any other injury arising from working in an enclosed space which: leads to hypothermia or heat-induced illness; or requires resuscitation or admittance to hospital for more than 24 hours).

Importantly the HSE acknowledged *"in the past, there has been some misunderstanding as to the range of accidents that should be reported under RIDDOR when they involve members of the public who are patients, residents, service users or visitors. The following examples will help you decide about reportability"*. Reportable falls would include the following:

Example 1

A service user (who is capable of understanding and following advice) falls off the toilet, having previously been advised not to get up, is injured and taken to hospital. They have been left alone for dignity reasons. Their care plan identified that the individual should have assistance or supervision.

Reportable

The member of staff left the service user out of earshot and without a call bell they could use, or had not responded promptly when they did call, as adequate supervision had not been provided.

Not reportable

The member of staff returned to help them as soon as they called to say they have finished. Or if the service user had got up without calling for help, it would not be reportable.

Example 2

An incontinent service user slips on their own urine when returning back from the toilet and receives a major injury.

Reportable if:

- *the assessment had identified the resident needed help for toileting and it was not provided;*
- *the fall took place in an area of the home where it was foreseeable the resident may slip due to a spillage and the home had failed to assess risks from floor surfaces or act on their assessment.*

Example 3

A patient falls from a stretcher while being manoeuvred into an ambulance and suffers a hip fracture.

Reportable if:

- *the paramedics had chosen the wrong piece of equipment to move the patient, or had not received the appropriate training about safe use of the equipment, or were not following a safe system of work;*
- *the paramedics were aware the patient had a history of aggression and failed to take this into account when moving them. The patient subsequently becomes aggressive and falls from the stretcher.*

Not reportable if:

- *the patient became unexpectedly aggressive, struggled and fell.*

You may need to consult the patient's/service user's care plan to decide what care was assessed as being appropriate for them. If you still are unclear, ask for advice[3].

The Coroner need only form a suspicion that the fall was reportable (and that the death was caused or contributed to by the fall) before the requirement for a jury is triggered. What this means in practice is that if any case falls within or near one of the examples given by the HSE in the 2014 Information Sheet then it follows that the inquest must

[3] www.hse.gov.uk/pubns/hsis1.htm

continued on page 17

continued from page 17

be held with a jury. In every falls case the Coroner will need to be shown a copy of the Information Sheet at a Pre-Inquest Hearing if the matter has not already been reported to the HSE by the Trust. Whether the matter has in fact been reported to the HSE is irrelevant to the application of Section 7(2)(c) of the CJA 2009.

Avoidable deaths

Avoidable deaths are by definition unnatural deaths and fall to be reported to and investigated by the Coroner under Section 1 of the CJA 2009.

In hospital cases where the deceased was not in state detention or where the Coroner has no reason to suspect that the death arose from a notifiable accident reportable under RIDDOR (see above), what is the scope for requesting that the Coroner nevertheless sit with a jury?

In ***Shafi v HM Coroner for East London*** **[2015] EWHC 2106 (Admin)** a checklist of factors were said to be relevant in each case to the Coroner's discretion under Section 7(3) of the CJA 2009. These include amongst others *"whether the facts of the case bear any resemblance to the types of situation covered by the mandatory provisions"* (as was set out at [45] in ***R (Paul) v Deputy Coroner of the Queen's Household*** **[2008] QB 172)**.

The Care Quality Commission (CQC), just like the HSE, is a Non-Departmental Public Body (NDPB). Under Regulation 16 of the Care Quality Commission (Registration) Regulations 2009 hospitals are required to notify the CQC where there is a death of a service user unless the death *"cannot, in the reasonable opinion of the registered person [the hospital], be attributed to the course which that service user's illness or medical condition would naturally have taken if that service user was receiving appropriate care or treatment"* – in order words an unnatural death.

The definition of an unnatural death is one that is both unexpected and the result of culpable human failure (***R (Touche) v HM Coroner for Inner North London*** **[2001] QB 1206** at [46]).

Reports to the CQC under Regulation 16 do not engage Section 7(2)(c) of the 2009 Act. The reason is that the CQC is not an inspector appointed under the Health and Safety at Work Act 1974 (s.7(4)(c) CJA 2009).

But that is about the only difference.

It follows the Coroner need only have 'reason to suspect' that the death was reportable under Regulation 16 of the Registration Regulations in order for a notification thereunder to effectively resemble a notifiable accident reportable under RIDDOR. In those circumstances it would be a powerful reason, absent any other views expressed to the contrary, for the Coroner to exercise the discretion to sit with a jury.

