

Lawyers Service Newsletter

APRIL 2019

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Editorial

Welcome to the first Lawyers Service Newsletter of 2019.

First, thank you to all those practitioners who completed the 2018/19 AvMA Lawyer Service Questionnaire; your responses are important to us and help to inform our approach to key issues on access to justice and patient safety.

The Civil Justice Council (CJC) clinical negligence fixed costs working group have been considering an improved process for clinical negligence claims valued at £25,000 or less. The group has been meeting regularly since April 2018 and a mediation between the parties took place on 21st March. The entire mediation is subject to confidentiality. The next stage is for the CJC to submit a report to the Department Health and Ministry of Justice, a DH consultation is expected to follow on from this.

On the 1st April the NHS launched a new state-backed indemnity scheme for GPs in England (CNSGP) for details of what this means for future claims against GPs please see [here](#):

Many of you will recall the Ministry of Justice's (MoJ) call for evidence in their review of legal aid for inquests which was issued last summer, the final report was published in February: see [here](#)

During the course of the review changes were made to the Lord Chancellors Guide to Exceptional Funding for inquests, the key changes for healthcare inquests are:

- The discretion to waive the requirement for financial means testing has been broadened.
- A relevant factor for consideration by the LAA caseworkers is whether the coroner has decided that Article 2 is engaged – note, it does not require the coroner to determine whether the inquest should be conducted in accordance with Article 2.
- Legal aid funding for Pre-Inquest Review hearings may be awarded retrospectively provided the application for funding is submitted prior to the PIR. This will depend upon the LAA being satisfied later in the process that legal aid should be awarded



Lisa O'Dwyer
Director, Medico-Legal Services

- Under the category of wider public interest, LAA caseworkers are to consider whether the case involves issues of wide scale systemic failures. However, if other investigations have taken place which have recommended improvements to the system, or where responsibility for failings relating to the death have been accepted then arguments on systemic failings are less likely to succeed.

It remains to be seen what difference, if any these changes will have in practice. We are pleased to include **Sara Sutherland's** article "*Hospital deaths and Article 2 inquests*" in the Newsletter, the article provides a helpful reminder of when Article 2 is likely to be engaged particularly since the case of Parkinson [2018] EWHC 1501 (Admin), Sara is a barrister at Exchange Chambers. In addition, **Abigail Telford** barrister at Parklane Plowden has written up one of AvMA's inquest cases (**The inquest touching the death of Thomas Holt**) which reminds us that coroner's will not make Prevention of Future Death reports in circumstances where they are satisfied that the trust has carried out a significant and extensive review of their own systems to prevent failings in those systems from recurring.

Despite the challenges of practising in healthcare law, the resilience, commitment and dedication claimant clinical negligence lawyers show in doing their best for their clients continues. **Andrew Bentham** at McMillan Williams and **Ben Collins QC** at Old Square Chambers case of **Asante v Guy's & St Thomas' Hospital NHS Foundation Trust [2018] EWHC 2578 (QB)**, is a good example of what can be achieved even when the odds appear to be stacked against the claimant. Andrew's case note takes a closer look at some of the difficulties encountered by the claimant legal team including managing an historic case where the breach of duty arose in or about 1999; paucity of information in the medical notes; problems tracing treating clinicians; the claimant independent medical expert being trained by the defendant expert; late disclosure of medical records with a large bundle of relevant records being disclosed late and only a few months before the trial date. Despite these hurdles Andrew and Ben were able to persuade the judge to find for the claimant.

Andrew Roy barrister at 12 Kings Bench Walk regularly contributes to the LS Newsletter. Following on from his article in November 2018 "*Duce v Worcestershire Acute Hospitals – the limits of informed consent*" this edition of the Newsletter, sees Andrew's article "**Khan v MNX – the SAAMCO principle in clinical negligence**" explore in more detail the causal connection between breach of duty, the injury consequent upon the breach and recoverability with reference to claims based on

lack of informed consent. **Jonathan Godfrey** barrister at Parklane Plowden Chambers explores the issue of lack of informed consent further in his article "**With the best of intentions**" a commentary on the case of **Hazel Kennedy v Dr Jonathan Frankel [2019] EWHC 106 (QB)**. Jonathan's article sets out the key points to be taken from the judgment and highlights Yip J's method of applying the Montgomery principles to the facts of the case. The article also reminds us of the importance of instructing the right expert and that a duty of care can arise even though an expert offers their advice without charge.

Tara O'Halloran barrister at Old Square Chambers looks at the recent amendments to **The Human Medicine (Amendment) Regulations 2019** which since 9th February 2019 allows pharmacists to alter the strength, quantity or type of drug without first obtaining permission from the prescriber; she also comments on the *Kennedy -v- Frankel* case.

Stephanie Prior is head of clinical negligence and Child abuse litigation at Osborne solicitors, her article "**Health Practice Associates – what are they about?**" draws attention to the NHS' use of private ambulance services. Stephanie's article asks if these private ambulance services are slipping under the accountability radar when things go wrong and explores the role of the Health Practice Associates (HPA) in holding individuals to account.

We are very pleased to include an article by **Sarabjit Singh QC** of 1 Crown Office Row on "**Relief from sanctions**" which draws attention to the factors which will be critical to the success or failure of an application for relief. Confidence in the use of mediation in clinical negligence claims appears to be growing amongst clinical negligence practitioners, the short, pithy article, "**ADR in clinical negligence claims**" by **Bill Braithwaite QC** of Exchange Chambers will be of interest to many of you.

We hope you enjoy this edition of the Newsletter and welcome your feedback (norika@avma.org.uk) on any of the articles included as well as enquiries from anyone who is interested in submitting an article for the next edition of the Newsletter which is due out in June. Finally, we draw attention to this year's **Rising Star Award** which is aimed at junior solicitors – applications must be received by **24th May 2019**, full details of this year's competition can be found in the Newsletter.

Best wishes



Hospital deaths and Article 2 inquests

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Article 2 of the European Convention on Human Rights provides that:-

'Everyone's right to life shall be protected by law. No one shall be deprived of his life intentionally save in the execution of a sentence of a court following his conviction of a crime for which this penalty is provided by law.'

This is an absolute right from which no derogation is allowed.

So when is Article 2 engaged within the Coronial process and what does it mean?

There are 4 fundamental questions to be answered during the course of an inquest; who has died, when did they die, where did they die and how did they come by their death. In those cases where Article 2 has been engaged the scope of the inquest is widened to consider 'how and in what circumstances' the Deceased came by their death.

So when is Article 2 engaged? The state's procedural obligations under Article 2 (to hold an effective public investigation by an independent official body) are engaged when the state is suspected of failing to have in place an appropriate system and regulatory framework to:-

- (a) protect life or to
- (b) safeguard lives or to
- (c) refrain from taking lives.

It is unlikely that these substantive obligations will have been violated where appropriate systems are in place and appropriate measures have been adopted for the protection of patients' lives (although there may be some exceptional circumstances where the acts and omissions of the authorities, engage Article 2, please see below).

How does this translate to those deaths that occur in hospital? The Chief Coroner in the case of R (on the application of Gerard Joseph Parkinson) v HM Senior Coroner for Kent & Dartford and Gravesham NHS Trust [2018] EWHC 1501 (Admin), confirmed that where

there has been adequate provision for securing high professional standards among health professionals and the protection of patients' lives, matters such as an error of judgment on the part of a health professional or negligent co-ordination among health professionals in the treatment of a patient are not sufficient of themselves to invoke Article 2.

In what 'exceptional circumstances' will Article 2 be engaged? The Grand Chamber of the European Court of Human Rights in Lopes de Sousa Fernandes v Portugal (app. No. 56080/13), judgment of 19th December 2017 identified "very exceptional circumstances" in which the responsibility of the state under the substantive limb of Article 2 may be engaged in respect of the acts and omissions of healthcare providers:-

- (a) "The first concerns a specific situation where an individual's life is knowingly put in danger by denial of access to life-saving emergency treatment ... It does not extend to circumstances where a patient is considered to have received deficient, incorrect or delayed treatment."
- (b) The second "arises where a systemic or structural dysfunction in hospital services results in a patient being deprived of access to lifesaving emergency treatment and the authorities knew about or ought to have known about that risk and failed to undertake the necessary measures to prevent that risk from materialising, thus putting the patients' lives, including the life of the particular patient concerned, in danger ..."

The ECHR identified that the factors which, taken cumulatively, must be met:-

- 1) "the acts and omissions of the health-care providers must go beyond a mere error or medical negligence, insofar as those health-care providers, in breach of their professional obligations, deny a patient emergency medical treatment despite being fully aware that the person's life is at risk if that treatment is not given ..."

- 2) "The dysfunction at issue must be objectively and genuinely identifiable as systemic or structural in order to be attributable to the state authorities, and must not merely comprise individual instances where something may have been dysfunctional in the sense of going wrong or functioning badly ..."
- 3) "There must be a link between the dysfunction complained of and the harm which the patient sustained."
- 4) "The dysfunction at issue must have resulted from the failure of the State to meet its obligation to provide a regulatory framework in the broader sense."

