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Editorial

Lisa O'Dwyer
Director, Medico-Legal Services

It would seem that consultations and reviews are much like buses, you wait 14 months for one to come along and then they all arrive at the same time!

FRC Consultation: The fixed recoverable cost in lower value clinical negligence claims consultation was issued on the 30th of January. The consultation closes on 1st May, we urge all claimant clinical negligence practitioners to respond. For ease of reference the consultation can be found at the following link: www.gov.uk/government/consultations/fixed-recoverable-costs-for-clinical-negligence-claims

AvMA was fortunate to have John Culkin, the DH's Policy Manager of Acute Care & Quality speak at our recent panel meeting on 9th March. John was at pains to explain at the outset that nothing in the consultation is set in stone, the DH are very much at the beginning of the policy, not the end. Nonetheless, it is clear that the object of the exercise is to make savings. John's presentation is on the AvMA members' section of the website: it can be accessed by members – you will need to login. If you have not registered, you can register here: www.avma.org.uk/resources-for-professionals/members-area/.

AvMA is busy continuing to work with other stakeholders and raising concerns about the FRC proposals with politicians and the media. At the end of this month we will be meeting with other patient groups to make sure they are aware of the implications for access to justice and to discuss an appropriate, collective response that has impact.

National Audit Office (NAO) Report: It is more difficult to know how responses to the clinical negligence FRC consultation are going to be considered within the context of findings from both the NAO, which is due to report in the summer and the Jackson review.

The NAO is inviting evidence for their study on whether the DH and the NHS LA understand what is causing the increase in clinical negligence costs. It will be evaluating the DH and NHSLA's efforts to manage and reduce the costs associated with clinical negligence claims as well as assessing the

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NHSLA's ability to share learning about past incidences. Please forward any evidence which you would like the NAO to consider to: enquiries@NAO.gsi.gov.uk.

Jackson Review FRC: The date for submitting evidence to Lord Justice Jackson's Review of fixed recoverable costs has now passed, it closed on 30th January 2017. The terms of reference for the Jackson review are **"to develop proposals for extending the present civil fixed recoverable costs regime in England and Wales so as to make the costs of going to court more certain, transparent and proportionate for litigants. To consider the types and areas of litigation in which such costs should be extended, and the value of claims to which such a regime should apply."** The report is to go to the Lord Chief Justice and the Master of the Rolls by 31st July 2017.

Legal Aid Sentencing & Punishment of Offenders (LASPO) Review: In January, the Justice Minister, Sir Oliver Heald, promised a review of LASPO by April 2018, he said ***"the Memorandum and Review will provide us with robust evidence-based picture of the current legal aid landscape and how it's changed since LASPO".*** That review may prove enlightening!

Rapid Resolution & Redress Scheme (RRR): The consultation on RRR for severe avoidable birth Injuries was published on 2nd March, the consultation closes on Friday 26th May 2017 and can be accessed here: www.gov.uk/government/consultations/rapid-resolution-and-redress-scheme-for-severe-birth-injury.

The RRR Scheme identifies that its compensation package is expected to comprise three main elements: (i) an early upfront payment; (ii) periodical payments and (iii) a lump sum award. The early payment will be in the range of £50,000 - £100,000 and would be issued when the injured child is 4 years of age. This sum is intended to ***"support families with any upfront costs required to care for their child, such as adaptations to accommodation"***. Subsequently, parents would be able to receive a further lump sum and periodical payments ***"calculated in line with need"*** through a personal budget type approach, administered by a case manager. This is said to be ***"different from, and more generous than, the personal budget administered by a local authority to access state funded social care".*** It is maintained that the average total value of compensation would be ***"around 90% of the average current court award"***. It is not clear whether this 10% reduction took into account the effect of changes to the discount rate.

Discount Rate Changes: Whilst many claimant lawyers were cautiously optimistic that there would be some change to the 2.5% discount rate, most of us were shocked at the -0.75% that was announced by the Lord Chancellor, Liz Truss on 27th February. The new discount rate came into effect on 20th March. The change in the discount rate will be a huge benefit for claimants, as demonstrated by the £5.5 million increase in the settlement in Leonie Millard's case (Forbes Solicitors). We understand this is the first case to be approved by the High Court following the rate change: www.litigationfutures.com/news/girls-damages-nearly-tripled-first-settlement-new-discount-rate. It is clear that the change to the discount rate will also undoubtedly increase the NHS deficit. The Chancellor of the Exchequer, Philip Hammond has ordered an urgent review of an adjustment of the discount rate. We will continue to watch this with interest.

Non Recovery ATE Premiums: The MoJ warned of its intention to consult on this issue back in September 2015. It is important that this consultation is published as soon as possible to enable claimant clinical negligence lawyers to have an accurate picture of the commercial landscape they are expected to work in, in the future.

If ATE premiums cease to be recoverable in clinical negligence claims many firms will find it difficult, if not impossible to carry the risk of funding expert reports. If firms are unable to assist with funding the experts' reports, it will fall to the individual claimants to fund these investigations. Many practitioners will remember the pre CFA market when claimants who were not eligible for legal aid were expected to fund their own investigations. Many valid claims were unable to proceed because the cost of investigating the claim was outside the reach of most people. The loss of recoverability of ATE premiums could herald the return of those pre CFA days.

As ever, in order to help you weave your way through the maze of changes and developments in the law, we are pleased to include some helpful articles from a number of different, but leading sources. Serjeants' Inn's John De Bono QC has written an article *"Roberts v Johnstone is dead"* which sets out some helpful bullet points on how the recent change to the discount rate has impacted on this approach to accommodation costs.

With the effect of the change to the discount rate looming large on everybody's mind, it is an ideal time to include a number of articles relating to the issue of damages. Richard Mumford, barrister at 1 Crown Office Row, has prepared a very interesting piece on whether the law of contributory negligence applies to clinical negligence damages at all. His article *"The blame game*

– some thoughts on contributory negligence in claims for medical accidents" looks at this issue in the light of the decision in *ZEB v Frimley Health NHS Foundation Trust [2016].* John-Paul Swoboda of 12 KBW takes a careful look at the court's approach to disability awards and warns of the risk of under compensating claimants particularly in light of the decision in *Kennedy v London Ambulance Service NHS Trust 2016.*

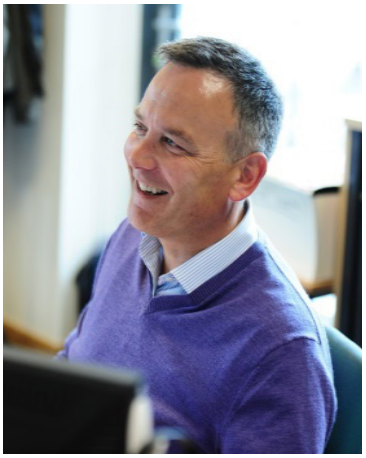
Sophy Miles, barrister at Doughty Street has considered the Court of Appeal's judgment in the Case of *R (Ferreira) v HM Coroner for Inner South London & Others* which was handed down on 26th January this year. Sophy examines carefully the tension between patients who lack capacity, deprivation of liberty and state detentions. On the subject of lacking mental capacity, we are pleased to include the article by Andrew Hanham and Lindsey Connett of Foot Anstey solicitors on *"Abuse and neglect of elderly or vulnerable residents at residential homes".* This is an issue which is receiving increased media attention; the article looks at a range of relevant issues from what constitutes abuse, to what can be achieved through the civil courts.

We are grateful to Benjamin Harrison, paralegal at 7BR chambers who has kindly written up Adam Weitzman QC's case of *Haywood v University Hospitals of North Midlands NHS Trust [2017].* This case notes how an expert's oral evidence can be severely undermined by failings in their earlier reports. Expert evidence is an issue which many claimant clinical negligence practitioners are considering carefully at the moment, particularly in light of the FRC proposals to place a cap on expert fees.

'Consenting, dissenting or simply in the dark – recent cases of Montgomery in practice' by Ben Collins QC and Sophie Beesley both of Old Square, looks at some of the recent case law to illustrate how the lessons from Montgomery have been confirmed and developed by the courts. The article includes a view of the recent decision of the Court of Appeal in *Webster (a child) v Burton Hospital NHS Foundation Trust [2017].*

Last but not least, we are grateful to Sophie Firth of Parklane Plowden who with AvMA's medico-legal advisors, Drs Charlesworth and O'Sullivan represented the family in the inquest touching the death of Dene Biggins. The circumstances of this case remind us that the primary purpose of the inquest is to find facts, not to assign blame.