The importance of Regulation 16 in the context of hospital inquests cannot be overstated. The Coroner's duty to investigate under Section 1 of the CJA 2009 is triggered only where he has 'reason to suspect' that the death was unnatural, or the cause of death is unknown, or the deceased died in state detention. In many, if not most hospital cases, the central issue is whether the death was unnatural. It follows that it is not open to the hospital trust to argue in such a case that Regulation 16 is irrelevant. If it were the Coroner would have already discontinued the investigation (under Section 4 of the CJA 2009). For the purposes of persuading the Coroner that a jury is required the 'reasonable opinion' of the hospital under Regulation 16 is immaterial. What matters is the Coroner's opinion. And, by definition, his opinion must already be one of suspicion.

Conclusion

Before 1926 all inquests were held with a jury. Since then Parliament has made significant inroads into the use of jury inquests. Section 8(3)(d) of the 1988 Act did not survive the 2009 Act, which in other respects brought about a significant strengthening of the ability of the coroner to conduct a full inquiry with the assistance of the family. But the role of the jury is an important one and is mandated in the most serious and high profile cases. These include deaths suspected to have been reportable to the HSE under RIDDOR. The examples given by the HSE are very wide-ranging and it is difficult to see an investigation in a patient hospital fall case falling totally outside the HSE guidance as reportable. The threshold for the Coroner (reason to suspect) applies, by definition, a lower standard of proof than the HSE's own guidance. There is a good case for suggesting that in every inquest into a hospital death (where the main issue is the unnaturalness of the death) the Coroner should be looking closely at the discretion to sit with a jury because the suspicion that the death was avoidable (and therefore reportable to the CQC) will already have arisen. ■

Edward Ramsay is a Barrister at 12 King's Bench Walk specialising in hospital inquests

Inquest touching the death of SP

REPRESENTED BY THOMAS BANKS OF 12KBW AND
DR RUTH O'SULLIVAN, MEDICO-LEGAL ADVISOR AT AVMA

An inquest touching the death of SP was heard on 1st September 2016 at Cardiff Coroner's Court.

Issues: elderly care; biliary obstruction; delay in obtaining CT results due to remote radiology arrangements; Delay resulting in lost opportunities to undergo treatment.

Background

SP developed the symptoms and signs of biliary obstruction early in 2015 at the age of 71. She was reviewed initially by physicians at the Royal Gwent Hospital who referred her to the specialist liver unit at the University Hospital of Wales (UHW). In March 2015 she was diagnosed with cholangiocarcinoma.

SP was readmitted to the Royal Gwent hospital on 7/5/15 and again on 18/5/15 with recurrent biliary sepsis. SP responded well to intravenous antibiotic therapy and underwent ERCP and stenting. Her pre-operative work up for the liver resection was also being done at this time.

SP had a past medical history which included obesity, antiphospholipid syndrome (IVC filter in situ and on warfarin) and COPD and lived at home alone prior to becoming unwell.

On 29th May 2015, at the recommendation of the MDT at UHW, SP underwent laparoscopy which confirmed absence of peritoneal disease. On this basis SP was deemed to be a candidate for liver resection, a potentially curative operation. Liver resection is a complex and high risk procedure with an associated mortality of 8-12%. However, chemotherapy is not effective for cholangiocarcinoma so without surgery life expectancy is a matter of months. SP was listed for surgery in June 2015 at UHW under the care of a liver surgeon, Mr K.

While an inpatient at UHW SP continued to receive thromboprophylaxis in accordance with hospital policy. On 1st June 2015 SP's condition deteriorated. SP complained of severe pain in her back and lower abdomen with radiation down her left leg. A CT abdomen on 1st June revealed no haemorrhage or haematoma. The surgical team considered metatastic spread as a diagnosis and requested an orthopaedic review. An MRI was requested but not performed. Instead, an assessment was made using the previous CT imaging and an orthopaedic cause for the pain was ruled out. By 2nd June 2016 a mass was noted in the left iliac fossa by medical and nursing staff and SP continued to be in severe unremitting pain.

On the evening of the 3rd June 2015 SP was reviewed by Mr K. Blood results were available at 5pm but when SP was reviewed by the Consultant at 7pm these results were not seen nor acted upon and the decision to give treatment dose enoxaparin (to prevent blood clots) was made by the consultant. (On 3/6 Haemoglobin had dropped to 92 having been 132 on admission) Haemorrhage was considered overnight by the registrar on call. A CT scan was requested at this stage but was refused by the radiologist on the basis that the clinical picture had not changed and this investigation was not indicated. This decision was not challenged by Mr K.