As the High Court set out in *Parkinson*; "at the risk of over-simplification, the crucial distinction is between a case where there is reason to believe that there may have been a breach which is a "systemic failure", in contrast to an "ordinary" case of medical negligence". Allegations of what are in truth allegations of "individual negligence" should not be "dressed up as systemic failures".

Parkinson confirmed that the primary procedural obligation of Article 2; "is to have a system of law in place, whether criminal or civil, by which individual failures can be the subject of an appropriate remedy. In the law of England and Wales that is achieved by having a criminal justice system, which can in principle hold to account a healthcare professional who causes a patient's death by gross negligence; and a civil justice system, which makes available a possible civil claim for negligence."

In my opinion the bar has been set high and it will follow that the number of Article 2 inquests will reduce. This will not however prevent Coroners conducting an independent, full, fair and fearless investigation.

Inquest touching the death of Thomas Holt

**ABIGAIL TELFORD
PARKLANE PLOWDEN**



Thomas Holt was an 84 year old gentleman who lived at home with his wife. His care was provided by his wife and other family members. Mr Holt was admitted to Tameside General Hospital on 25 November 2017 with symptoms of a fever, fatigue and decreased appetite. Mr Holt was treated with antibiotics after a Staph Aureus infection was identified. Mr Holt's condition fluctuated over the course of December 2017 and January 2018 and the source of the infection was not identified. Mr Holt was documented as having redness to the sacral area in November and December 2017, and a moisture lesion/grade 2 pressure sore on two occasions in January 2018, but no referral was made to the tissue viability service. Mr Holt's condition declined throughout January 2018 and on 21 January 2018 he was documented as having overwhelming sepsis. He was placed on an end of life care plan and was transferred to Willow Wood Hospice on 22 January 2018. Upon arrival at Willow Wood Hospice, Mr Holt was identified as having a grade 4 pressure sore to the sacral area which was undressed and was not documented in any of Mr Holt's transfer information. Mr Holt died on 25th January 2018. The coroner concluded that there were missed opportunities to identify and treat Mr Holt's pressure sore and that treatment would have prevented the progression of the lesion.

Background

Thomas Holt was an 84 year old gentleman who had a number of conditions, including dementia, atrial fibrillation, type 2 diabetes, anaemia, hypertension and hypopituitarism. Mr Holt had no issues with skin viability. He lived at home with his wife and care was provided by family members. On 16 November 2017, Mr Holt was admitted to Tameside General Hospital following a collapse and bang to the head, no issues with skin care were identified at this point. Mr Holt was discharged on 20 November but was re-admitted on 25 November with a history of fever, fatigue and decreased appetite. At admission, a SSKIN body map documented redness to the sacral area.

Mr Holt was managed for suspected sepsis with IV antibiotics and was then declared fit for discharge on 1 December 2017. Unfortunately, prior to discharge he declined again and was recommended on IV Tazocin. Blood cultures were taken, which tested positive for Staph Aureus. Mr Holt's IV antibiotics were changed to cover this bacteria.

On 18 December, Mr Holt was again declared medically fit for discharge, but this did not take place due to concerns about the level of care he required and steps being put in place to manage this. On 27 December, a Ward Manager, completed a SSKIN body map which identified redness and a moisture lesion to the sacral area. No care plan or system of review was put in place at this time.

On 2 January 2018, a further body map documented an area of concern which queried whether there was a moisture lesion or grade 2 pressure sore to the sacral area. There was no further follow up or referral to the tissue viability services regarding this, however Mr Holt had developed symptoms of a chest infection and was commenced on oral antibiotics. Mr Holt was then recommenced on IV Tazocin on 4 January due to suspected sepsis. The source of the recurrent infections and sepsis were unidentified.

A body map completed on 12th January 2018 again identified grade 2 skin damage. No referral was made to the tissue viability services and no care plan, wound evaluation or plan for escalation was put in place.

A referral to tissue viability services was eventually made on 17 January 2018, but the lesion was identified as a moisture lesion rather than a grade 2 pressure sore. It was therefore not prioritised and, due to staffing issues over a weekend, Mr Holt was not reviewed by tissue viability services.

Mr Holt's condition continued to decline and on 21 January it was identified that he had overwhelming sepsis, albeit that the source remained unidentified.

On 22 January 2018, Mr Holt was transferred to Willow Wood Hospice for end of life care. Upon admission to

Willow Wood, a body map was completed and a grade 4 pressure sore was identified to his sacrum. There was no dressing in place and this sore had not been identified on any of the transfer documentation sent with Mr Holt from Tameside General Hospital.

The Inquest

The inquest was heard in the South Manchester Coroner's Court before Assistant Coroner Mr Morris over one day. The clinicians and nurses involved in Mr Holt's care at Tameside General Hospital and Willow Wood Hospice gave evidence.

During the course of evidence, it became clear that although SSKIN body maps were being filled out, they were not being completed fully and did not provide descriptions or the locations of any lesions identified, making it impossible for any progress to be monitored.

The evidence given by nursing staff indicated that a referral should have been made to the tissue viability service no later than 4 January 2018, which would likely have been accepted and a review taken place within 24 hours. Similarly, once a grade 2 pressure sore/moisture lesion was identified on 12 January 2018, a referral to tissue viability services should have been made.

The evidence given suggested that the scoring of pressure sores was not straightforward and there were also difficulties in identifying the difference between pressure sores and moisture lesions as they started to form. Moreover, the difference between a grade 3 and a grade 4 pressure could also be difficult to evaluate, albeit that the witnesses accepted that any grade 3 or 4 pressure sore should have been subject to a tissue viability referral and a care plan and dressings put in place.

Over the course of the evidence, nursing and medical staff from Tameside General Hospital gave evidence about significant amendments to the documentation and handover procedures regarding body mapping, the identification, documentation and assessment of pressure sores and moisture lesions, and the system of oversight regarding those procedures. There was said to be a new skin bundle body map, which was required to be filled in by a qualified nurse, rather than the previous practice where such body maps could be filled in by healthcare assistants.

Conclusions and Comments

Mr Holt was found to have died following the development of a sacral lesion which remained unassessed and untreated.

A referral to tissue viability services should have been made on 4 January 2018 and, by the latest, 12 January 2018. The referral eventually made was too late and inadequately and improperly made, which meant that Mr Holt was not assessed before discharge.

The coroner stated as a matter of common sense, he thought that proper treatment would have prevented progression of the lesion, that there were missed opportunities to manage the pressure sore and that this may have made a difference to Mr Holt's condition.

The coroner looked in some detail at what had been done since Mr Holt's death, including considering in some detail the sufficiency of the procedures subsequently put in place.

The coroner found that there were no regulation 28 (preventing future death) issues to consider as Tameside General Hospital's witnesses had given extensive evidence about the changes to the systems and procedures involved in the identification of and management of pressure sores following Mr Holt's death.

Comment

The evidence given by the witnesses for Tameside General Hospital was key in satisfying the coroner that this was not a case in which it was appropriate or necessary for him to exercise his powers under regulation 28 of the Coroners (Investigations) Regulations 2013 to make a report in order to try to prevent future deaths.

Whilst the systems in place for the identification and treatment of pressure sores were found by the coroner to be wanting, resulting in missed opportunities for treatment of Mr Holt's condition, the coroner found that there had been a significant and extensive review of those systems which he was satisfied meant that the risk of future deaths had been reduced.

This case therefore demonstrates that even where systems and procedures have gone significantly wrong in relation to the care and management of a patient, the coroner will be keen to look at the new procedures and systems with a critical eye to ensure that a recurrence of the same situation can try to be avoided.

Case Note: Asante v Guy's and St Thomas' Hospital NHS Foundation Trust [2018] EWHC 2578 (QB)

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Lloyd Asante suffers from sickle cell disease (“SCD”). He came to the UK from Ghana in 1999 and shortly thereafter underwent treatment at St Thomas’ Hospital for acute osteomyelitis in his right tibia. His treatment was unsuccessful and he has been left with a serious injury to his right leg. He brought a claim against the Trust. In October 2018 Her Honour Judge Taylor gave judgment for the Claimant on liability and causation following a five-day trial. The case highlights some interesting issues, which are considered in this case note.

The authors represented the Claimant at trial, and continue to do so.

Facts

SCD is a hereditary blood disorder with consequences which include restricted blood flow within bone, which can lead to infection (osteomyelitis). The Claimant was first diagnosed with osteomyelitis in his right shin in August 1999. On 13 August he underwent surgery to lift off the outer layer of the infected bone (the periosteum) and drill holes to allow the release of pus. Further debridement (removal of infected tissue) was considered, but was not in the event undertaken. By 20 August a note recorded that the wound remained open with approx. 5cm of exposed bone. An attempt to close the wound on 3 September was not successful, and on 15 September the Claimant was discharged with bone still exposed, with the expectation that the wound would heal by secondary intention (i.e. naturally).