In the forthcoming months claimant clinical negligence lawyers will face unprecedented challenges. Lawyers need to hold on tightly to their commitment and dedication to righting wrongs and to know that these are strengths that are admired by claimant and defendant lawyers alike. To illustrate how these qualities can hold individual lawyers in good stead, we are pleased to draw your attention to the recognition given to one of our longstanding panel members, Mike Bird, a partner in Foot Anstey's Truro office. Mike has been ranked amongst **"the UK's most innovative and inspirational lawyers in the legal profession in 2017"**.



Mike's outstanding work has been noted but particularly with regard to the work he has carried out *"for women who received negligent care from gynaecologist Rob Jones"* this work has raised him head and shoulders above many London, commercial lawyers to be recognised in the **"The Lawyers Hot 100 List"**. The accolade is well deserved and AvMA is delighted that one of our many "hot" AvMA panel members has been given been given due recognition for the important and life changing work they carry out. Congratulations Mike, absolutely sizzling!

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

Roberts v. Johnstone is dead

JOHN DE BONO QC

SERJEANTS' INN

On 27th February, the Lord Chancellor announced that the discount rate would be revised from 2.5% to -0.75%. This clearly has major implications for the calculation of future losses and will lead to much higher awards and settlements than we have seen before. There are also major implications for the calculation of damages for accommodation where this is required as a result of negligently caused injury. *Roberts v. Johnstone* is dead.

The decision in *Roberts v. Johnstone*

Since March 1988 and the decision in *Roberts v Johnstone* [1989] Q.B. 878; the cost of future accommodation has been calculated on the basis of compensation for the loss of use of capital required by the purchase of a more expensive property. In *Roberts* the Court of Appeal held that appropriate compensation would be calculated on the basis of an assumed rate of return of 2%. In 2001 the Lord Chancellor exercised his power under the Damages Act 1996 to set the discount rate at 2.5% and this figure has been used for *R v. J* calculations ever since.

R v. J doesn't work with a negative interest rate

It is a statement of the obvious to say that *R v. J* does not work with a negative interest rate. Claimants using an *R v. J* calculation would be paying money back to the defendant.

It was time for a change anyway

For many years claimants have been arguing that the *R v. J* calculation is outdated in an era when house prices are so much greater and where a low multiplier (e.g. in cases of limited life expectancy) would not produce a large enough capital sum to fund the purchase of a property. Today's announcement cuts through these arguments. *R v. J* was only ever intended as a pragmatic fudge, once it ceases to be pragmatic it simply disappears as an option.

So what are the alternatives?

I suggest three:

(a) Damages to cover the cost of a mortgage.

(b) Damages to cover capital purchase with a charge on the property so that it reverts to the Defendant at the end of the Claimant's life.

(c) Actual or notional rental costs.

Cost of a mortgage

It is worth going back to *George v. Pinnock* [1973] 1 W.L.R. 118 where Orr LJ held that the Claimant should not be entitled to the capital cost of the property, as this would leave a windfall on her death, but she was entitled *either* to the additional mortgage interest on the additional cost *or* to damages for loss of income from the capital:

"An alternative argument advanced was, however, that as a result of the particular needs arising from her injuries, the plaintiff has been involved in greater annual expenses of accommodation than she would have incurred if the accident had not happened. In my judgment, this argument is well founded, and I do not think it makes any difference for this purpose whether the matter is considered in terms of a loss of income from the capital expended on the bungalow or in terms of annual mortgage interest which would have been payable if capital to buy the bungalow had not been available. The plaintiff is, in my judgment, entitled to be compensated to the extent that this loss of income or notional outlay by way of mortgage interest exceeds what the cost of her accommodation would have been but for the accident."

So the first option for a claimant is to obtain expert evidence as to the cost of financing the difference in property price by way of a mortgage and claiming these mortgage costs.

Mortgage costs and PPOs

There is no reason in principle why instead of claiming the notional cost of borrowing the funds to purchase a

property the claimant should not recover the actual costs of borrowing with periodical payments order to cover those costs, or at least the interest (rather than capital repayment) element of the mortgage.

Capital purchase

The objection to an award of the capital purchase costs was recognized in *George v. Pinnock*. It would give the Claimant's estate a windfall on her death which meant that she would be overcompensated.

That objection could be met by the claimant giving a voluntary undertaking that the property will be restored to the defendant on his/ her death. This option was not considered in *George* but would be a similarly pragmatic solution to that adopted in respect of the cost of private care in *Peters v. East Midlands SHA* [2009] EWCA 945. Of course this ties the claimant and defendant together but no more than a PPO already does.

Rental cost

A claimant can usefully advance an argument that he is entitled to the rental cost of a property for life if there is no other feasible option available. The rental costs, not least when multiplied by eye-wateringly high new multipliers, will in most cases give a much higher award than the capital purchase cost.

Conclusion

None of the above is advice, nor is it novel. Similar suggestions have been made by others over the years. What has changed is that a new approach to *R v. J* is now definitely required. What was always a 'pragmatic fudge' will have to be replaced by a new one. ■

The blame game – some thoughts on contributory negligence in claims for medical accident

RICHARD MUMFORD, 1 CROWN OFFICE ROW

When will an injured patient's damages be reduced to reflect fault on their part? Does the law of contributory negligence apply to clinical negligence damages claims at all? Is there a trend towards blame being placed on the patient for 'failing' to look after themselves properly? These are some of the issues I hope to shed light on in this article.

One thing that can said with confidence is that the courts have historically been slow to reduce the damages awarded to an individual who has been injured through medical accident simply on the grounds that he or she has been at fault in some way. Claimants guilty of what might be described as unwise lifestyle choices are for the most part protected by the analysis of Dyson LJ in *St George v Home Office*[1] that "the claimant's fault in smoking or consuming excessive alcohol over a period of time is not a potent cause of the injury suffered as a result of the negligent medical treatment. The fault is not sufficiently closely connected with the defendant's negligence. Rather, the fault is part of the claimant's history which has led to his being a man who is suffering from a particular medical condition."

To my knowledge the only reported case in which an English court has actually reduced an injured patient's damages on grounds of contributory fault is *Pidgeon v Doncaster*[2]. In that case, the defendant had in 1988 negligently failed to report as positive the results of a cervical smear. The claimant proceeded to develop cervical cancer, for which she underwent surgery in 1997. Between 1991 and 1997 the claimant had been urged repeatedly to have further smear tests but had refused to do so, on the grounds that she had found the 1988 test painful and embarrassing. It was held that this refusal was not sufficient to break the chain of causation (i.e. did not completely absolve the defendant from liability) but did amount to contributory negligence and the claimant's damages were accordingly reduced by two-thirds (i.e. the Mrs Pidgeon only received one third of the full value of her claim).

One does not however need to change the facts very much to arrive at a different result; in *P v Sedar*[3] a patient presented to her GP with a lump in her breast and was referred to the breast clinic. Two letters offering clinic appointments were sent to an old address and not received by Mrs P. The defendant argued that because Mrs P (who had died by the time of trial) would nonetheless have been aware that a referral had been made (presumably having been told by her GP that was what was going to happen) and did not do anything to find out why no appointment had been received, the damages awarded to her estate and dependants should be reduced. The judge declined to do so, commenting that it was difficult to make any findings about Mrs P's reasons for not making her own inquiries as to the status of her referral, not least because Mrs P was no longer alive to give evidence on the issue. Interestingly, the judge inaccurately records that the reduction in damages in *Pidgeon* (which he regarded as an extreme case of non-responding) was only one third – it was in fact two thirds; the inaccuracy might be said to be material to the judge's reasoning since it appears to have falsely narrowed (in the judge's mind) the range of available responses to any fault in the case before him. However, no appeal was pursued and in truth it would be hard to say the judge would necessarily have arrived at a different conclusion had he accurately summarised *Pidgeon*.

However, a pair of fairly recent cases suggests that another *Pidgeon* may be on the horizon. In *Sims v MacLennan*[4] a claim was brought by the estate and dependants of a man who had been found by the defendant GP to have high blood pressure in 2002. On the facts, the judge rejected the claim that the defendant GP had failed to advise the deceased appropriately of the need for follow-up of this abnormal reading. The deceased had seen a different GP in 2007 and been advised to attend the practice nurse for a blood pressure reading, which he did not do. The court held that even if it had accepted that the defendant had been at fault in relation to the 2002 consultation, the deceased's failure to follow the GP's advice in 2007 would have led to a 25% reduction in damages.