A CT scan was finally performed on 4th June 2015 following further clinical deterioration characterised by oliguria, tachycardia and hypotension. A delay of over 6 hours in obtaining the result of the CT scan followed owing to technical difficulties encountered between UHW and the remote radiology provider in Australia. Once the scan was reported, some 6 hours later, a large haematoma consistent with retroperitoneal haemorrhage was identified. Attempts were made to reverse the anticoagulation and red cell infusion was given. At angiography no definitive bleeding point was identified and it was on this basis that SP was not deemed to be a candidate for embolisation.

SP continued to deteriorate and having been as an "advanced stage down the road to surgery" was not considered to be a candidate for HDU/ITU on the basis that she was not now a candidate for potentially curative resection owing to her "performance status"; she was considered now to be "too high a risk". SP remained on the ward where resuscitation measures were unsuccessful. SP died on the afternoon of 4th June 2016.

A post-mortem examination was performed and the medical cause of death was stated as:

continued on page 20

continued from page 19

1A Retroperitoneal haemorrhage

1B Anticoagulant therapy

Conclusion

SP died of complications from necessary medical treatment.

Involvement of AvMA

The inquest was listed for 1 day in September 2016 before senior coroner for Cardiff. Mr Thomas Banks of 12 Kings Bench Walk was instructed by AvMA after SP's family approached AvMA's pro-bono inquest team.

Issues in this case

1. Cause of the haemorrhage: IVC filter perforation of the IVC v spontaneous bleed secondary to thromboprophylaxis
2. Delay in diagnosis and management of a major retroperitoneal bleed

(c) Administration of therapeutic dose of heparin when there were clinical signs of haemorrhage

1. Cause of bleed

The pathologist, Dr M, gave evidence that there was a full thickness defect, approximately 4mm in size, in association with a limb of the IVC filter with adherent clot. The defect and the clot were in continuity in addition to approximately 2 litres of blood in the abdominal cavity. A review of the literature provided by Dr M revealed that while perforation/erosion of the IVC is not uncommon, there have been no reports of a major haemorrhage secondary to erosion as described in this case. This being the case, Dr M opined that this case may represent a unique finding worthy of a scientific case report. In Dr M's opinion the bleed was more likely than not to have arisen from this site.

Dr W, an independent expert in radiology instructed by the Coroner also gave evidence on the cause of the bleed having reviewed the available imaging. Dr W had considered that the bleed was spontaneous in nature although having listened to the post-mortem findings Dr W did concede that it may have been possibly the result of erosion of the strut. Dr W opined that the imaging was more likely than not consistent with spontaneous haemorrhage.

The Coroner accepted evidence that the bleed was more likely to have been venous in nature than arterial given that there was no identifiable artery at post-mortem or on imaging and the "slow to medium" estimate of the rate of haemorrhage given. He concluded that on the balance of probabilities the bleed had been spontaneous secondary to anticoagulation therapy. It is noteworthy that current practice is to retrieve these IVC filters rather than leave them in situ as in this case.

2. Delay in the diagnosis and management of the haemorrhage

The management of retroperitoneal haemorrhage was explored by the Coroner with Mr K. The evidence was that such haemorrhages were rarely operated on, save for exceptional circumstances where they have arisen from trauma. The mainstay of treatment is conservative with the withholding of anticoagulant therapy and reversal of its effects coupled with resuscitation of the patient.

During questioning Mr K conceded that SP was at high risk of a bleed owing to her anticoagulant medication, that there were signs of haemorrhage characterised by oliguria, hypotension and tachycardia and low haemoglobin evident on 3rd June 2015 and that ultimately there had been delays in the diagnosis and management of the haemorrhage. However, in Mr K's opinion these delays had not altered the outcome.

With specific regard to delays in obtaining the CT scan results, the coroner stated that there was "no blame for that" but did add that it inevitably led to further delays in SP receiving treatment. The delays evident in this case certainly raise concerns about the use of remote radiological reporting in such circumstances and the systems in place locally for emergency situations. In this case, there appeared to be a lack of familiarity among members of the surgical team with local policies whereby on-call radiologists were available locally albeit not resident in the hospital overnight. This was not fully explored at the inquest but had the local systems been known to the staff on duty, it is arguable that local personnel could have reported the scan earlier which would have prompted earlier reversal of the anticoagulants and resuscitation efforts and may have led to a better outcome.