By March 2000 the wound had still not healed and the osteomyelitis remained present. Further surgery, for

removal of dead bone, was undertaken on 17 March. Problems with wound healing again arose and there was some discussion about covering the wound with a muscle flap. The procedure was not undertaken, however, and the Claimant was discharged on 18 April.

The Claimant has since 2000 suffered from chronic osteomyelitis. He has in particular suffered from pain and scarring over his right shin – an area including a “crater” measuring around 7cms in length and around 2cms in maximum diameter. The skin over the crater is thin and friable. The Claimant suffers from serious problems with chronic pain.

Passage of time - medical records

It is not unusual for clinical negligence claims to require consideration of treatment provided many years earlier. In the present case the medical records were nearly 20 years old. That was a time when, as the Defendant’s expert asserted without contradiction, practice was for note-taking to be briefer (in his words, more “telegraphic”) than would be considered appropriate now. That presented a difficulty for the Claimant – how to prove his case when the records did not set out all of the reasoning for decisions taken?

The Defendant did not call evidence from the treating clinicians. It appears there were difficulties tracing some or all of them - hardly surprising given the passage of time. The Defendant submitted that the events were so long ago that oral evidence would have been of limited assistance in any event. The Claimant’s case was that the court was asked to draw inferences from the notes, given

the absence of the clinicians to explain their meaning, and that the absence of defendant witnesses meant that any inferences should be drawn in the Claimant's favour – see *Keefe v Isle of Man Steam Packet Company* [2010] EWCA Civ 683; *Raggett (deceased) v King's College Hospital NHS Foundation Trust* [2016] EWHC 1604 (QB); and *Harding v Buckinghamshire Healthcare NHS Trust* [2017] EWHC 2393. The Judge broadly accepted that submission, holding (at para 66) that,

"Where the notes fall short, and are ambiguous or there are gaps, I accept that even though the burden remains on the Claimant, the Defendant should not have the benefit of those deficiencies, nor of unexplained lack of explanatory witness evidence."

This approach may be an important one to bear in mind in any case where Defendant witnesses have not been traced or called. It is a rare clinical negligence trial which does not require the court to draw inferences from the notes. Where those notes are less than comprehensive (and the older the claim, the more likely that is), a Claimant faced with a missing witness, for whatever reason, should be alert to the possibility of asking the Court to make its findings of fact judging the Claimant's case benevolently and the Defendant's case critically.

Passage of time – Experts

It is not always an easy task to find an expert to give an informed opinion as to the standard of care decades in the past. This case provides an unusual example of the importance of good quality expert evidence in an old claim.

The Claimant's orthopaedic expert did not become a Consultant until 2006. At the time of the Claimant's treatment, he was working as an Orthopaedic Registrar in Cape Town. He returned to the UK in late 2000, at which time he acted as Registrar to a Consultant who was, it emerged, none other than the Defendant's orthopaedic expert. Neither of the writers have previously come across a case in which one expert had trained the other.

In reality, the relationship between the experts was no more than an oddity. The judge rejected the Defendant's submission that the Claimant's expert was unqualified to give evidence about care in 1999/2000, a time when he was not practising as a consultant, nor in the UK. She concluded (at para 36),

"As Mr Collins QC pointed out, there are many instances of experts giving evidence about matters which pre-date their own expertise. Mr McFadyen's experience began in the mid-1990s, and he has been a consultant since

2007. He acknowledged that in 1999/2000 his own decisions would have been subject to the final judgment of a consultant, but that in itself does not disqualify him from giving evidence as to what those judgments would have been, and whether a reasonable body of opinion at the time would support them, by reference to his own experience and contemporaneous texts."

In fact it emerged that there was little difference in relevant practice in 1999, 2006 or indeed 2018. The experts' evidence was treated on its own merits.

Expert evidence and disclosure

Another curiosity of this case was a problematic history in relation to disclosure. Litigation had started in 2012. A trial was originally listed in March 2017. Then, in 2016, after the experts' reports had been exchanged, it became clear that there had been an accidental failure on the part of the Defendant to disclose a large volume of medical records. The trial was vacated and fresh reports had to be commissioned and exchanged.

Substantial new material had become available in the course of the new disclosure. Furthermore, by the time of trial it had become clear that the experts' view of the size of the wound was due to a mis-reading of the notes. A note of wound size which appeared to read 15 cm (but was difficult to decipher due to photocopying) was eventually agreed to read 1.5 cm. The Defendant's expert had initially relied on the large wound size to support his opinion. Having had the measurement corrected, however, his conclusion remained the same, although his reasoning inevitably did not. A further matter noted by the judge was that the Defendant's expert expressed the view that in 1999 free flap surgery was not in existence - a view with which neither the Claimant's expert nor the plastic surgeons agreed.

The judge concluded that the Defendant's expert's evidence was less reliable than that of the Claimant's. As she put it (at para 67), once the errors were identified, the expert *"changed his approach, but only so as to maintain his original position, continuing to ignore some of the available documentary evidence."*

That was far from the end of the story but, given the demands of Bolam, it was essential to the Claimant's case that the Defendant's expert evidence on breach be rejected. Ultimately it was, and the authors identify two points of practice which are demonstrated by the judgment.

Firstly, it is essential for an expert to be flexible. If the facts change, an expert who changes their view to take

account of the change of facts is likely to be viewed by the court as more credible than an expert who remains wedded to their original opinion.

Secondly, where the facts change it is essential to test an expert's evidence against the new facts before trial in order to understand what their response will be when challenged about them.

The judge's conclusion

The judge concluded that the Defendant's failure to take further steps by way of debridement, antibiotics and muscle flap surgery was a breach of duty. She concluded (at para 95) that,

"had he been treated by debridement, flap and antibiotics, the likelihood is that he would have been cured of osteomyelitis, or at least free from it for a long period. Flap surgery would have succeeded and the current type of crater with friable skin would have been avoided. He would have avoided the long subsequent history of infection and pain specifically attributable to it."

The case continues in relation to quantum.

Khan v MNX - the SAAMCO principle in clinical negligence

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Introduction

Khan v MNX [2018] EWCA Civ 2609 is an important case clarifying that the **SAAMCO** principle that losses are only recoverable if they fall within the scope of a defendant's duty applies to clinical negligence claims, including those based upon informed consent.

In a previous article on informed consent published in the November 2018 edition of the AvMA Newsletter entitled "*Duce v Worcestershire Acute Hospitals – the limits of informed consent*" I wrote:

An injury which would have been avoided by serendipity but for the breach of duty would appear squarely within Lord Hoffman's famous example in SAAMCO (Banque Bruxelles Lambert SA v Eagle Star Insurance Co Ltd [1997] AC 191) of a mountaineer who is negligently advised by a doctor that his knee is fit for a difficult climb and then suffers an injury which is a foreseeable risk of mountaineering but has nothing to do with the state of his knee. Although he would not have gone mountaineering but for the negligent advice, the doctor is not liable as there is an insufficient causal connection between the injury and the subject of the duty which was breached. It therefore could not be said to be an effective legal cause of the injury. Chester v Afshar [2004] UKHL 41; [2005] 1 AC 134 precludes reliance on this principle in informed consent cases; MNX v Khan [2017] EWHC 2990 (QB) (although note that the defendant's appeal in this case is to be heard by the Court of Appeal in October 2018; this might ultimately be a vehicle for challenging Chester in the Supreme Court).

In the event, the Court of Appeal in *Khan* distinguished *Chester* on the facts in order to apply the **SAAMCO** principles to the duty to give informed consent. This reflects a consistent judicial approach (as discussed in my previous article by reference to *Duce v Worcestershire Acute Hospitals NHS Trust* [2018] EWCA Civ 1307; [2018] P.I.Q.R. P18) of circumventing *Chester* so as to obviate the need to challenge it head on. This sequel article will examine the decision in *Khan* and discuss its implications.

Background

The claimant wished to avoid having a child with haemophilia. She consulted the defendant GP to discuss blood tests obtained for that purpose. She was told that the results were normal. She was thus led to believe that any child she had would not have haemophilia.

The claimant gave birth to a son, FGN, who was diagnosed with haemophilia. But for the defendant's negligence the condition would have been identified in utero and the claimant would have terminated the pregnancy.

FGN's haemophilia was severe. Its management was complicated by the fact that he also suffered from autism. His autism was entirely unrelated to the haemophilia. The autism by itself was likely to prevent him living independently or being in paid employment in the future.

It was accepted that the claimant was entitled to recover the additional costs associated with FGN's haemophilia (i.e. excluding any costs which would have been incurred in any event as a result of his autism). Damages on that basis were agreed at £1,400,000. The disputed issue was whether, as a matter of law, the defendant was liable for the additional losses associated with both conditions. Damages on that basis were agreed at £9,000,000.

Decision at first instance

Yip J accepted that the purpose of the service offered by the defendant was not to prevent the claimant having any child. It was limited to preventing her having a child with haemophilia. It was agreed that the risk of autism was a risk that existed with every pregnancy. This inherent risk was not increased, nor were the chances of avoiding it lessened, by the failure to properly manage the risk of the claimant having a child with haemophilia.