1 *[2008] EWCA Civ 1068; [2009] 1 WLR 1670*
2 *[2002] Lloyd's Rep Med 130 (Doncaster County Court)*
3 *[2011] EWHC 1266 (QB)*
4 *[2015] EWHC 2739 (QB)*

Similarly, in *ZEB v Frimley Health NHS Foundation Trust*[5] Garnham J held (on an appeal in relation to an interim payment application) that he "could not be confident that the claimant would do better than a finding against her of 50% contributory negligence" in circumstances where she and her husband had (the defendant argued) misled practitioners about a previous diagnosis of tuberculosis. In so finding, he commented that he had "no hesitation in rejecting [the Claimant's] argument that because the claimant attended the hospital and put herself in the hands of experienced clinicians there can be no contributory negligence. The need for an accurate history from a patient is fundamental to any medical assessment, especially in circumstances such as the present."

Suicide and self-harm cases have understandably attracted attention in the consideration of an individual's contribution to injury but as yet no decided case has sought to apply the reasoning from *Reeves v Metropolitan Police Commissioner*[6] (damages reduced by 50% where individual "of sound mind" hanged himself in police custody) to the clinical negligence sphere. In so far as the point arises predominantly in relation to psychiatric treatment, it is hard to imagine a situation in which the court could find that there has been a negligent failure to respond to a psychiatric condition in need of treatment but at the same time that the patient has been at fault in harming himself. Put another way, cases involving psychiatric treatment would seem *de facto* to be within the category of cases where the patient's "will and understanding [are] so overborne by his mental state" that no reduction for contributory fault is appropriate – see *Corr v IBC Vehicles Limited*[7].

What then can be said of this modest clutch of cases? First, it is clear that any finding of contributory fault / negligence is intensely fact-sensitive. Second, the court is looking at whether the patient has been careless in some way and, if so, whether such carelessness can be said to be a direct cause of their injury, not merely the backdrop or circumstances such as led to them becoming ill. Third, the court may be receptive to a wider range of explanations of apparently careless conduct on the part of an injured patient than would be the case in relation to the acts or omissions of a medical practitioner; these might include (in the typical case of non-response to an invitation or instruction to seek follow-up care) pressure of work or other commitments, lack of appreciation of the seriousness of the situation or administrative/logistical mistakes in planning or attending appointments. Advancing such explanations will require careful consideration in the drafting of pleadings and witness statements.

Can there be said to be a trend in the cases? It would be hard to draw a line between the small number of cases in order to discern a 'direction of travel'. However, two factors may point towards contributory negligence being more frequently and persistently advanced as a defence to clinical negligence claims. First, defendants may be tempted to argue that patient responsibility goes hand in hand with patient autonomy – in the post-*Montgomery* world, if a patient has autonomy over what treatment she undergoes or refuses then why (it may be argued) should she not share the responsibility for injury to which her own choices have contributed? Second, the alteration to the discount rate (assuming it really happens) shifts the cost/benefit calculation of taking what might be considered to be 'risky' points in litigation, of which pointing the finger of blame at the injured patient is surely one. ■

5 *[2016] EWHC 134 (QB)*
6 *[2000] 1 AC 360*
7 *[2008] UKHL 13*

Thou shall not sit with statisticians: disability awards following Kennedy v London Ambulance Service NHS Trust [2016]

JOHN-PAUL SWOBODA, 12 KING'S BENCH WALK

Following the recent case of *Kennedy v London Ambulance Service NHS Trust* [2016] EWHC 3145 in my opinion there are two factors which are essential to understand the courts approach to disability awards, which seek to compensate for loss of future earnings due to disadvantage on the open labour market. The first is the courts' readiness to alter the reduction factor which seeks to take into account sex, age, educational status, employment status and disability. The second is that threshold for proving 'disability' is not high. We as litigators should be careful not to dismiss the possibility of disability given the potential for under-compensation.

The facts in *Kennedy*

Mrs Kennedy had worked as a sole responder for the London Ambulance Service for about 10 years which required her, amongst other things, to drive an emergency vehicle. On 12 April 2011 she was provided with a Vauxhall Astra for her 12-hour shift. As a result of an undetected fault on the exhaust carbon monoxide leaked into the drivers compartment. By 11pm Mrs Kennedy complained of feeling unwell.

Liability was admitted by the London Ambulance Service and as a result of the exposure to carbon monoxide Mrs Kennedy suffered from migrainous headaches which resolved and a chronic psychiatric condition[1] which was capable of some improvement with treatment but was permanent.

Deciding on the reduction factor

At para 90 of his judgment in *Kennedy* (supra) HHJ Hughes QC, sitting as a Deputy High Court judge, quoted WH Auden who stated *"thou shall not sit with the statisticians"*. This scepticism of a purely statistical approach helps to understand why HHJ Hughes QC, and other judges, have been willing to depart from a strict adherence to the methodology in the Ogden Tables for the calculation of the disability award. The preferred route of the courts' when making a disability award is to allow for judicial assessment of disability by adjusting the reduction factor provided by the tables A-D but otherwise to maintain the methodology contained within the Ogden tables.

The court's preference to stick with the Ogden methodology (other than adjustment of the reduction factor) rather than abandon it or revert to a *Smith v Manchester* approach is reflected in in the judgment of LJ Jackson in *Billet v MOD* [2015] EWCA Civ 773 at para 98 who accepted tables A-D of the Ogden Tables, which contain the reduction factors, *"will be a valuable aid to valuing the Claimant's loss of earning capacity."* The preference for the Ogden methodology is also to be found in HHJ Hughes QC judgment in *Kennedy* at para 98 where he stated *"the court should not depart from the multiplier/ multiplicand* [Ogden] *approach unless... it throws up an obviously unreal result"*.

The preference to adjust the reduction factor is shown by the court's acceptance, and sometimes endorsement, of such an approach in *Connor v Bradman* [2007] EWHC 789, *Billet* (supra) and *Kennedy* (supra). This preference is probably borne of many factors, not least the court's jealous guard of its role and its unwillingness to 'sub-contract' the role of assessing disadvantage on the open labour market to statisticians or actuaries. However, the most intellectually coherent reason for maintaining the Ogden approach apart from adjustment of the reduction factor is that the explanatory notes to the Ogden Tables refer to the adjustment factors provided in tables A-D as a *"ready reckoner* [which] *cannot take into account all circumstances and it may be appropriate to argue for higher or lower adjustments in particular cases"*.

Whilst it is difficult to argue against the logic of each case being judged on its own merits rather than being based purely on statistics, there are likely, in my opinion, to be some adverse effects caused by the preference to adjust the reduction factor. Perhaps the most invidious part of judicial assessment of reduction factors is the apparent if not actual consequence that a judge decides (by implication if not explicitly) how disabled a particular

1 *It was disputed whether the ongoing psychiatric condition was attributable to the exposure to carbon monoxide but HHJ Hughes QC, sitting as a Deputy High Court judge was satisfied that the psychiatric condition would not have been suffered by Mrs Kennedy but for the breach of duty.*

claimant is. This is bound to lead to comparison between cases and potentially appeals as one claimant feels aggrieved that they were assessed not to be particularly disabled when compared to other claimants. A retort to such a complaint would be that the reduction factor, and its adjustment, takes into account numerous contingencies and not just an assessment of disability.

The threshold for disability

The second proposition I set to make out in this article is that the threshold for proving a particular person is disabled is not particularly high. In the case of *Kennedy* (supra) HHJ Hughes QC did not spend much ink in his judgment grappling with the issue of whether Mrs Kennedy was disabled. That probably reflected the fact that her psychiatric condition rendered her unfit to work. Further it is not clear whether it was disputed that Mrs Kennedy was disabled.

Most readers of this article will be aware of the guidance notes which accompany the Equality Act 2010 and which set out various of examples of what is likely to, and what is not likely to amount to a disability. A fairly standard course of action taken by many litigators is to provide a medical expert with these guidance notes and to ask for an opinion on whether a claimant is disabled. This may be setting the bar too high and potentially leading to under-compensation.

Disability as defined under the Equality Act 2010 requires the person to suffer from a "substantial adverse effect" on their "ability to carry out normal day to day activities". This threshold requirement of disability was considered by Mr Justice Langstaff in *Aderemi v London & South Eastern Railway* [2013] ICR 591 in an appeal against an Employment Tribunal decision. Langstaff J stated:

> *Because the effect is adverse, the focus of a tribunal must necessarily be upon that which a claimant maintains he cannot do as a result of his physical or mental impairment. Once he has established that there is an effect, that it is adverse, that it is an effect upon his ability, that is to carry out normal day-to-day activities, a tribunal has then to assess whether that is or is not substantial. Here, however, it has to bear in mind the definitions of substantial which is contained in section 212(1) of the Act. It means more than minor or trivial. In other words, the Act itself does not create a spectrum running smoothly from those matters which are clearly of substantial effect to those matters which are clearly trivial but provides for a bifurcation: unless a matter can be classified as within the heading "trivial" or "insubstantial", it must be treated as substantial. There is therefore little room for any form of sliding scale between one and the other.*

In *Billet* Jackson LJ described this passage as extremely helpful and adopted the test set out to decide whether Mr Billet was disabled so that the Ogden approach to disadvantage on the open labour market was applicable. The evidence about whether the injury causes an adverse effect which affects the ability to carry out normal day to day activities comes directly from the claimant; either the claimant says (s)he fulfils these requirements or not. The only objective part of the threshold requirement for disability is whether the adverse effect is substantial. Given the Court of Appeal in *Billet* endorsed the interpretation of "substantial" in this context meaning anything more than trivial, I consider most injuries which have an adverse effect on a claimant's ability to carry out normal day to day activities are likely to amount to a disability.