Once the haemorrhage was known however, the Coroner was satisfied that the appropriate care was taken. Having looked at the legal tests and errors the Coroner was

continued on page 21

satisfied that these did not make any difference to the outcome and did not find that these errors amounted to neglect in a Jamieson or Khan sense. However, while the coroner declined to add a rider of neglect to his narrative conclusion he did acknowledge in his closing remarks that:

There was no doubt that errors were made. It was an error not to look at the blood results at 1920 by Mr K. Had he done so he would have been persuaded that this was a haemorrhage. It was an error that anti-coagulation medication was given at 1830. It may also have been an error that reversal therapy was not given sooner.

Such criticism suggests that while the threshold for neglect was not thought to have been made out in this case, it is arguable that the mismanagement of the retroperitoneal haemorrhage may have contributed more than minimally, negligibly or trivially to the death of SP and Counsel advised the family to seek specialist legal opinion on the merits of a civil claim on this basis. ■

Inquest touching the death of DI

REPRESENTED BY: RHODERICK CHALMERS OF ONE CROWN OFFICE ROW AND DR RUTH O'SULLIVAN, MEDICO-LEGAL ADVISOR AT AVMA

Issues: A&E; missed opportunities to diagnose acute coronary syndrome sooner by OOHGP service; ambulance service grading of incident and delays; systems issue between OOHGP service, 999 and 111.

An inquest was heard on 28–29 September 2016 at North Yorkshire Coroner's Court in Scarborough touching the death of DI.

DI was 62 when he was admitted to the accident and emergency department of Scarborough Hospital on the morning of 10 January 2016. He was diagnosed with acute coronary syndrome and was found to be in cardiogenic and haemorrhagic shock. The medical team were unable to resuscitate him and he died within hours of his admission.

This admission was DI's fourth attendance at Scarborough Hospital in the span of three days. Following referrals via the 999 and 111 services, DI had consulted GPs in the Out of Hours GP (OOHGP) service located at the hospital during three appointments on 8 and 9 January.

There were several issues for the inquest to consider. First and foremost was the clinical care provided by the three GPs who assessed DI. Secondly, there was a significant delay between the 999 service deciding that an urgent ambulance should be despatched and the arrival of an ambulance. Thirdly, there were systemic questions in relation to the OOHGP service, the 111 service and the 999 service.

DI had a medical history of dystonia and alcohol dependency. In the three days prior to his death he had complained of severe pain in both of his arms, his chest, shortness of breath, nausea and vomiting and feeling clammy and generally unwell. DI's general condition was such that he had not been able to eat or drink over this period. Members of DI's family told the inquest that despite his chronic problems, DI coped well with daily life and was not given to complaining about his condition. Against this background, the acute severe pain that prompted him to make successive visits to the OOHGP service was exceptional.

DI's first appointment resulted from an initial 999 call. The 999 service referred him to the 111 service (the non-emergency NHS service) at 23:51 on 7 January 2016. He was assessed over the telephone and given an appointment for the out of hours OOHGP service. Having made his way to the hospital, he was reviewed by Dr R on 8 January at 01:06. Dr R attributed the pain in DI's arms to arthralgia and prescribed analgesia.

DI's symptoms did not respond to this treatment but became, if anything, more severe and unremitting. DI made a further call to 111 and was referred back to the OOHGP service where he was seen by Dr B in the early hours of 9 January. Dr B likewise diagnosed arthralgia and prescribed analgesia. However, DI's complaint of chest pain also prompted Dr B to advise DI to present to A&E for further assessment. DI did not do so but instead returned home.

Following a worsening of the pain, two further reviews were arranged through the 111 service with the OOHGP service on 9 January. The first appointment, with Dr S, was at 14:44; this was followed up with a telephone consultation with Dr S at 17:15. At the first consultation Dr S diagnosed generalised pain and anxiety; following the second, Dr S diagnosed alcohol dependence syndrome. DI's daughters accompanied him to the first appointment.

At around 9am on the morning of 10 January, DI's daughter "B" rang her father. He told her that he had fallen overnight, that the pain in his arms and chest was worsening and that he had been vomiting. On learning of this "B" visited her father and found him in a "terrible" state.