The judge considered several wrongful birth cases. The leading such case is *McFarlane v Tayside Health Board* [2000] 2 A.C. 59. This was a failed sterilisation case. The House of Lords there allowed recovery to the mother for the loss and damage associated with her pregnancy itself

but rejected on policy grounds the parents' claim for the costs of raising a normal healthy child.

The claimant relied upon two subsequent Court of Appeal decisions, *Parkinson v St James and Seacroft University Hospital NHS Trust* [2001] EWCA Civ 530; [2002] Q.B. 266 and *Groom v Selby* [2001] EWCA Civ 1522; [2002] P.I.Q.R. P18. In *Parkinson* the claimant became pregnant following a negligently performed sterilisation. She subsequently gave birth to a child with severe congenital abnormalities. In *Groom* the defendant negligently failed to identify that the claimant was pregnant. Had he done so, the claimant would have terminated the pregnancy. The child suffered from salmonella meningitis contracted during the delivery. In both cases the court allowed the costs associated with the child's disability. It was held that, as the defendants' duty was to prevent the pregnancy, they were liable for the foreseeable consequences of pregnancy (excluding the costs of raising a healthy child as per *McFarlane*). The disabilities suffered by the children were held to be a foreseeable consequence and not intervening acts which broke the chain of causation.

The claimant also relied upon *Chester*, supra. It will be recalled that the defendant in that case failed to warn of a small (1-2%) surgical risk of a very serious complication (cauda equina syndrome). He thus breached his duty to obtain informed consent. This risk eventuated. Whilst the claimant would ultimately still have undergone the operation had she been informed of the risk, she would not have done so on that day. The chances of that risk eventuating during a subsequent operation were much less than 50%; they were 1-2%. Had the claimant been warned of the risk the injury would probably have been avoided, albeit by serendipity. Factual causation was therefore established. The House of Lords, by a majority, found for the claimant. It recognised that, as the defendant's failure to warn neither affected the risk nor was the effective cause of the injury, legal causation was not satisfied on conventional principles. However, it held that on policy grounds this conventional test fell to be modified in order to vindicate the claimant's right as to whether and, if so, when and from whom to receive treatment.

Yip J accepted that, with regard to the risks that a parent was willing to run, there was a distinction between a case where a parent does not want to have any child and one where a parent does not want to have a child with a particular disability. However, she was not persuaded that this is the appropriate starting point.

Her key findings were that:

- (a) But for the defendant's negligence FGN would not have been born.
- (b) Whilst the claimant would have gone on to have another later pregnancy carrying the same risk of autism, that risk would probably not have eventuated.
- (c) The case was therefore analogous to *Chester* as opposed to with the mountaineer's knee in *SAAMCO*. The avalanche risk in *SAAMCO* had nothing to do with the hypothetical mountaineer's knee. The inherent risk of autism in this case had everything to do with pregnancy just as the inherent risk of cauda equina in *Chester* had everything to do with the operation.
- (d) Although, unlike in this case, the misfortune in *Chester* was the very misfortune which the defendant was duty bound to warn against, the defendant's duty was to provide the claimant with the necessary information so as to allow her to terminate any pregnancy afflicted by haemophilia. This pregnancy was a pregnancy afflicted by haemophilia. The continuation of the pregnancy was as unwanted as that in *Groom*.
- (e) There was no logical distinction between the parent who did not want any pregnancy and one who did not want a particular pregnancy. In both cases, the effect of the doctor's negligence was to remove the mother's opportunity to terminate a pregnancy that she would not have wanted to continue. It would be unattractive, arbitrary and unfair to draw a distinction based upon the underlying reason why, but for the negligence, the claimant would have terminated the pregnancy.

Yip J herself granted the defendant permission to appeal.

Decision on Appeal

The defendant's central argument was that autism-related losses were outside the scope of the defendant's duty and therefore irrecoverable by reference to *SAAMCO*. The Court of Appeal agreed.

Nicola Davies LJ gave the only substantive judgement, with which Sir Ernest Ryder and Hickinbottom LJ concurred. She observed that *SAAMCO* had been clarified in *Hughes-Holland v BPE Solicitors* [2017] UKSC 21; [2018] A.C. 599. Lord Sumption therein drew a distinction between (1) "information" cases where the defendant supplies the claimant with information which the client will take into account along with information from other sources in making his own decision on the basis of a broader assessment of the risks; and (2) "advice" cases where the defendant's duty to identify and take into account all relevant matters in deciding whether to

advise the claimant to take a particular course of action. A defendant in an "information case" does not assume legal responsibility for the claimant's decision to pursue the course of action in question. He is only responsible for the consequences of the information being wrong. He is not responsible for losses which would have occurred even if the information which he gave had been correct. Her Ladyship also noted that in **Chester** Lord Hope at [51] stated that: "...damages can only be awarded if the loss which the claimant has sustained was within the scope of the duty to take care. ...the issue of causation cannot be properly addressed without a clear understanding of the scope of that duty."

Against this background, this case was materially different from **Parkinson** and **Groom**. The duty of care in those cases was to prevent the birth of any child. They thus assumed responsibility for the consequences of the births. Here the focus was solely on the risk of haemophilia. There was no discussion of the wider question of whether or not the claimant should give birth. That was not within the remit of the defendant's advice. It was a decision for the claimant to make taking into account a range of factors, most of them unknown to the defendant. Critically, there was no advice sought or given on the risks of autism.

Applying **SAAMCO**, the court had to answer three questions: i) what was the purpose of the procedure/information/advice which is alleged to have been negligent; ii) what was the appropriate apportionment of risk taking account of the nature of the advice, procedure, information; iii) what losses would in any event have occurred if the defendant's advice/information was correct or the procedure had been performed?

In this case:

- i) The purpose of the consultation was solely to enable the claimant to make an informed decision as to the risk of giving birth to a child with a haemophilia gene.
- ii) The defendant was liable for the risks of the claimant giving birth to a child with haemophilia. The claimant bore all the other risks associated with the pregnancy and birth.
- iii) The loss which would have been sustained if the correct information had been given would have been that the child would have been born with autism.

The defendant was therefore not under a duty to protect the claimant from all the risks associated with becoming pregnant and continuing with the pregnancy. The defendant had no duty to prevent the birth of FGN.

By reference to **SAAMCO** there was an insufficient link between the breach of duty and the particular type of loss claimed. It was not enough for there to be a link between the breach and a stage in the chain of causation, in this case the pregnancy itself, and thereafter to conclude that the defendant was liable for all the reasonably foreseeable consequences of that pregnancy.

The court distinguished **Chester** on the basis that the misfortune which befell the claimant was the very misfortune that the defendant had a duty to warn against. That was a fundamental difference with the facts of this case. The more appropriate analogy is with the passenger in a speeding taxi which is hit by a tree as identified by Lord Walker in **Chester** at [94]. The injury caused by the falling tree had nothing to do with the taxi driver's duty not to speed. That the injury would not have occurred but for the speeding was pure coincidence. FGN's autism here was likewise a coincidental injury outside the scope of the defendant's duty.

The court did not consider it necessary to address separately the issue of whether the outcome was fair, just and reasonable. The application of **SAAMCO** encompassed those concepts. It was only necessary to resort to this criterion when established principles did not provide the answer; **Robinson v Chief Constable of West Yorkshire Police** [2018] UKSC 4; [2018] A.C. 736. In this case they did.

Discussion

Whilst the result in **Khan** might appear harsh, its logic is difficult to dispute. The loss here was clearly outside the scope of the defendant's duty. Applying well established principles, such a loss is not recoverable.

Khan is thus perfectly cogent as to why the disputed losses in that case were not recoverable. It is perhaps less satisfactory as an explanation as to why damages in **Chester** were.

Prima facie, the distinction between **Khan** and **Chester** appears logical. However, it might be said that on closer inspection the duty in **Chester** was a narrower one than this distinction recognises. The surgeon's duty was not to prevent the cauda equina. Nor was it an abstract duty to inform the patient of the risk as a matter of general information. It was a practical one to enable the patient to choose not to undergo a procedure she considered too risky. Injury from a procedure which the patient would not have considered too risky and which she therefore would have consented to in any event is outside the scope of that duty. It is difficult to see how the injury in

Khan was any more coincidental with the breach than was the injury in **Chester**. See in this regard Leggatt LJ's trenchant observations in **Duce** at [85].

It is readily understandable why the court in **Khan** strove to distinguish **Chester**. However, the grounds upon which it did so are perhaps somewhat specious.

It seems likely that sooner or later the Supreme Court will reverse **Chester**. In the meantime, it is safe to predict that judges will continue to distinguish **Chester** if at all possible. The **SAAMCO** principle will generally be applied. The practical upshot is that claims based purely on a failure of informed consent will be even more difficult to establish than previously appeared to be the case.