This low hurdle as to disability is in some respects surprising. It may well provide another reason for the court's willingness to adjust the reduction factor. More importantly we, as professional litigators, must be careful not to dismiss a claimant's injury as not amounting to a disability given the potential for under-compensation. ■

Judgment of the Court of Appeal in R (Ferreira) v HM Coroner for Inner South London and others [2017] EWCA Civ 31.

SOPHY MILES, DOUGHTY STREET CHAMBERS

The Court of Appeal has handed down its judgment in this appeal on 26 January 2017.

The decision under challenge was the decision of the coroner not to hold an inquest with a jury in relation to the death of the claimant's sister Maria, who had died in an intensive treatment unit on 7 December 2013. Maria had what the Court of Appeal had described as a "severe mental impairment".

The coroner reached the view that an inquest should be heard. The claimant argued that an inquest with a jury should be convened, pursuant to section 7 Coroners and Justice Act 2009, on the basis that Maria had been deprived of her liberty for the purpose of Article 5, and was therefore in "state detention" at the time of her death. In the last days of her life when she was in intensive care Maria was sedated, intubated and placed in mittens so that she did not reflexively remove the tubes in place.

The hospital had not applied for a standard authorisation and therefore had not granted itself an urgent authorisation under schedule A1 Mental Capacity Act 2005 (MCA).

In holding that he was not bound to sit with a jury, the coroner noted a number of "features" in relation to Maria's death. One of these was that – as explained above- no formal authorisation had been granted. This was a clear reference to paragraph 66 of the Chief Coroners Guidance No 16 on the Deprivation of Liberty Safeguards.

The court had to decide whether Maria was in state detention ("compulsorily detained by a public authority") at the time of her death. If she was then the Coroner's decision not to summon a jury for the inquest would have been wrong.

There are two first instance judgments, one by Gross LJ and one by Charles J. Both dismissed the application for different reasons. Gross LJ considered that there might be some cases where a person was deprived of their liberty for the purpose of `article 5, but not in state detention, but this was not one of these cases. He noted that the decision in **Cheshire West** should not be applied mechanistically, but on the facts of each case. To find that all patients lacking capacity receiving treatment in an ITU were deprived of their liberty would not be to apply Cheshire West but to extend it (including to patients with no preceding lack of capacity). It would be wholly artificial on the facts of this case to say that Maria was deprived of her liberty: she was in hospital because for pressing medical and treatment reasons she was unable to be anywhere else.

Charles J found that there was a distinction between deprivation of liberty and "compulsory detention" – compulsory detention involves over-riding the person's will. In some Article 5 cases the substituted decision-making in the MCA exercises choice for the person. Following this reasoning someone who dies under DOLS might be deprived of their liberty but not "compulsorily detained". He found that Maria was not deprived of her liberty and that it was fanciful to speculate as to what would have happened if her sister attempted to discharge her. He further found that Maria was not "compulsorily detained".

Lady Justice Arden upheld the coroner's decision. In summary she held that

> "Applying Strasbourg case law, Maria was not deprived of her liberty at the date of her death because she was being treated for a physical illness and her treatment was that which it appeared to all intents would have been administered to a person who did not have her mental impairment. She was physically restricted in her movements by her physical infirmities and by the treatment she received (which for example included sedation) but the root cause of any loss of liberty was her physical condition, not any restrictions imposed by the hospital. The relevant Strasbourg case law applying in this case is limited to that explaining the exception in Article 5(1)(e), on which the Supreme Court relied in *Cheshire West*, and accordingly this Court is not bound by that decision to apply the meaning of deprivation of liberty for which that decision is authority."

Furthermore she held that if this was wrong, Maria was "free to leave" and therefore the "acid test" in Cheshire West would not have been satisfied.

Importantly Lady Justice Arden preferred the first instance reasoning of Gross LJ to that of Charles J, holding that there is a "substantial overlap" between

the concepts of "state detention" and "deprivation of liberty". "State detention" does not require the state to have taken a decision to detain the person- this could for example have happened by mistake. Referring back to the decision of the Strasbourg Court in Austin v UK, [2012] 55 EHRR 359 she observed that some interference with a person's liberty falls outside Article 5. "Commonly occurring restrictions on movement" will not give rise to a deprivation of liberty; and can occur in respect of those with and without capacity to consent to it.

She continued (§88):

> "In my judgment, any deprivation of liberty resulting from the administration of life-saving treatment to a person falls within this category. It is as I see it "commonly occurring" because it is a well-known consequence of a person's condition, when such treatment is required, that decisions may have to be made which interfere with or even remove the liberty she would have been able to exercise for herself before the condition emerged. Plainly the "commonly occurring restrictions on movement", which include ordinary experiences such as "travel by public transport or on the motorway, or attendance at a football match", can apply to a person of unsound mind as well as to a person of sound mind. Moreover, my conclusion in this paragraph removes what Ms Clement rightly submits would otherwise be the absurd consequence of the absence of any lawful basis in Article 5 for depriving individuals of sound mind of their liberty for the purposes of administering life-saving treatment (see paragraph 68)."

Therefore

> "....any deprivation of liberty resulting from the administration of life-saving treatment to a person falls outside Article 5(1) (as it was said in *Austin*) "so long as [it is] rendered unavoidable as a result of circumstances beyond the control of the authorities and is necessary to avert a real risk of serious injury or damage, and [is] kept to the minimum required for that purpose". In my judgment, what these qualifications mean is in essence that the acute condition of the patient must not have been the result of action which the state wrongly chose to inflict on him and that the administration of the treatment cannot in general include treatment that could not properly be given to a person of sound mind in her condition according to the medical evidence."

She thus distinguished Maria's case from cases such as NHS Trust v G [2015] 1 WLR 1984 where a hospital wished to provide obstetric treatment to a pregnant woman of unsound mind who objected to the treatment- because this was materially different to the treatment that would be given to someone who was of sound mind. Cheshire West was directed to a different situation namely the living arrangements for those of unsound mind and there was no policy need to extend it. Maria's treatment was not arbitrary nor was it the consequence of Maria's impairment.

At §95 she observed that:

> "In addition, in my judgment, Article 5(1)(e) is directed to the treatment of persons of unsound mind because of their mental impairment. The purpose of Article 5(1)(e) is to protect persons of unsound mind. This does not apply where a person of unsound mind is receiving materially the same medical treatment as a person of sound mind. Article 5(1)(e) is thus not concerned with the treatment of the physical illness of a person of unsound mind. That is a matter for Article 8. Where life-saving treatment is given to a person of sound mind, the correct analysis in my judgment is that the person must have given consent or the treating doctors must be able to show that their actions were justified by necessity or under section 5 of the MCA. If this cannot be shown, then there has to be some method of substituted decision-making, such as obtaining an order from the Court of Protection".

Furthermore there was no evidence that Maria was not free to leave: there was no suggestion that the hospital would have refused a proper request to remove Maria, or that Maria would have asked to leave.

Lady Justice Arden held that to be in "state detention" did not require an authorisation to have been granted`; this would be an "absurd" result which Parliament cannot have intended. She held that therefore that paragraph 66 of the Chief Coroners Guidance 66 was wrong in law. She further accepted that the coroner was incorrect to suggest that Maria had validly consented to her admission.

However, these were not the only features relied on by the coroner in finding that an inquest with a jury was not required. Lady Justice Arden noted that whilst s64(5) MCA expressly links the interpretation of "deprivation of liberty" to Strasbourg jurisprudence, there is no equivalent provision in the Coroners and Justice Act 2009. There is no clear and consistent Strasbourg jurisprudence that treatment in an ITU violates Article 5, and the courts are not bound to follow it in any event.

It is understood that permission is being sought to appeal to the Supreme Court.

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Practitioners will note that this judgment would not prevent the coroner from holding an inquest at his or her discretion pursuant to s 7(3) CJA 2009, on the basis that there was "sufficient reason" to do so.