"B" called 111 at 10:42 and was informed that an ambulance would arrive within 40 minutes or so. The family waited approximately 2 hours, during which time they called 999 twice for updates on its progress. An ambulance eventually arrived at 12:32. At this stage DI was in a state of collapse. He was suffering from all the complications of an acute anterior myocardial infarction complicated by a profound anaemia secondary to a gastro-intestinal haemorrhage. A post mortem examination conducted on 13 January 2016 found that DI's death was due to (a) acute myocardial infarction due to (b) coronary thrombosis due to (c) coronary heart disease.

The inquest heard from 15 witnesses. These included DI's two daughters and his daughter-in-law; the three OOHGP service doctors who had assessed DI; the two ambulance personnel and one paramedic who treated DI and transported him to A&E on 10 January; the A&E consultant who oversaw DI's treatment from his admission until his death; the pathologist; and representatives of the OOHGP service, the 111 service and the 999 service, who had all conducted reviews of their respective organisations' roles in the events leading to DI's death. The Coroner had also commissioned two expert reports, from a cardiologist and a general practitioner; both experts appeared to give evidence.

In terms of the first question, that of the care provided by the GPs, no criticism was made of Dr R. In the course of their evidence, however, both Dr B and Dr S admitted that they had missed opportunities to diagnose, or facilitate the proper diagnosis, of DI's condition.

Dr B accepted that merely advising DI to make his own way to A&E for further tests was an inadequate response to his symptoms and circumstances. Although the OOHGP surgery was co-located with the A&E department in the hospital, Dr B admitted that he should have accompanied DI to A&E and ensured that he was transferred into the care of the A&E doctors. Had a patient with the same history and symptoms presented to Dr B's own surgery, he would have called an ambulance himself and considered himself responsible for the patient's care until taken over by the ambulance staff. Dr B accepted that he had made an error of judgment not to adopt the same approach with DI.

Dr S was the third GP to review DI. Although he had been forewarned of DI's attendance when the appointment was arranged by the 111 service, Dr S admitted that he had not checked DI's notes, which were available on the computerised system. He was therefore unaware of Mr Ireland's previous consultations with Dr R and Dr B. Had he been aware, Dr S's evidence was that he would have been unlikely to dismiss DI's symptoms as generalised pain and anxiety. Dr S apologised for this missed opportunity.

In terms of the 999 response, the inquest was unable to shed much light on the admitted delays beyond what was already known to DI's family. The family had no complaints about the care provided by the ambulance staff and paramedic, whom they praised for their professionalism. The representative of Yorkshire Ambulance Service (YAS) attributed the delays to the initial coding of the request as "Green 2" (non-urgent) and to a shortage of available vehicles; the YAS serious incident report concluded that the dispatcher failed properly to carry out resource checks.

According to the YAS evaluation of their records for 10 January, demand was high across the YAS region and especially in North Yorkshire and East Riding. However, a specialist cardiac response car was available at 11:42 and, had the 111 service referred the call to 999 as a code "Red", that car would have been despatched followed by an ambulance as soon as one was available. Further, the YAS evidence was that they had revised their systems and a similar referral would now be coded Red (with an 8 minute response target) or Amber (a new designation, with a 19 minute response target). The Coroner made no express criticism of the 111 service but noted that it too had altered its procedures such that the same circumstances would now result in a Red coding.

The result of the 111 and 999 delays on 10 January was that by the time the ambulance reached DI he was already too unwell to be sufficiently stabilised for the one-hour journey to Hull, the nearest centre for Percutaneous Coronary Intervention (PCI). Dr Clancy, the A&E consultant, confirmed that DI satisfied the admission criteria for PCI and that had it been possible to stabilise him in Scarborough Hospital she would have arranged for his transfer to Hull.

As the Coroner recorded, DI's underlying condition, which had formerly been asymptomatic, represented in any event a real risk of death at some point. However, although DI died from a natural disease there were missed opportunities for more timely medical intervention which could have prolonged his life. ■

Forthcoming conferences and events from AvMA

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

AvMA Specialist Clinical Negligence Panel Meeting & Christmas Drinks Reception

2 December 2016
America Square Conference Centre, London

The annual meeting for AvMA Specialist Clinical Negligence Panel members provides the opportunity to meet, network and discuss the latest key developments and issues facing clinical negligence law. This year's meeting will take place on the afternoon of Friday 2nd December - registration and a networking lunch will commence at 12.30, with the meeting starting at 13.30 and closing at 17.30.

AvMA's Christmas Drinks Reception, which is also open to non-panel members, will take place immediately after the meeting, also at America Square Conference Centre. The event provides an excellent opportunity to catch up with friends, contacts and colleagues for some festive cheer!