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With the best of intentions: a commentary on Hazel Kennedy v Dr Jonathan Frankel [2019] EWHC 106 (QB)

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Introduction

The Claimant is a retired primary school teacher. She is married to a retired Consultant Neurologist, Dr Kennedy. In 2006, when aged 44, the Claimant developed a tremor in her left upper limb. Her husband harboured suspicions that she may have Parkinson's disease. As a result, he arranged for her to see a former colleague of his, Dr Jonathan Frankel (" the Defendant "), a Consultant Neurologist with a specialism in movement disorders. The Defendant agreed to see the Claimant on a private basis and to not charge for doing so. He made a diagnosis of Parkinson's disease and he advised on her treatment. Medication, dopamine agonist, which the Claimant took on the Defendant's advice, unfortunately caused the Claimant to suffer from serious psychiatric side effects, including an impulse control disorder (" ICD ") and more latterly psychosis.

The Claimant brought a claim as against the Defendant for :

- i. failing to advise her of the risk of ICD associated with dopamine agonist medication ; and
- ii. that he failed to respond in a timely or appropriate way when she developed ICD.

Causatively, the Claimant accepted that she would have taken the medication initially had the appropriate warning been given, but that had she been properly advised she would have ceased taking it far earlier and consequently she would have avoided the serious effects that developed.

The Claimant brought a claim based on the losses sustained from ICD and psychosis. The elements of the claim consisted of the customary claims for loss of earnings and care, but also comprised of more novel elements relating to the increased costs of spending caused by the ICD.

The matter was heard by Yip J at the Royal Courts of Justice over a five day period between 17th to 21st December, 2018.

Legal Standpoint

It was accepted that the standard of care to be expected of the Defendant was that of a consultant neurologist with a speciality in movement disorders, including Parkinson's disease.

The allegation that the Defendant failed to warn the Claimant of the risk of ICD and to advise as to alternatives to dopamine agonists was decided according to the well versed test set out in *Montgomery v Lanarkshire Health Board [2015] AC 1430*, and recently summarised by the Court of Appeal in *Duce v Worcestershire Acute Hospitals NHS Trust [2018] EWCA Civ 130*. The judgment of Yip J at Paragraph 12 sets out the comprehensive yet compact aide memoire of Hamblen LJ's dicta in *Duce* (at Paragraphs 32 and 33), namely :

" 32. The nature of the duty was held to be " 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 .

33. In the light of the differing roles identified this involved a twofold test :

(1) What risks associated with an operation were or should have been known to the medical professional in question . That is a matter falling within the expertise of medical professionals.

(2) Whether the patient should have been told about such risks by reference to whether they were material. This is a matter for the Court to determine. The issue is not therefore the subject of the Bolam test and not something that can be determined by reference to expert evidence alone " .

The advice tendered by the Defendant was to be considered according to the test in *Bolam v Friern Hospital*

Managemnt Committee [1957] 1 WLR 582, whereby the advice would be considered reasonable if it was in accordance with a responsible body of consultant neurologists with a particular subspecialty interest in movement disorders, notwithstanding that other such neurologists may have given different advice.

Establishment of breach would require that causation was established. The mere failure to warn of a *Montgomery* " material risk " is not in itself sufficient to give rise to liability. It is necessary to establish that had the Claimant been given the appropriate warning/advice she would have ceased taking in dopamine agonist medication at an earlier point in time and thereby reduced the severity and/or the duration of the side effects.

Expert Evidence

The Claimant relied on Dr Guy Sawle, a Consultant Neurologist with an appropriate sub-specialism in movement disorders. The Defendant relied on the expert evidence of Dr CMC Allen, a recently retired Consultant Neurologist. Dr Allen was a " general " neurologist with experience of seeing and treating patients with Parkinson's disease. Yip J noted at Paragraph 31 of the judgment that " *unlike Dr Frankel and Dr Sawle, he does not have a specialism in movement disorders* ". The evidence of Dr Sawle was found to be " *balanced and fair* " and Dr Allen's evidence " *was less impressive* . *It was apparent that he was less knowledgeable than Dr Sawle in this field* ".

At Paragraph 33 of the judgment Yip J commented that " *I bear in mind that the appropriate standard of care is that of a consultant neurologist with sub-specialism in movement disorders and that Dr Sawle falls into that category, but Dr Allen does not* ".

Breach of duty and Causation

The Claimant first saw the Defendant in January, 2007. No treatment was recommended at that juncture. By August, 2007, the Claimant felt that her symptoms had worsened and she returned to see the Defendant . He advised medication in the form of amantadine with the idea of moving onto selegiline and after that a dopamine agonist.

By February, 2008 a little more tremor and some other symptoms were noted and the Defendant recommended a " gentle introduction to dopaminergic medication " in the form of rotigotine patches.

The Claimant did not see the Defendant again until April, 2010. She was having difficulties with the rotigotine

patches. There was a reluctance on her part to change to another form of treatment as she considered that the rotigotine was " otherwise working well ".

In his evidence, Dr Sawle was clear that he was not critical of Dr Frankel's advice at any time prior to 2010. The knowledge of ICD as a side effect of dopamine agonist medication was evolving and ICD was " clinically invisible " and was regarded as a very rare side effect for a number of years. While Dr Sawle and some other neurologists were themselves giving warnings about ICD earlier in time, other neurologists in the sub-speciality disorder movement were not.

The Claimant saw the Defendant on 26th April, 2010. In view of the difficulties with the rotigotine, he recommended that the Claimant should start taking ropinirole (an oral dopamine agonist). There was no mention in the medical notes or a subsequent letter to the Claimant's GP of any discussion about ICD or behavioural issues per se. The Defendant could not say one way or the other whether he gave any warning about behavioural symptom risks in April, 2010. He confirmed that he did not specifically warn patients about the risk of ICD until 2013.

Yip J concluded that the Claimant was not given any warning about ICD or behavioural changes in April, 2010. Dr Sawle was clear that it was mandatory to give specific warnings about ICD by April, 2010. Dr Allen did not agree that a specific warning about ICD was required at that time. He did however agree that a general warning about behavioural problems should be given. The difference as between the experts was not considered by Yip J to be material to the case. Yip J considered that the risk of developing compulsive behaviour was a material risk as per *Montgomery*, and that accordingly the Defendant was in breach of duty for failing to give a warning at that time.

Notwithstanding, Yip J did not find that any such breach was causative of loss as medication change was unlikely to have occurred had the correct warning been given.

In August, 2010 the Claimant wrote to Dr Frankel indicating that side effects were worse with rotigotine but that they had settled.

The Claimant indicated in evidence that she first suspected that things were not right towards the end of 2010. She described doing " silly things ". Dr Kennedy described their house as becoming " like a shop ". Numerous deliveries were being made to the house. Dr Kennedy formed the view that his wife had developed ICD at that juncture. He did not however instantly report his suspicions to the Defendant.

In January, 2011, Dr Kennedy wrote to the Defendant requesting an appointment for his wife. It took a form more akin to that of a medical report than a general letter with separate headings. One heading was "impulse control disorder" which was noted as having "been recognised since we last met and has taken various guises". Details were supplied about weight loss; hobbies and impulse buying.

The Defendant saw the Claimant on 18th January, 2011. The experts were agreed that Dr Kennedy's letter had "put the Defendant on notice that the Claimant had ICD" and that it was therefore essential to discuss discontinuing the dopamine against medication. The Claimant should have been informed that her ICD was due to her medication and that her options included stopping the medication and taking an alternative drug (levodopa), which was likely to eradicate the ICD symptoms without any deleterious effect on her Parkinson's symptoms. There were no contra-indications for the Claimant in moving drugs.

Yip J considered that the Defendant did not clearly explain to the Claimant that levodopa was likely to eradicate her ICD symptoms and at the same time providing good control of the symptoms of her Parkinson's. He had however canvassed the possibility of a change in medication before making a positive recommendation that the Claimant remain on dopamine agonist medication which was apparently providing excellent control of her symptoms of Parkinson's disease. She considered that it was reasonable at that time to recommend the continuation of the drug. However, with regard to the fact that the Defendant did not sufficiently discuss levodopa as an alternative, as both experts were agreed he should have done, Yip J did not consider that omission to be causative of any loss. Yip J found as a fact that the Claimant would have followed the Defendant's advice to continue with her existing medication. On Yip J's assessment, this was the case as:

- i. "Her Parkinson symptoms were well controlled;
- ii. In the past she had expressed some reluctance to change a treatment that was working well in controlling a disease;
- iii. She did not feel that her ICD symptoms were out of control or significant;
- iv. Even had levodopa had not been specifically discussed, the Claimant was well aware of alternative drugs, and was happy to continue on her existing medication; and

- v. Dr Kennedy was aware of levodopa as a drug option and had been ready to recommend alternative treatment previously, but he considered the advice reasonable at that time."

In April, 2011 the Claimant attended upon her GP complaining of feeling down. The GP raised the possibility of the Claimant seeing the specialist Parkinson's nurse, Nurse Morgan. In August, 2011 the Claimant attended upon Nurse Morgan. Nurse Morgan advised the Defendant that she thought that she had ICD and should change her medication. Following the discussion with the Claimant, Nurse Morgan wrote to the Defendant setting out that the Claimant appeared to have developed an ICD in the form of compulsive buying, which had caused problems with her husband. She was noted by Nurse Morgan as "she is struggling to control, is out of character". She informed the Defendant that there had been a discussion about decreasing or withdrawing the dopamine agonist medication, but that the Claimant was reluctant to consider this as her motor function was stable. The Defendant in fact had discussed matters with Nurse Morgan before her letter reached him.