Practitioners will be aware that the Policing and Crime Bill has amended the definition of "state detention" for the purposes of sections 1, 4 and 7(2) of the Coroners and Justice Act 2009 to exclude those who are subject to authorisations under DOLS or an order of the Court of Protection. Whilst the rationale behind the amendment – to reduce the number of unnecessary inquests into entirely natural deaths – is understandable, the blanket nature of the amendment is of concern. The death of a patient who takes their own life whilst detained under the Mental Health Act 1983 will automatically lead to an inquest with a jury. But if a patient lacking capacity with a history of self- harm takes their own life whilst under DOLS in a care home, where he or she may have been under significant levels of restriction, then the summonsing of a jury will be a matter for the Coroner's discretion (even if Article 2 is found to be engaged). In those circumstances practitioners may want to rely on the proposition that in deciding whether to exercise of the discretion to summons a jury should be considered by reference to the categories in which the summonsing of a jury would be mandatory: *R (Paul and others) v Deputy Coroner of the Queen's Household and Assistant Deputy Coroner for Surrey* [2007] EWHC 408 (Admin), at para. 45. ■

Clinton House – abuse and neglect of elderly or vulnerable residents of residential home

FOOT ANSTEY

Foot Anstey has recently been instructed by the families of former residents of Clinton House Care and Residential Home in St Austell, Cornwall after a secretly filmed BBC Panorama investigation broadcast, on 21 November 2016, showed evidence of residents being neglected and abused by staff.

Panorama sent three undercover journalists to Clinton House following allegations of neglect being made. Two obtained employment as care assistants, whilst a third posed as a resident requiring respite care. All three recorded video footage of their experiences whilst at Clinton House. The footage showed poorly staffed homes where there were insufficient staff to cope with the needs of the residents (many of whom were immobile and required assistance with personal hygiene), including one incident where a resident who needed to use the toilet was left for so long in their wheelchair that they were incontinent and another who was left on a bedpan for an excessive period of time.

The programme also showed a nurse employed by the home recommending that a resident (who was feeling unwell and wanted to be taken to hospital) be given morphine to *"shut her up"*, rather than her health concerns being investigated.

Clinton House was run by the Morleigh Group, who also operated three other care homes in the Cornwall area. The Morleigh Group have confirmed that, following being notified of the Panorama investigation, they have suspended the nurse involved pending an investigation. It is reported that a police investigation is taking place. Clinton House has now closed. The Care Quality Commission carried out a detailed review of all four homes operated by the Morleigh Group and rated them as 'Inadequate' or 'Requiring Improvement'.

Following the closure of Clinton House, residents were moved to new placements, where physical injuries including bruising and pressure sores have been identified. Residents have also started to make disclosures of specific abuse and neglect, whilst relatives have raised issues of institutional abuse. As well as seeking compensation for the residents, their families have many questions about the care their relatives received and how the situation was able to deteriorate to the situation found by Panorama and subsequently by the CQC.

What can be achieved for victims of residential care or nursing home abuse?

Residents in residential care or nursing homes are some of the most vulnerable in society. Those in residential care range from young adults with mild learning disabilities who need support to live semi-independently all the way to those with the most severe learning and physical disabilities who require 24 hour care. Residents in nursing homes are often elderly with significant health needs or cognitive impairments. The nature of a resident's age and/or disability often means that they are extremely vulnerable to physical/psychological abuse or neglect. They are often unable to speak up for themselves or unable to realise (because of their cognitive impairments or learning disabilities) when they are victims of abuse. They may feel unable to report incidents of abuse for fear of reprisals from their abuser. They may be living in a placement where the abuse of residents is seen as normal day-to-day activity and residents assume that it is just something that they have to deal with on their own.

What constitutes abuse?

Abuse is defined as any action that intentionally harms or injures another person. This can be by way of physical, verbal or psychological abuse. Intentional neglect of a person's health needs also falls within this definition where a victim suffers physical injuries or deterioration in their physical condition as a consequence. Institutional abuse (such as that which occurred at Winterbourne View hospital in Bristol) can occur where a residential or nursing home/hospital setting is run according to the needs of the business rather than the needs of the residents, and so residents are deprived of free choice and forced to abide by a regime imposed upon them to their detriment.

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What can be achieved through the civil courts?

Claimants will pursue civil claims for a number of reasons, including:

- Closure
- Justice
- Apology
- Answers
- Renewal of trust in professionals
- Acceptance and belief of what has happened
- Raise awareness
- Avoid reoccurrence
- Financial support

Ultimately, however, the central tangible outcome is the recovery of damages to compensate them for their experiences and to provide for future needs. These amounts vary depending on:

- The type of abuse and the nature of the injuries suffered
- The vulnerability of the Claimant (level of disability, cognitive impairments and/or communication difficulties)
- Whether there have been any criminal convictions arising out of the abuse
- Whether there is a need for future treatment arising as a consequence of the abuse
- Whether the family of the Claimant provided any 'emergency' care if there was a delay in identifying a new placement

The engagement of the defendant is key to the swift resolution of these types of claims. Early notification to them of the civil claims can often result in the matter being settled prior to the need to issue proceedings and a resolution of the matter which is to the satisfaction of both parties. Where abuse claims are made against a private limited company, it is important at the very earliest stage to investigate the issue of whether they had insurance in place and whether the insurer will agree to indemnify. If an insurer is unwilling to indemnify, further investigations into the assets of the company and their ability to pay any damages will need to be ascertained.

Case study - abuse of adults with learning disabilities – Gloucester case

Foot Anstey recently represented a group of clients following allegations of abuse being made arising from events at a privately run supported living home in Gloucester. Anonymity provisions in both the criminal and civil proceedings prevent the name or location of the home being published, as well as the identity of the claimants or their families.

All the Claimants have mild to moderate learning disabilities and varying degrees of communication difficulties. They were placed by Gloucester County Council at a residential home owned and operated by a private limited company. There was a mix of female and male residents. The company employed the husband of the Registered Manager as a lone night worker (despite previous allegations of sexual assault being made against him by current residents and residents at previous homes where he worked). He sexually abused and raped the female residents, as well as subjecting all residents to verbal and physical abuse.

Criminal proceedings

Following the first allegations of rape being made by one of the female residents, the police quickly became involved after a member of staff contacted them directly about the allegations. The allegations had previously been reported to the manager of the limited company, but he did not contact the police immediately, rather preferring to handle the matter internally. The member of staff to whom the initial allegation disclosure had been made was not happy with this response and felt that the allegation was not being dealt with seriously enough, leading to the referral directly to the police.

Once the police became involved, all of the other residents were interviewed (with appropriate support and communication experts). It quickly became apparent to the police that all of the female residents had either been sexually assaulted or raped at some point. For some, it had been a repeated occurrence over a number of years. Police interviews with the victims demonstrated that all had been severely psychologically affected by their experiences.

The male care worker was duly convicted after criminal proceedings in April 2014. During the course of his defence, he sought to minimise the learning disabilities of the victims, suggesting that they had been complicit in consensual intercourse. The Judge dismissed this, saying in sentencing that *"the three ladies had the bodies*

of adults but the minds of children and little children at that." Following his conviction, he was sentenced to 14 years imprisonment.

During the course of the police investigation into the sexual abuse, it transpired that the Registered Manager (the wife of the male care worker) had been stealing money from the residents. She was subsequently arrested on suspicion of theft and suspended from her position. In April 2014, she pleaded guilty to three counts of fraud by abuse of position and was sentenced to 8 months imprisonment. She was convicted in relation to the sum of £1,000 but the families believe that the true amount runs into many thousands of pounds.

Civil proceedings

Foot Anstey were then instructed to pursue civil claims for compensation on behalf of the six claimants affected. A Letter of Claim was sent to the defendant company in February 2015. Their insurers admitted vicarious liability immediately upon receipt of the Letter of Claim. They invited the claimants to enter settlement discussions. Quantum investigations (through detailed and considerable review of voluminous records) were undertaken and a joint settlement meeting proceeded on 07 September 2015.

Quantum

All claims were settled before issue, with sums for general damages varying depending on whether there was an associated conviction for rape and on the basis of evidence obtained from available records. Expert evidence was not obtained as it was considered it would be harmful to the claimants to be assessed. All parties agreed to this.

As often is the case in care home abuse cases, there were two aspects of these claims which made coming to a figure for general damages particularly challenging: (1) due to the nature of the Claimants' learning difficulties it was difficult to know the full extent of the abuse suffered; (2) linked to this is the fact that there was no expert medical evidence in respect of the injuries suffered, given the likely adverse effect that being assessed by an expert may have on the Claimants. It was therefore difficult to assess the impact and any long-term effects on each Claimant.