Medico-Legal Issues in Diabetes

8 December 2016
Doubletree by Hilton Hotel, Leeds

Many people with diabetes have multiple and complex health problems and, with this significant risk in mind, the potential delay or missed diagnosis of the patient can have serious consequences. This conference looks at the condition in detail, types of diabetes, risk factors and complications of treatment, co-morbidity, including gestational diabetes, cardiac complications, peripheral vascular disease and diabetic neuropathy and retinopathy. The impact of diabetes on causation arguments will also be discussed highlighting how the condition affects the way the clinical negligence practitioner looks at injuries. Booking now open.

The Human Rights Act and its Application in Healthcare

25 January 2017
America Square Conference Centre, London

The Human Rights Act 1998 sets out the fundamental rights and freedoms that everyone in the UK is entitled to, therefore impacting on aspects of healthcare provision, end of life and mental health issues.

At the end of this conference, you will understand how to apply the Human Rights Act and its relevant articles to healthcare practice and clinical negligence cases. Fatal accident claims, the inquest process, end of life issues, withdrawal of treatment and mental health detentions will all be examined. You will also understand how to challenge decisions using the Human Rights Act, as well as recognise the impact of Brexit on the HRA, the possible introduction of a British Bill of Rights and how this might affect patient safety and access to justice. Booking now open.

Clinical Negligence: Law Practice and Procedure

2-3 February 2017
Jury's Inn Hotel, Birmingham

This is ***the*** course for those who are new to the specialist field of clinical negligence. The event is especially suitable for trainee and newly qualified solicitors, paralegals, legal executives and medico-legal advisors, and will provide the fundamental knowledge necessary to develop a career in clinical negligence. Expert speakers with a wealth of experience will cover all stages of the investigative and litigation process relating to clinical negligence claims from the claimants' perspective. Places are limited to ensure a focused working group. Booking now open.

Medico-Legal Issues in the Care of Older People

28 February 2017
America Square Conference Centre, London

Over the past 6 years there has been a 50% increase in the number of older people not receiving appropriate care, according to research published by Age UK, the Alzheimer's Society and the BBC. Join the 'Medico-Legal Issues in Older People Care' conference to recognise the issues impacting on older people's care, differentiate expected complications from negligent treatment and understand the legal and costs implications for bringing a claim.

This is a must-attend conference for clinical negligence solicitors and barristers and healthcare professionals specialising in older people care and clinical governance, and will provide the most up-to-date practical and legislative information to help ensure older people get the best care possible and are properly represented. Booking now open.

Medico-Legal Issues in Surgery

9 March 2017
Bristol Marriott Royal Hotel

This one day conference has been designed for solicitors, barristers and junior doctors to illustrate the key medico-legal issues in surgery and is an excellent opportunity to learn from leading surgeons and develop your understanding to assist you in your cases. This course does assume basic medical knowledge, and is aimed towards those looking to develop their medical knowledge further. The medico-legal issues arising in gynaecological, cardiothoracic, cholecystectomy, colorectal and urology surgery and hospital acquired infection will all be examined. A day not to be missed and essential for your caseload! The programme will be available and booking will open in December.

Cerebral Palsy & Brain Injury Cases – Ensuring you do the best for your client

15 March 2017

America Square Conference Centre, London

This popular AvMA conference returns to London on 15th March and will discuss and analyse the key areas currently under the spotlight in Cerebral Palsy and Brain Injury Cases so that lawyers are aware of the challenges required to best represent their clients. Determining causation, neonatal risk factors and intrapartum fetal distress and surveillance focusing on CTGs will be covered by leading medical experts. Guidance will also be provided on alternative and augmentative communication and assistive technology for children with brain damage, as well as looking at case management, tactical budgeting and the current issues in CP and brain injury claims. The programme will be available and booking will open in December.

Best Practice in Quantum

28 March 2017

Radisson Blu Hotel, Liverpool

Quantifying damages and costs in clinical negligence cases requires maintaining balance between the clients' needs, expectations and financial compensation. This conference will assess general and special damages in quantum cases, looking at past and future loss; care costs and negotiating and settlement. Quantifying heads of damage in fatal accidents and dependency claims, life after settlement from the client's perspective and common issues with accommodation will also be examined. We will also look at quantifying in professional negligence, and a legal update on quantum cases will be provided. The programme will be available and booking will open in December.