A further appointment took place with the Defendant on 25th October, 2011. Following the consultation the Defendant wrote to the Claimant's GP stating that "she had been a little concerned about the effects of ropinirole on her behaviour in terms of buying things both she and Philip did not think it was a significant problem". There was no evidence of the letter having been copied to Nurse Morgan. It was suggested by Counsel for the Claimant that the inference to be had from the letter of the Defendant and the failure to copy to Ms Morgan was that the Defendant had overlooked the letter from Nurse Morgan to him, or that it was not in the forefront of his mind. Yip J considered that to be a reasonable inference.

Dr Sawle stated, and it was accepted by Yip J, that a specialist receiving the letter from Nurse Morgan "would have started with expectation that a change of drug was required". To be persuaded otherwise would have needed a "real drilling down" into the symptoms and for something compelling emerging from the discussion so as to justify not making the change. Dr Allen did not disagree in cross-examination. In Yip J's opinion there had only been a brief discussion without any proper documenting of what was discussed and it was not sufficient to displace the material contained in Nurse Morgan's letter. Yip J found that the Defendant should have advised the Claimant about levodopa and that switching would probably have removed the ICD symptoms while still giving good control of the Parkinson's symptoms. The additional information from Nurse Morgan should

have necessitated a clear recommendation to reduce or discontinue the dopamine agonist to control the ICD. The recommendation to increase could not be considered reasonable. The Defendant breached his duty in failing to properly advise her in October, 2011.

In so far as causation, given that real concern had been expressed by the Claimant to Nurse Morgan about her ICD, Yip J considered that she was satisfied that the Claimant would have changed to levodopa had the Defendant properly advised her that her Parkinson's symptoms were likely to have been controlled but her ICD would cease.

Subsequent

No allegation of breach as against the Defendant was maintained after October, 2011.

Problems worsened from the end of 2011. The experts agreed that the Claimant may have been developing psychosis by July, 2012. She was complaining about her husband and said "she feared him". If not by July, 2012, the psychosis was probably developing in later 2012, and certainly by early 2013. The Claimant made serious unfounded allegations about her husband and in January, 2013 she left the matrimonial home and commenced divorce proceedings. This was found to result from the psychosis.

Yip J found that there was no evidence that ICD worsened from October, 2011.

In February, 2013 ropinole was reduced by the Defendant and in February, 2013 he advised of an appropriate plan to cease the ropinole.

The Claimant had a bad time coming off her medication, but went on to make a good recovery. Her ICD and psychosis resolved completely. The marriage was reconciled. Upon withdrawing from ropinole, the Claimant did not develop the motor symptoms she would have been expected to exhibit, and in April, 2013 second opinion confirmed that she did not have Parkinson's disease. It was never alleged that a diagnosis of Parkinson's disease had amounted to negligent misdiagnosis.

Housekeeping

At the commencement of the hearing, Counsel for the Defendant raised an additional argument to those which had been set out in the skeleton arguments filed by the parties. Following the Court of Appeal's decision in *Khan v MNX [2018] EWCA Civ 2609*, (which by way of chance Yip J was the judge at first instance, and was overturned on

appeal), it was contended that the Claimant's psychosis was a coincidental injury, which fell outside the scope of the Defendant's duty, in that the duty to warn related only to the risk of ICD and did not extend to the risk of psychosis, which in itself was a very rare complication.

It was discussed whether the Defendant was entitled to raise the argument proposed at trial and whether it required an amendment to be made to the Defence. As matters transpired, Yip J was not required to make any pronouncement on whether the defendant was allowed to raise the issue, it being proposed by Counsel jointly that consideration of all matters (both procedural and substantive) based on the Khan decision should be deferred pending determination of the issues of breach of duty and causation. Yip J considered the proposal a sensible way forward. It was also canvassed that in view of the sums involved a settlement may be reached on quantum once the issues of breach of duty and causation had been addressed. Accordingly, Yip J adopted the approach and excluded any judgment relating to "scope of duty". Quantum was adjourned to be determined at a later stage, and at which stage the Defendant's position on Khan could also be considered, if still advanced.

It remains to be seen following Yip J's pronouncement on breach of duty and causation whether the argument on "scope of duty" will be advanced further by the Defendant, particularly given Yip J's views that had the medication been changed in October, 2011, the Claimant would have "recovered quickly from the ICD and not going on to develop the psychosis". Conversely, given that the psychosis resolved in a relatively short period of time issues of proportionality will have to be factored into account in advancing any "scope of duty" argument.

Commentary

There are a number of issues that fall to be gleaned from the judgment, namely:

1. Yip J's practical application of the legal principles on informed consent enunciated in *Montgomery* and *Duce* relating to the myriad of complex factual issues posed in relation to breach of duty and causation. The methodology of the application of the principles to the facts is a valuable tool for everyday use.
2. The importance of instructing the most appropriate expert. The case was based upon the standard of care required of a consultant neurologist with a sub-specialism in movement disorders. Dr Sawle on behalf of the Claimant fulfilled the criteria, Dr Allen on behalf of the Defendant, was a general neurologist

with experience of seeing and treating patients with Parkinson's disease. While Yip J thought that there was " little of real substance between the experts in the evidence that they gave " she made clear that " I bear in mind that the appropriate standard of care is that of a consultant neurologist with a sub-specialism in movement disorders and that Dr Sawle falls into that category, but Dr Allen does not ". Yip J specified that " it was apparent that he [Dr Allen] was less knowledgeable than Dr Sawle in this field ".Ultimately, in the context of this particular case, respective expert evidence was not determinative. In many cases however the distinction between expert evidence is vital , and thereby the instruction of the appropriately qualified expert all important.

3. Despite the best and most reasonable intentions of providing his expertise privately and without charge, it did not alter the duty of care that the Defendant owed to the Claimant. The Defendant readily acknowledged the duty owed to the Claimant as his patient.

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The Human Medicine Regulations 2012 and Kennedy v Frankel

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Under regulation 214 of **The Human Medicine Regulations 2012**, no person may sell or supply a prescription only medicine except in accordance with a prescription given by an appropriate practitioner. That position has now changed. Since 9 February 2019, pharmacists have been able to alter the strength, quantity or type of drug without permission from the prescriber (usually the GP) where the drug prescribed is in short supply and the substitute drug has a similar effect as the original: see regulation 226A of **The Human Medicine (Amendment) Regulations 2019**. The new legislation is intended to minimize disruption to patients, GPs and pharmacists in the event of serious shortages (as a result of Brexit), but may have the opposite effect and compromise patient safety. Pharmacists may know about the function of drugs but little if anything about the patient's history or condition, meaning they may not be in a position to properly determine whether one drug is an appropriate equivalent. But, the change is now in place and may give rise to increasing litigation against pharmacists, so watch this space.

A recent case of interest is **Kennedy v Frankel [2019] EWHC 106 (QB)**, which involved a claimant who developed Impulse Control Disorder (ICD) and psychosis as a result of dopamine agonist medication prescribed for suspected Parkinson's disease. Yip J held that the Defendant neurologist had been negligent for failing to advise the Claimant about the side effects of the medication and failing to advise an alternative medication when those side effects began to emerge. Yip J recited the Montgomery principles as summarised in **Duce v Worcestershire Acute Hospitals NHS Trust [2018] EWCA Civ 1307**, at paras 32 and 33:

"32. The nature of the duty [is]:

'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'

33. In the light of the differing roles identified this involves a twofold test:

(1) What risks associated with an operation were or should have been known to the medical professional in question. That is a matter falling within the expertise of medical professionals [83].

(2) Whether the patient should have been told about such risks by reference to whether they were material. That is a matter for the Court to determine [83]."

In this case, expert evidence suggested that by April 2010, it was mandatory for specific warnings to be given about ICD as a side effect of dopamine agonist medication. Yip J found that no such warning had been given by the neurologist (breach of duty) but that this had no causative effect because the Claimant would have continued to take the drug in the initial stages even if she had been properly advised. There was however a causative breach of duty for the later consultation when the Claimant returned with evidence of ICD and the Defendant recommended an increase in the same medication. Yip J found that the Defendant should have advised the Claimant about alternative medication at that stage (breach of duty) and this had causative effect because the Claimant would, at this stage, have changed her medication and recovered from her ICD within a short time and not gone on to develop psychosis.

The judgment is a helpful reminder of the duties owed by clinicians when advising on medication, particularly in relation to side effects or suitable alternatives. And the importance of discussing with the claimant whether any failure to properly advise would really have made a difference.

Health Practice Associates - What Are They About?

STEPHANIE PRIOR
OSBORNES



Osbornes | Law^o

Several years ago I acted for a woman who had tragically lost her husband due to substandard medical care by the Private Ambulance Service.