Counsel's advice was sought in respect of quantum. Their advice was that quantum should reflect a) whether there was a criminal conviction and, if so, was it for rape or sexual assault; b) how long an individual Claimant had lived within a 'violent regime'; and c) whether there was any evidence of psychiatric injury. Due to the nature of the Claimants' disabilities, it was difficult to obtain witness evidence directly from them. It was also important not to cause any further undue distress. Forensic analysis of the records was therefore undertaken for each Claimant in order to piece together the evidence required to quantify the claim.

The range of settlements for general damages agreed was from £15,000 at the lowest end (where there was little or no evidence) to £55,000 at the top end of the group (where there were associated convictions of rape). These sums reflected the three issues identified by Counsel in their advice. All the Claimants then had modest special damages claims in addition.

At the time of settlement, the Claimants were already beginning to engage in local psychological treatment provided by the NHS in respect of their traumatic experiences. In order to have costed full private future psychiatric treatment, it would have required the instruction of a psychiatric expert, who would have had to assess each Claimant. It had already been agreed that such assessment would be detrimental to the Claimants' well-being. It was agreed by all the litigation friends that a separate sum for future private psychological treatment should not be sought as a result.

Human Rights Act

The appropriateness of making claims under the Human Rights Act 1998 was considered during the settlement process. It was clear from the evidence (both from the records and from the families of the Claimants) that the Claimants had suffered breaches of Article 3 (inhumane and degrading treatment) and Article 8 (right to a private and family life). However, Counsel had concerns in these cases about bringing such claims. Firstly, by the time that Foot Anstey were instructed, the Claimants were already outside the limitation period for bring a claim under the Human Rights Act. The limitation period for such claim is a strict one year from the date of incident and the Claimants' incapacity to litigate did not prevent the limitation period from running.

In addition to concerns regarding limitation, it was Counsels' advice that the general damages agreed upon between the parties adequately compensated the Claimants for the abuse suffered. Claims under the Human Rights Act are generally to be seen as a remedy of last resort. In these cases, it was considered that there was

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a viable remedy available to the Claimants via the usual personal injury route. There were also potential issues around whether the private company operating the home could be considered a public authority – it was known as a 'supported living home' rather than a 'care home'. The Claimants held individual tenancies, with rent being paid for by a combination of Housing Benefit and private funds. The care provided to the Claimants was termed 'domiciliary care' rather than 'residential care' as it was seen as being technically provided within the Claimants' own home.

Deprivation of Liberty claims were also investigated but it was felt that there was insufficient evidence to substantiate those allegations.

Management of the damages awards

Prior to commencing the litigation, one Claimant already had a Court of Protection Deputy in place. During the course of the litigation, applications were made to be appointed Deputy by two of the litigation friends for other Claimants in anticipation of a successful outcome. A further application for Deputyship was made post-settlement in respect of a fourth claimant. These applications were made, in the main, as a consequence of the Claimants receiving in excess of £50,000 in damages. The Civil Procedure Rules provide that in the case where an incapacitated adult receives greater than £50,000 of damages, that sum must be transferred to the Court of Protection and managed by a Court-appointed Deputy, who will be subject to regular checks and balances by the Court to ensure the money is being appropriately managed and accounted for.

In respect of the single Claimant who received less than £50,000, their damages were paid into the Court Funds Office, with a litigation friend appointed to manage the funds on their behalf. The Court Funds Office allows the litigation friend to apply for funds to the benefit of the Claimant as and when required. Each request submitted must be approved by a Judge before funds are released. Again, this was because the Claimant was an incapacitated adult and it was felt that judicial oversight was required to ensure that the damages were not misused. At the approval hearing, the Judge approved the appointment of the Claimant's litigation friend to this role and provided investment directions for the Court Funds Office to follow.

Counsel involvement was limited to advice on quantum and advice for approval. Andrew Hannam, Partner at Foot Anstey, led the cases in all other aspects (with assistance from Lindsey Connett), including conducting the settlement meeting. The Court approved settlement of claims and deduction of success fee from damages on 22 April 2016. Costs had been agreed with the defendant prior to the approval hearing taking place. ■

Oral evidence from an expert witness on the back of a misconceived report: fruit of a poisoned tree?

BENJAMIN HARRISON, 7BR CHAMBERS

Introduction

The case of *Haywood v. University Hospitals of North Midlands NHS Trust* [2017] EWHC 335 (QB) bucks the recent trend of the NHSLA winning trials on liability. Whilst the case does not involve any new or novel legal issues the analysis of the facts may be of interest, not least because the NHS Trust's ("D's") obstetric expert, Derek Tufnell, came in for some criticism from the judge.

The claimant was represented by Adam Weitzman QC, of **7BR Chambers**, instructed by Mandy Luckman and Jenna Harris of **Irwin Mitchell**, Birmingham.

Facts

On 17 September 2010 Sarah Haywood ("C") gave birth to her first child, which was delivered by emergency caesarean section. It was accepted that, during the course of the caesarean section, bacteria entered C's surgical wound, developed into an infection, and led to C suffering a stroke on 3 October 2010. She continues to suffer a right-sided hemiparesis, speech impairment and cognitive defect.

The issues in this case centred on the significance of the hospital's response to the following sequence of events:

1. C developed a persistent tachycardia whilst in hospital (her pulse rate was measured at **130 bpm** on the night of 18 September and early in the morning of 19 September);
2. other tests undertaken on a sample of C's blood (early in the morning on 19 September) also showed an elevated white cell count; however,
3. by around noon, C's pulse rate had dropped to **80 bpm** (i.e. within the normal range).
4. As a result, C was discharged from hospital in the afternoon, without *any* further tests being carried out to measure either her pulse, or white cell count.

It was the decision to discharge C in these circumstances which was said to have been negligent. C's case comprised three points.

First, C claimed that there was a negligent failure to investigate the cause of the persistent tachycardia so as to exclude the possibility of post-operative infection.

Second, it was negligent to discharge C on the basis of the single pulse rate measurement of 80 bpm. This was because her tachycardia and her raised white cell count were caused by—and were signs or symptoms of—her developing infection.

Third, D should have considered the possibility of infection and carried out further tests—had that been done, these further tests would have shown the presence (or likely presence) of the infection. This would, in turn, have led to C being administered a broad spectrum of antibiotics, and thus saved C from her subsequent ill health and stroke (D admitted that such treatment would have resolved the infection: para 4).

In the end, Holroyde J. concluded (at paras. 124 – 125) that, in all the circumstances of the case, no reasonable body of doctors would have discharged C on 19 September 2010 without having carried out the further tests: there was a breach of duty on the part of D; and C's stroke was caused by that breach of duty.

Criticism of the expert witness

An interesting aspect of this case, which this note focusses on, is found at paras. 114 – 118 of the judgment. It is at this point that Holroyde J. discusses the evidence of Mr Tufnell (D's obstetric expert).

In his initial report, Mr Tufnell failed to refer to C's pulse readings of 130 bpm on the night of 18 September and early the following day (he only referred to C's initial pulse on 19 September of 115 bpm and the afternoon reading of 80 bpm). Mr Tufnell asserted that, just because he did not mention certain observations and measurements in his report, this "did not mean that he failed to take them into account".

In cross examination, Mr Tufnell was forced to address the omissions just referred to, but by then it was too late to salvage the damage done to the quality of his evidence.

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Holroyde J. held (at para. 118) that Mr Tufnell's evidence was "seriously undermined by his failure to...report...the high pulse rates". Moreover, it set the "wrong course" for Mr Tufnell's subsequent oral evidence "because it was based on an incomplete recital of the details [of C's] persistent tachycardia". Even if Mr Tufnell did have the findings concerning the persistently-elevated pulse rate "in mind" when writing his report, "he failed to give sufficient weight to them, and the conclusions in his report [could not] be regarded as reliable, because they did not address the most important factors militating against his conclusions".

Comment

Expert witnesses and practitioners would do well to bear Holroyde J.'s criticisms in mind to ensure that their future reports do not befall similar unfortunate omissions. As *Haywood* shows, a misconceived initial report, by an expert witness who has failed to take into account salient factors, has the potential to completely undercut any subsequent oral evidence that the expert has to offer.

Indeed, in *Haywood* itself, subsequent oral evidence on the back of the suspect report seems to have been treated as irredeemably tainted, and was unable to survive scrutiny. ■

Consenting, dissenting or simply in the dark – recent case studies of Montgomery in practice

BEN COLLINS QC & SOPHIE BEESLEY

It has long been the case that medical practitioners have been required to obtain consent to treatment from their patients. Until March 2015, the assessment of alleged breaches of this duty by the Courts was thought to be subject to the *Bolam* test. This provided a defence to a doctor who could satisfy a judge that he or she had acted in accordance with an accepted responsible body of medical opinion[1]. A patient's right to be informed about their treatment was to be judged by reference to the view of the profession rather than to what a patient might want to know.