Essential Medicine for Lawyers

9 May 2017

Manchester Conference Centre

This essential conference has been structured to ensure delegates gain a good grounding in the key areas of the major body systems. The increased understanding gained will underpin all future medical learning in relation to clinical negligence and enable you to apply medical knowledge to your cases. Each speaker will address the essential areas that clinical negligence solicitors need to know, including an introduction to the anatomy and physiology of each system, useful terminology and an examination of the common conditions that affect these systems, their symptoms and standard procedures for diagnosis and treatment. The programme will be available and booking will open in early 2017.

AvMA Annual Charity Golf Day

22 June 2017

Rudding Park, Harrogate

The thirteenth AvMA Charity Golf Day will take place on Thursday 22 June 2017 at the stunning Rudding Park in Harrogate. The Welcome Event for the Annual Clinical Negligence Conference will take place later that evening in Leeds (30 minutes' drive away) so the Golf Day offers the perfect start to the essential event for clinical negligence specialists.

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

Annual Clinical Negligence Conference 2017

23-24 June 201

Royal Armouries Museum, Leeds

The Annual Clinical Negligence Conference (ACNC) is the event that brings the clinical negligence community together to learn and discuss the latest developments, policies and strategies in clinical negligence and medical law.

As ever, it will be an event not to be missed, with the usual high standard of plenary presentations and focused breakout sessions that you would expect from this event, ensuring that you stay up to date with all the key issues and providing 10 hours CPD (SRA, Bar Council and APIL).

As well as providing you with a top quality, thought provoking, learning and networking experience, the success of the conference helps AvMA to maintain its position as an essential force in promoting justice. The programme will be available and booking will open in February.

Sponsorship and exhibition opportunities at ACNC 2017

The unique environment of the ACNC offers companies the ideal opportunity to focus their marketing activity by gaining exposure and access to a highly targeted group of delegates and experts. Contact us for further details on the exciting opportunities available to promote your organisation at ACNC 2017.

AvMA 35th Anniversary Gala Celebration

1 December 2017 (evening)

Grand Connaught Rooms, London

Join us on the evening of Friday 1 December 2017 to celebrate AvMA's 35th anniversary and to mark the progress that has been made in patient safety and justice since AvMA was formed in 1982.

The evening will be one of celebration, with a drinks reception followed by a fantastic three course meal with wine, live entertainment, dancing and some special surprises!

It will be the perfect event to entertain clients / contacts or reward staff, on an evening that will bring together the key people from the patient safety and medico-legal worlds. AvMA's Specialist Clinical Negligence Panel Meeting will take place that afternoon at the same venue - the Grand Connaught Rooms - a short walk from Covent Garden and Holborn underground stations.

Make sure you're there on AvMA's big night! It promises to be the most memorable of occasions and we look forward to seeing you there. Look out for further details soon.

Tel: **0203 096 1140**
Email: conferences@avma.org.uk
Web: www.avma.org.uk/events

Putting Profit Back into Legal Costs

PIC – Clinical Negligence Legal Cost Specialists

For 20 years PIC have been the primary Clinical Negligence claimant-only specialist in the market.

We have a proven track record for delivering the highest level of customer service for our clients and we offer the following benefits:

- ☑ Cost budgeting.
- ☑ No win no fee.
- ☑ All fees deferred.
- ☑ Full cost and case management service.
- ☑ Consistent high recovery of costs for NHSLA.
- ☑ High hourly rates achieved.
- ☑ Payments on account achieved quickly and efficiently.

PIC
PARTNERS IN COSTS

PIC provide regional coverage with dedicated teams to release your lock up in the shortest possible time.

For further information:

@PIC_Legal pic.legal PIC Legal Costs Specialists

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

Instant access to medico-legal learning

Take advantage of our 20% off Winter Webinar Subscription Offer!

AvMA Lawyers' Service members Was £1,200 + VAT Now just £960 + VAT

Standard rate Was £1,900 + VAT Now just £1,520 + VAT

Working on a client file and looking for more information to assist you with your case? AvMA webinars give you immediate access to medico-legal talks on subjects ranging from interpreting blood test results to medico-legal issues in surgery.

Featuring some of the UK's leading authorities on medico-legal issues, AvMA's webinars bring you all the benefits of a specialist targeted seminar, all without having to leave your office. Covering over 20 of the most popular subjects, AvMA webinars are a vital addition to any clinical negligence solicitor's library.

The webinars can be watched at a time convenient to you. On average they last approximately 60 minutes and can be accessed on any device with an internet connection. You can watch the video as many times as you want.