By way of background information, in February 2016 my client's husband Mr P complained of chest pain shortly after he returned home from work. His wife telephoned 111 to seek advice as he had taken Gaviscon thinking he had indigestion but had vomited afterwards and he was complaining of right shoulder pain.

An ambulance arrived shortly after her call and 3 members of the crew attended Mr P's home. The lead ambulance technician was of the opinion that Mr P was fine and that he had pulled a muscle and there was nothing to worry about.

An ECG was performed by her colleague and the ECG was noted to be abnormal by the lead technician's colleague. The print out of the tracing read

*'Abnormal ECG **unconfirmed** lateral T wave abnormality is nonspecific, *possible anteroseptal infarct – age undetermined'.*

Despite this finding the lead technician refused to accept the ECG was abnormal and did not recommend that Mr P be transported to hospital. In fact, she persuaded him there was no need for him to attend hospital as he was definitely not having a heart attack and she had reached this conclusion before the ECG had been performed.

The ambulance crew then left and Mr P went to bed and sadly died 10 hours later in the presence of his wife. He was 54 years old. An internal report was prepared following the death and the report confirms the root cause for Mr P's death was:

'The decision made by the Emergency Medical Technician not to take this patient to hospital was based upon their incorrect analysis of the patient's ECG and presenting signs and symptoms. When challenged by a lower qualified colleague of the ECG, the EMT is alleged to have ignored their colleagues concerns and dismissed the changes on the ECG....'

At the inquest, the coroner's verdict stated serious failing of medical care provided by the private ambulance service in February 2016. The coroner also recommended that the court write to the contractor and subcontractor in regard to how they bring about improvement and lessons learned as a result of this incident. The saddest part of this was that the deceased lived 8 minutes from his local hospital, which had a specialist cardiac centre and if he had been transported to hospital when seen by the ambulance crew he would not have died.

My client was unaware that her husband was treated by a private ambulance service, she assumed that the ambulance was an NHS Trust crew. In any event, the case settled and the Private Ambulance Service went into liquidation.

My client's main concern was that the individual ambulance technician was not held accountable for her husband's death. She did not even attend the inquest to face my client and post Mr P's death, all she was made to do was complete a form reflecting how she would do things differently next time. There were rumours that she had also been under the spotlight previously in other parts of the country for substandard medical care. However, this individual slipped through the net as far as accountability stands.

She was not on any database, any register and at the time of settlement of the case, we heard that she was training to be a paramedic in yet another part of the country.

Who are HPA?

Health Practice Associates (HPA) www.hpa-uk.org is a not-for-profit regulated community interest company (publicly owned) that seeks to hold individuals to account for the efficacy of the care provided, acts or omissions, in so doing trying to prevent rogue staff members slipping through the net.

It maintains a register of emergency and non-emergency medical care staff who are not required under statute

to register as clinical practitioners, such as ambulance technicians, emergency care assistants, ambulance care assistants and similar, who are expected to uphold the standards for their vocational skills and abide by HPA's code of conduct, performance and ethics

The role of HPA is to protect the health and wellbeing of patients who use the services of registered individuals and only register those who are competent. HPA seeks to ensure expert, ethical and peer reviewed governance and oversee all registrants.

HPA has a governing panel made up of 18 members who's backgrounds include NHS, private & voluntary sector directors, executives, senior managers/partners, managers; as well as registered members of the occupations on HPA UK. The panel acts a steering group and also leads on policy and procedure regarding HPA's governance of registrants and organisational use of the system.

The HPA register displays qualifications and professional development of all registered individuals and highlights those individuals who fail to meet the acceptable standards preserving role autonomy for safe practising clinicians. As part of the registration individuals can develop their CPD training and expand their skills linking their profile with the clinical education department/s of organisations they work for. Organisations are also enabled through the HPA document dissemination portal to closely monitor whether registrants are keeping up to date with relevant policies and procedures to ensure compliance.

The important benefit is like the GMC and HCPC (for Paramedics), the HPA register is a public register and displays the qualifications and professional development for registered individuals. Members of the public can also see other basic information about the registered individual but they cannot, upload, store or share information about individual patients.

If a registered HPA member receives a complaint about his or her practice or there is a serious concern notified about that individual to the HPA which after investigation warrants being added to their profile on the register, the trust or organisation that they work for will receive an instant notification. What they do with that information is up to the trust or organisation.

HPA has a process for managing any causes for concern raised by employers, organisation, patients or even members of the public. The process provides for sanctions to be taken against the registrant; depending on the seriousness of the concern, these include the

registrant being removed from the register and this being noted on their record.

Benefits

The HPA improves accountability, and if a registered individual is reported to their employer then any restriction on their employment must be proportionate.

HPA's platform allows organisations to:

- *check and confirm a registrant's scope of practice*
- *check and confirm a registrant's driving level*
- *check and confirm a registrant's professional updating*
- *check on complaints/adverse incidents for registrants*
- *receive real-time safeguarding alerts regarding registrants*
- *report causes for concern, whether the individual is registered or not*
- *check if a registrant has any outstanding action plans from a Trust or other organisation*
- *closely monitor if documents such as internal and external policies and procedures are being read by associated registrants via a compliance dashboard*
- *strengthens and compliments an organisations clinical governance framework by ensuring employees operate within their scope of practice*

For registrants, the HPA platform provides

- *confirmation of a registrant's scope of practice*
- *confirmation of their driving capability eg, blue-light emergency*
- *a platform for recording professional development and updating*
- *a framework for managing causes for concern fairly but robustly*
- *confirmation of their criminal record background check*
- *evidence grade, driving and status via a high-grade drivers licence style ID card with live qr links to their profile*
- *be nationally visible to potential employers who can confirm a reliable track record*

The NHS access portal on HPA has an Alert system within the NHS parent group to internally and instantly alert

Trusts about individuals under investigation, sanction or dismissed for misconduct/malpractice

These individuals often seek employment in the private ambulance sector, which until the launch of HPA was an unwitting safe-haven, with individuals able to operate 'under the radar'.

Although the HPA register is voluntary to adopt, the key question for employers is to ask is if an employee isn't on the register, then why not? For organisations hiring staff to provide cover at events, for example music festivals, checking that staff are on the HPA register provides both assurance and significantly reduces the risk to all parties.

In summary, the HPA register provides increased assurance for employers, commissioners and users of services that registrants are 'fit for purpose', and a mechanism for ensuring individuals are held to account. If the ambulance technician who treated Mr P had been registered and an alert had come to light in regard to her fitness to practise then Mr P may still be with us today and the pain and anguish his widow suffers each day would have been avoided.

The HPA public registrar can only be a good thing.

Stephanie Prior, Partner Osbornes Law & Legal Compliance Lead at HPA

Grant De Jongh Chief Executive HPA & Alan Howson Vice Chairman HPA

Relief from sanctions

SARABJIT SINGH QC
1 CROWN OFFICE ROW



The terms of CPR r. 3.9(1) are well known and provide as follows:

“On an application for relief from any sanction imposed for a failure to comply with any rule, practice direction or court order, the court will consider all the circumstances of the case, so as to enable it to deal justly with the application, including the need—

- (a) for litigation to be conducted efficiently and at proportionate cost; and*
- (b) to enforce compliance with rules, practice directions and orders”*

The process that applies when the court is considering any application for relief from sanctions under CPR r.3.9 is the well-established three-stage process prescribed by the Court of Appeal in *Denton v T H White Ltd* [2014] EWCA Civ 906, [2014] 1 WLR 3926 of: (1) identifying and assessing the seriousness and significance of the breach which engages r.3.9(1) (if the breach is neither serious nor significant, the court is unlikely to spend much time on the second and third stages), (2) considering why the default occurred, and (3) evaluating all the circumstances of the case so as to enable the court to deal justly with the application, with particular weight given to r.3.9(1)(a)&(b).

Two factors have emerged as critical to the success or failure of an application for relief from sanctions: (1) whether the breach imperils future hearing dates or otherwise disrupts the conduct of litigation, and (2) whether the breach has caused any prejudice to the opposing party. The importance of these factors can be illustrated by brief reference to the following cases.

In *Yeo v Times Newspapers* [2014] EWHC 2853 (QB), by reason of oversight the claimant’s solicitors failed to file or serve a notice of funding when the claim form was issued, as required by the CPR. However, this caused no prejudice to the other side as they knew about the funding details in any event and the impact of the oversight on the efficient and proportionate conduct of litigation was negligible. Therefore, the breach was not considered to be serious or significant and relief from sanctions was granted.

In *Jackson v Thompsons Solicitors & Ors* [2015] EWHC 549 (QB), there was also a failure by reason of oversight to provide information about funding arrangements as required by the CPR. Again, because the other side had been notified of those funding arrangements informally by way of correspondence, the court did not consider that any prejudice had been caused to them. Moreover, even though the breach in this case was considered to be serious and to have been caused for no good reason, it had no effect on the conduct of the case nor any impact on other court users. Accordingly, relief was granted.