As readers will be aware, this position changed significantly following the Supreme Court's judgment in *Montgomery v Lanarkshire Health Board* [2015] UKSC 11; [2015] 2 WLR 768. In *Montgomery*, the Supreme Court held that patients should be regarded by courts as more akin to consumers with rights, who are free to exercise choices, rather than passive recipients of care. As such, the model of a doctor-patient relationship as something close to medical paternalism was no longer appropriate. Instead, and with very limited exceptions:

> *"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."*

In the two years since this landmark decision, medical professionals, their advisors and representatives have been unpicking what the decision means for everyday practice and how it applies to individual cases.

It is no easy task to extract points of general application. In each case, the court must decide what a prudent person in the patient's position would have wanted to know about a proposed treatment, as well as what the individual patient in fact wanted to know. No longer can it be left to the medical profession to decide what the patient should be told. Cases have been very fact specific and arguments interwoven with other issues, such as causation, which inevitably influence overall decisions. Unsurprisingly, courts' views have varied significantly.

Practitioners are familiar with the way in which the facts of a particular case, and in particular relating to an individual patient, influence, and on occasion determine, arguments in relation to causation. For example, in the Scottish case of *Britten v Tayside Health Board* [2016] SC DUN 75, the claimant had previously suffered from bipolar disorder. He was diagnosed with pan-uveitis in his left eye and was prescribed oral steroids. He suffered systemic steroid exacerbated psychosis and was admitted to a psychiatric hospital for two months. He spent a further three months recovering post-discharge. It was agreed that it was highly likely that the claimant's relapse was caused by the steroids. He alleged that he had not been advised of the risk of relapse or the alternative treatment of steroid injections.

The court preferred the doctors' evidence that the claimant had been advised of the risks associated with treatment. However, it found that steroid injections were a reasonable alternative treatment and that a reasonable person might have opted for such treatment had he or she been made aware of the relative risks and benefits. The claimant had not been told that this alternative treatment was available and this was a breach of duty.

In this example, therefore, breach of duty was established on the basis of what a 'reasonable patient' would have wanted to know, but the case failed on causation because the claimant failed to establish that he would have opted for the alternative had it been offered.

The decision shows, as is often the case, that much can turn on the court's impression of the patient's factual evidence. At one level, this is an obvious point. From the

1 *Sidaway v Governors v Bethlem Royal Hospital [1985] AC 871*

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day *Montgomery* was handed down, it was clear that the law was to be patient-centred, and judges have always been affected by their view of claimants. However, the importance of the patient's factual evidence has grown since *Montgomery* introduced the subjective element into the test for breach of duty, where previously it had been more of an issue of causation. In respect of breach, cases may now also turn on questions as to what that the individual patient believed was significant.

Risks do not, of course, exist in isolation. Each has a statistical probability of occurring and its own potential consequences if it is to materialise. Together, these factors influence whether the risk is material, but where courts would place the line between material and immaterial risks has been difficult to predict. The complication is deepened further by the subjective element of the individual patient's perceptive because this, arguably, can influence the significance of different statistical risks.

This point began to emerge in one of the early post *Montgomery* cases: *A v East Kent Hospitals University NHS Foundation Trust* [2015] EWHC 1038 (QB). The claimant argued that the Trust had failed to warn her of the risk of her baby having a chromosomal disorder. She argued that if she had been informed, she would have undergone an amniocentesis to test for the condition and would then have terminated the pregnancy. The claim was dismissed. The court held that there was no evidence of a material risk that the child would have a chromosomal abnormality to which the claimant should have been alerted. In any event, the claimant would not have opted for an amniocentesis because the risk to the baby of disability caused by the procedure would have been greater than from continuing with the pregnancy. And even if she had had such a test, she would not have terminated the pregnancy.

The discussion in the judgment on materiality of risk focused on the relative merits of the statistical information presented by each party. The Trust argued, and the court accepted, that the risk of chromosomal abnormality was about 1 in 1,000 whereas the claimant argued that it was about 1-3 in 100. The court accepted the Trust's evidence and concluded that the risk was therefore *"theoretical, negligible or background"* and not one which needed to be discussed with the claimant. Against this finding, the court concluded that the claimant would not have opted for amniocentesis even if it had been discussed because the risk of provoking premature delivery by undertaking the procedure was about 1 in 100.

The guidance in *Montgomery*, however, was that the materiality of a risk should not 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."*

In *A*, given that the court found that even if the claimant had known about the chromosomal abnormality she would have continued with the pregnancy, there was nothing in the court's findings in relation to the characteristics of the patient which contradicted its view on the non-material nature of the risk. But the case highlights the question about where the boundary lies between risks which are material and those which are not in cases where the risk is very small or not well researched, but where the consequences, should they materialise, may be significant or even catastrophic for the patient.

The judgment quoted the GMC Guidance that *"a small but well established risk of a serious adverse outcome"* is significant. It now appears increasingly the case that the principle of the *Montgomery* decision (and the emphasis which it placed on patient choice) means that there are few risks which patients should not be warned about, particularly where they carry potentially significant consequences. Far better for clinicians to raise uncertainties with patients than carry the responsibilities of not doing so.

This view was confirmed by the recent decision of the Court of Appeal in *Webster (a child) v Burton Hospitals NHS Foundation Trust* [2017] EWCA Civ 62, which provided the opportunity for the Court of Appeal to review questions of consent in light of *Montgomery*.

The claimant was born with profound physical and cognitive impairment caused by a brain injury which occurred between 72 and 48 hours before his delivery. An earlier ultrasound scan had shown abnormalities and it was admitted that the treating consultant obstetrician and gynaecologist had failed to note these. It was also agreed that the consultant should have arranged further scans. The claimant's case was that his mother should have been offered an induction on her due date and that if she had been, his injury would have been avoided. The hospital argued that had further scans been offered, these would have provided reassurance and that the anomalies relied on would not have indicated the need

for heightened vigilance or advice about dangers which might be avoided by induction. The trial judge found that had the claimant's mother been advised there was an increased risk in waiting, she would have wanted to proceed with the birth, but found against the claimant by adopting the *Bolam* test. The issue on appeal in the light of *Montgomery* concerned the advice and information which should have been given and what would then have happened.

The Court of Appeal held that the information presented to the claimant's mother should have included not only a list of the anomalies and complications which could not be avoided by earlier delivery, but also the increased risk of perinatal mortality (including antepartum mortality) as a result of waiting, even though the figures were based on a very small statistical sample. More specifically, in a case with the combination of features shown on her ultrasound scan, she should have been told that there was *"emerging but recent and incomplete material showing increased risks of delaying labour"*. In those circumstances, the court found that, even if the information had been couched in terms of contrary arguments in favour of non-intervention, the claimant's mother would have asked for her labour to be induced on her due date and the claimant's injury would have been avoided.

In relation to factual causation, the court relied on factors such as the claimant's mother being fed up with the pregnancy, her lack of wellbeing, not wanting the delivery put off when induction was looming in any event, her evidence that if there was any suggestion of risk she would have opted for delivery, that she was a graduate with a degree in nursing and that she had demonstrated her willingness to take responsibility for her pregnancy (evidenced by an earlier decision not to stay in hospital overnight against medical advice).

Webster sets the bar relatively low for claimants (in terms of breach) by finding in favour of telling the patient about small risks which carried significant consequences. As for causation, it emphasises what has always been the case: the importance of factual evidence as to decisions which individual patients would have taken if they had been provided with more information.

FM v Ipswich Hospital NHS Trust [2015] EWHC (QB) provides another useful example. The case concerns a brachial plexus injury. The court found that if the claimant's mother had been properly advised of the risk of shoulder dystocia during a vaginal delivery, she would have opted for a caesarean section and the injury would have been avoided. The claim succeeded on causation because the claimant's mother had undergone a traumatic birth with her first son and her evidence, which the court accepted, was that she would have opted for the caesarean rather than run any risk of repeating such an experience. That was the case even if the advice from the obstetrician had been to go ahead with a vaginal birth.

It is significant that the precise risk of shoulder dystocia in the case of *FM* was not quantified. The court found that it was sufficient to establish breach of duty in that the claimant's mother would not have wanted to run even a comparatively small risk of having a disabled child. *"She was not herself particularly mathematical and for her the key thing would have been the identification of the risk not its quantification."* Similarly, in the (later) case of *Webster*, the court's view was that the consultant obstetrician should have informed himself of the implications of the rare combination of factors seen on the ultrasound scan and then informed the claimant's mother, even though the research underpinning the risk was neither well established nor well proven.