Our leading medical experts include:

- **Professor David Warwick**
  Consultant Orthopaedic and Hand Surgeon, Southampton University Hospital
- **Dr Christopher Jenner**
  Consultant in Pain Medicine, Imperial Healthcare NHS Trust
- **Dr Mark Vanderpump**
  Consultant Physician and Honorary Senior Lecturer in Diabetes and Endocrinology, the Royal Free London NHS Foundation Trust in London
- **Mr Jonathan Miles**
  Consultant Orthopaedic Surgeon, Royal National Orthopaedic Hospital
- **Dr Nelly Ninis**
  Consultant General Paediatrician, St. Mary's Hospital, Imperial College Healthcare NHS Trust
- **Mr Mark Waterstone**
  Consultant Obstetrician & Gynaecologist, Darent Valley Hospital
- **Mr Nicholas Parkhouse**
  Consultant Plastic & Reconstructive Surgeon, Queen Victoria Hospital, East Grinstead

Current webinar titles include:

- Medico-Legal issues in Obstetric Emergencies
- Cerebral Palsy and Brain Injury - understanding your clients' needs
- How to became a Panel Member
- Medico-Legal Issues in Orthopaedics – a paediatric focus
- Hand and Wrist Surgery
- Upper Limb Surgery Focusing on Shoulder Surgery
- Spinal Surgery
- Foot and Ankle Surgery
- Knee Surgery
- Joint Replacement of the Hip and Knee
- Cauda Equina Syndrome
- Medico-Legal Issues in Pain Management
- Medico-Legal Issues in Diabetes
- Medico-Legal Issues in Meningitis and Septicaemia
- Marketing for Lawyers

Book your webinar subscription now!

Use discount code: **Ho2016**

Discount code valid until the 20 January 2017
Offer valid for online purchase only

www.avma.org.uk/learning

Why choose AvMA's specialist medico-legal seminars?

AvMA is the leading patient safety and justice charity in the UK. We have over 30 years of hosting specialist medico-legal conferences and events and that experience has gone in to creating the ultimate series of webinars on the key subjects you need. Featuring some of the UK's top medico-legal experts, AvMA's focus on clinical negligence is unparalleled. ■

2017 is the 35th Anniversary of AvMA

We ask you to make AvMA your Charity of the Year 2017

Though we have had many significant achievements, the need for our work remains as great as ever. As a charity we cannot exist without your donations and support. It enables us to continue helping thousands of families who have suffered a medical accident. We are a powerful voice for the injured patient and their families. Together we can improve patient safety to vulnerable families.

Our need is great and resources are stretched to the limit with an increasing demand for our patient advice line, specialist client case work and our highly successful inquest support services. In addition, we continue to fight to preserve access to justice for victims of clinical negligence, their families and the great British public.

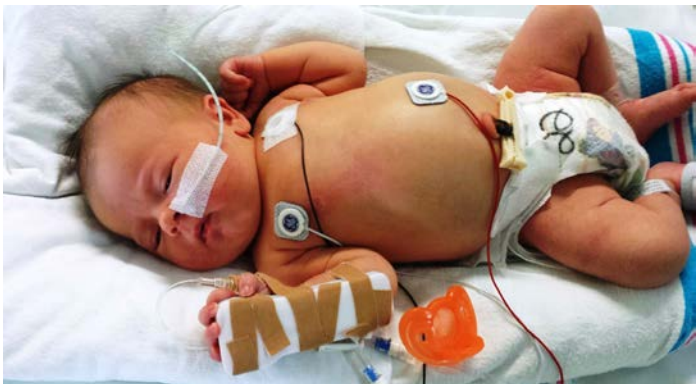
AvMA's recent record of achievement includes:

- Being an active member of the Mid Staffs public inquiry
- Instrumental in the introduction of "Duty of Candour"
- Our support of the campaign for a Chief Coroner

Here is how you can best help AvMA meet the challenges ahead:

1. **Nominate AvMA as your Charity of the Year 2017**
2. **Join our sponsored parachute jump 18th June 2017**
3. **Organise an event in your area such as a curry night or quiz night**
4. **Encourage staff to become a regular giver to AvMA**
5. **Just £5 pcm would help us train a new volunteer**

35 YEARS avma action against medical accidents



For further details contact:

Philip Walker, Fundraising Manager

Tel: **020 8688 9555**
Email: philipwalker@avma.org.uk

Help us do more good work – we need your support in 2017

Action against Medical Accidents (AvMA)

Freedman House
Christopher Wren Yard
117 High Street
Croydon
CR0 1QG

DX: 144267 CROYDON 24

www.avma.org.uk