By contrast, where a breach does disrupt the orderly progress of the litigation, the court is more likely to refuse an application for relief from sanctions. This can be seen in *Jamadar v Bradford Teaching Hospitals NHS Trust* [2016] EWCA Civ 100, in which a misinterpretation of the rules caused the claimant’s solicitor to fail to file a costs budget on time. In upholding the lower court’s refusal to grant relief from sanctions, Jackson LJ specifically focused on the fact that granting relief would have involved the listing of another CMC thereby adding both to the costs and to the length of the litigation as well as making additional demands on the resources of the court.

Similarly, in *British Gas Trading Ltd v Oak Cash and Carry Ltd* [2016] EWCA Civ 153, the defendant’s conduct in failing to comply with an order of the court and then with an unless order, before failing to file an application for relief from sanctions promptly, substantially disrupted the smooth conduct of the litigation. Predictably, the defendant’s application for relief was refused.

These cases indicate that if a party is put in the position of having to make an application for relief from sanctions, it is far more likely to succeed in obtaining relief if it can show that the breach did not imperil the conduct of the litigation or cause the other party prejudice. Equally, if a party seeks to resist an application for relief, its prospects of success will be improved if it is able to identify any delay or other impact on the litigation process of the other party’s breach and/ or highlight any prejudice it has been caused by the breach.

ADR in clinical negligence

BILL BRAITHWAITE QC
EXCHANGE CHAMBERS



EXCHANGE
CHAMBERS

AvMA put on a really good talk in February, the theme of the day being "Alternative Dispute Resolution – Effective Use & The Way Forward". One of the speakers was Julianne Vernon, Head of Claims Management Quality at NHS Resolution; her talk was very well informed and interesting, making it clear that clinical negligence claims are hugely costly. Of course that raises questions about the best way to avoid the cost of such claims (eg better training of clinicians), but that's not what really interested me about her talk. I have settled claims worth £50 million against the NHS in the last six months, and I wonder whether my experience resonates with her perception.

In the first case, mother and grandmother had phoned the hospital to report a problem, and they were not given the correct advice (very similar to *TW v Burton NHS Trust 2017 EWHC 3139 (QB)*). As a result, baby was born with severe cerebral palsy. Liability was denied until the settlement meeting 7 weeks before trial (three and half years ago). At that meeting, we were assured by the defence silk that they expected to win, and so the offer was 33% - followed by 50%, 67%, 75% and finally 80%, which we accepted (and which was the percentage we had told them at the outset was the minimum acceptable). Some might see that as good negotiation, but I would differ; it was a huge waste of money.

It was followed by a trial being listed on quantum in October 2018. The settlement meeting was arranged for two months before trial, and failed. The final offer of half a million more was made two weeks before trial, which accepted. The same comment would apply, in my opinion.

ADR is supposed to be flexible, but this was just old fashioned litigation at its worst.

The second case was an improvement, because liability was sort of admitted, but only ten days before trial in 2014. A settlement meeting on quantum was arranged for three months before trial (listed in October 2018), but it failed. We suggested mediation (they did not initiate it, but did agree), and that failed. We then initiated further settlement

discussion, and the case settled on an increased offer a week before trial.

The third case was different. The trial was listed for November 2019, and the settlement meeting arranged for February; the case settled.

Because I specialise in brain injury rather than clinical negligence, only part of my work is against the NHS, and so my perceptions are bound to be limited. Having said that, I can't remember a single case other than the third one above in which I have thought that the conduct of the defence was really sensible. Of course my practice is claimant only, so that I'm bound to see the claimant view, but I have to say that, when confronted with the third case above it was easy to see how different it was from the other two.

Similarly, I can't remember a single case in which the NHS has offered mediation. Ms Vernon said in her AvMA talk that "less than 1% of the cases we handle go to trial. NHS Resolution has long been an advocate of alternative dispute resolution (ADR) for claims resolution.". NHS Resolution was launched in December 2016, and they have three "service providers"; I think I understood in the first of the cases above that they would only engage in mediation if we agreed to use one of their selected providers (which we did) – but is that a good start to a mutual dispute resolution process? However, they do declare that they will pay the mediator's fees/travel/accommodation costs in cases where liability is admitted in full or in part, or the claimant is unrepresented. They have completed over 500 mediations, and 75% settle on the day or within 28 days of mediation.

In 2017/8, obstetric clinical negligence claims made up 48% of the £4.5 billion spent, even though they represented only 10% of the number of clinical negligence claims. In other words, nearly half the outlay was on claims like the ones above. That might make you think that they would concentrate on those claims, and try to make sure that they saved as much cost as possible. Of course, they could say that, by taking cases close to trial, they were

negotiating effectively, but I really doubt whether an analysis of the costs would bear that argument out.

Bearing in mind that ADR is hugely flexible, and can be used at any stage of the case, including early on, I wonder whether it might be possible for the NHS to save costs by initiating the process earlier and more often?

Forthcoming conferences and events from AvMA

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10am Tea/coffee and sausage roll

First tee 11 am

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Networking is also a big part of the ACNC experience. On the evening of Thursday 27th June we will be holding the conference Welcome Event at the SkyLounge at the Doubletree by Hilton Hotel in Leeds, and the Mid-Conference Dinner will be held on the Friday evening at the Royal Armouries Museum.

Early bird booking is now open (early bird booking deadline 22 March) and the full conference programme will be available by the end of March. Sponsorship and exhibition packages are still available.

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Professor Linda Hands, Consultant Vascular Surgeon, John Radcliffe Hospital, Oxford

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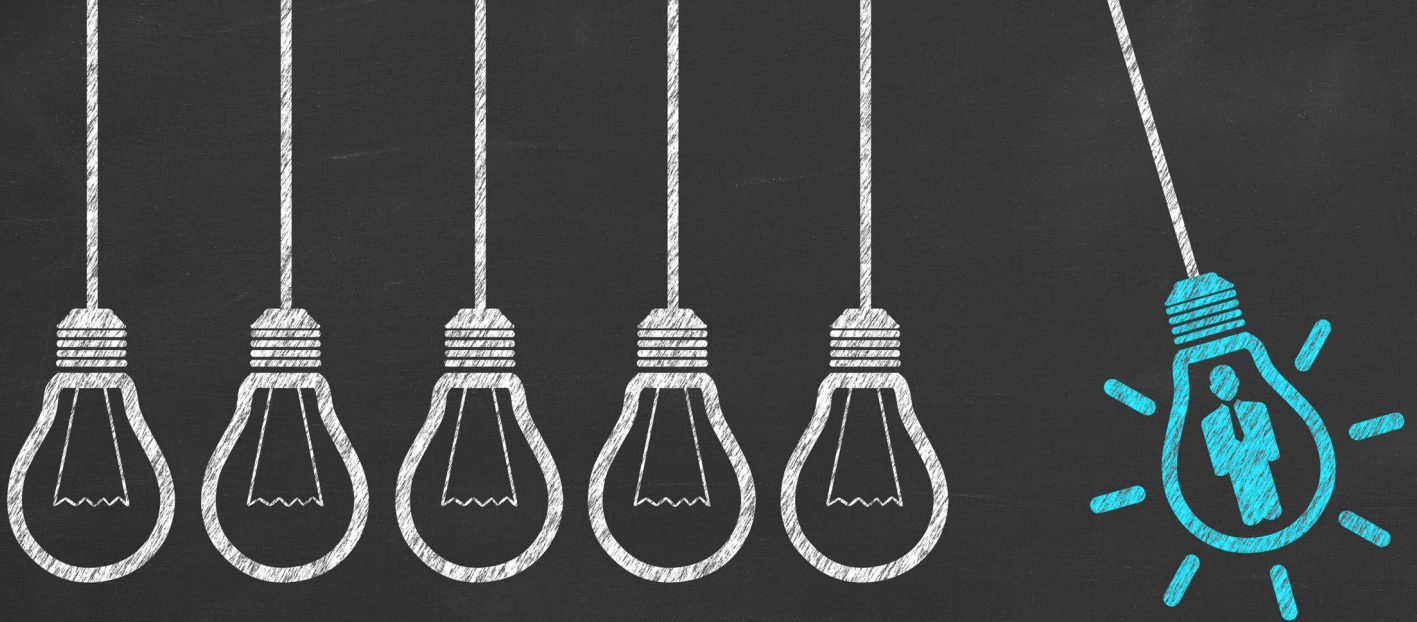
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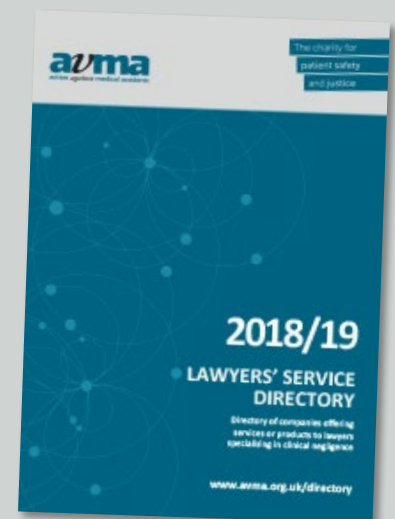
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