This small sample of cases illustrates how the lessons from *Montgomery* are confirmed and developed by the courts. Medical practitioners must engage with each individual patient, as an individual, during the consent process. They must consider the individual patient's needs, opinions, background and concerns. They must discuss all appropriate treatment options, along with the risks and benefits of each, even where those risks are very small, and should include in these discussions not only statistical probabilities but also the seriousness of potential consequences. Importantly, even before they have these conversations, they must access up to date information based on the latest research. In conclusion, whilst medical practitioners can advise on the most appropriate option, it is now patients (having been provided with the information needed to understand the risks, benefits and options available to them) to decide between alternatives. It is also clear that practitioners must stand back from pressures on budgets and resources in giving advice.

It may be said, therefore, that the burden on the practitioner is a heavy one. Given that the procedure for obtaining consent now includes not only hard facts, but also risk analysis and many subjective elements, courts will be astute to confirm whether clinicians have documented carefully their discussions with patients and the information and advice which has been given and received (in case of doubt as to the importance of the notes, compare *Lunn v Kanagaratnam* [2016] EWHC 93 (QB) and *Grimstone v Epsom and St Helier University Hospitals NHS Trust* [2015] EWHC 3756 (QB)).

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Contemporaneous notes have never been more powerful in their potential to influence the course of litigation.

A number of cases show that the claimant's factual evidence is key. It is crucial to help claimants to provide evidence which identifies and articulates the advice they would (even with hindsight) have wanted; and which explains (in this case setting hindsight aside) why they can be clear that they would have taken a particular course if the advice had been given. Arguments on this issue, as can be seen from the *Webster* and *FM* decisions, can be strengthened by the supporting evidence of spouses and relatives, and evidence generally of the relevant elements of a patient's background or education, previous experiences and examples of where patients have weighed up advice and made decisions about their care and treatment in the past.

Montgomery has provided a real opportunity for claimants to bring to the attention of both defendants and courts cases where clinicians have failed to recognise a patient's real, human need for information about their treatment. It is to be hoped that its indirect effect is to improve standards in the consenting process for clinicians themselves. ■

Inquest touching the death of Dene Biggins

AVMA MEDICO-LEGAL ADVISORS:
CHRISTOPHER CHARLESWORTH & RUTH O'SULLIVAN
COUNSEL AND ARTICLE AUTHOR:
SOPHIE FIRTH OF PARKLANE PLOWDEN CHAMBERS

Background

Mr Biggins was a smoker and had a complex medical history of chronic obstructive pulmonary disease, hypertension, peripheral vascular disease and alcoholic liver disease, having given up alcohol the year before his death.

On Tuesday 12 January 2016, Mr Biggins had an elective ventral hernia repair at Sheffield Teaching Hospital. His immediate post-operative situation was complicated by urinary retention and vomiting which settled on 14 January.

By Friday 15 January Mr Biggins had vomited again and was experiencing, abdominal soreness and distension, low oxygen saturations and features of sepsis including CRP in which had remained in the region of 300 since the operation. Antibiotics were given for suspected pneumonia.

On Saturday 16 January, the picture was similar and pulmonary embolism was considered as a diagnosis. Mr Biggins started vomiting again and Core Trainee 1 Dr Hague noted a fluctuant midline swelling over the surgical wound, prompting an ultrasound scan (USS) which diagnosed an ileus.

On Sunday 17 January Mr Biggins' CRP had dropped slightly to approximately 140 but he remained on oxygen and was noted to be vomiting bile. Persistence of the midline swelling prompted a diagnosis of haematoma or seroma.

By Monday 18 January, Mr Biggins was noted to be off oxygen, but hadn't opened his bowels or passed flatus. Despite this, discharge was briefly considered.

On Tuesday 19 January – 7 days post-operation – Mr Biggins began regularly vomiting faecal fluid and Surgical Registrar Dr Salih requested a CT scan which revealed failure of the hernia repair and mechanical bowel obstruction. Upon discussion with Consultant Surgeon Mr Adam, Mr Biggins was returned to theatre for a laparotomy which showed a strangulated hernia with peritonitis. Ischaemic and necrotic bowel was removed and an ileostomy formed. Mr Biggins was not seen by a consultant before this point, being examined only by various junior doctors.

On Wednesday 20 January, Mr Biggins was admitted to the intensive care unit. A second laparotomy removed further ischaemic bowel but sadly Mr Biggins did not recover and died on 21 January 2016.

Pro bono expert evidence

Consultant Surgeon and Surgical Oncologist Mr FD Skidmore had briefly looked at the case for AvMA on a pro bono basis. He expressed his concern about the lack of consultant input until 7 days post-operation and that a Serious Untoward Incident Enquiry (SUI) had not been set up by the Trust.

I later had a conference with Mr Skidmore. His view on the basis of the evidence he had seen was that that Mr Biggins' hernia may have recurred as early as 15 / 16 January and he provided academic articles which supported that contention. Key indicators of recurrence at that time were sepsis, especially raised CRP and abdominal swelling.

Pre-inquest review (PIR) – 7 July 2016

The PIR was heard at Sheffield Coroners' Court by Assistant Coroner Louise Slater.

Mr Skidmore's letter was submitted to the Coroner along with a request to have expert evidence from him at the inquest. The Coroner was not receptive to this approach, expressing the view that it would be sufficient to have evidence from the consultants involved in Mr Biggins' care. She noted that if she later considered expert evidence to be necessary, she would select an expert of her own choosing.

The Coroner was unable to compel the Trust to undertake an SUI. However, she did accede to a request to have evidence from Dr Salih, who was regularly involved in Mr Biggins' care prior to diagnosis of recurrence, along with Dr Hague and another junior doctor. This extended the length of the inquest from half a day to one day. Prior

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to this, evidence was only to be heard from consultants who were not involved in Mr Biggins' care during his deterioration and prior to the diagnosis of recurrence. Additional disclosure was also ordered from the Trust.

Inquest – 9 November 2016

The inquest was also heard at Sheffield Coroners' Court by Assistant Coroner Louise Slater. Live evidence was heard from: Rebecca Webster, Mr Biggins' daughter; Dr Savanah, Pathologist; Mr Boyes, the Consultant in charge of Mr Biggins' care; Dr Salih, Surgical Registrar; and Mr Adam, the Consultant who performed the initial hernia repair and the first laparotomy. Other witnesses' statements were read.

The articles provided by Mr Skidmore were passed to the Coroner.

Mr Adam gave evidence that the normal structure within the team was that the majority of care and ward rounds were done by junior doctors, unless there was concern about a patient. Dr Salih was in charge of reviewing Mr Biggins. There was therefore nothing abnormal about the lack of Consultant input.

The thrust of the evidence from the treating doctors was that there was nothing which would necessitate Consultant input prior to 19 January, nor any obvious clinical indication that the hernia had recurred. The clinical picture prior to the weekend pointed to pneumonia and pulmonary embolism was reasonably considered. Raised CRP and ileus are common in the post-operative phase and can resolve themselves. Faeculant vomiting is a common symptom of ileus. Dr Salih's evidence was that when he examined Mr Biggins after the weekend on Monday 18 January the picture was one of improvement and this was supported by Mr Boyes. Therefore, there was no need to escalate to Consultant level prior to 19 January and if the case had been escalated, almost nothing would have been done differently.

The only significant concession from both Consultants was that if they had seen Mr Biggins over the weekend, they would have ordered a CT scan of the abdomen. However, Dr Hague's decision to perform a USS instead was reasonable and a CT would not have revealed anything more than the USS did. In any event, whilst by the time the laparotomy on 19 January was carried out there was bowel ischaemia, the CT earlier that day had shown that the bowel was enhancing (i.e. healthy).

The family raised concerns about the insertion of the naso-gastric tube and Mr Boyes also said he may have inserted this earlier.

The Coroner accepted the cause of death, merely inserting "operated" into 1b. The cause of death was:

- 1a Sepsis
- 1b Small bowel necrosis (operated)
- 1c Ventral hernia repair dehiscence
- 2 Liver fibrosis and emphysema

The Coroner gave a narrative conclusion: "Died as a result of complications of abdominal surgery". In Box 3 she recorded: "Mr Biggins had an elective ventral hernia repair, developed post-surgical complications and remained in hospital until death". She did not consider there was any evidence to warrant ordering a Prevention of Future Deaths Report.

Comment

The Coroner's attitude to Mr Skidmore's evidence is a reminder that the primary purpose of the inquest process is to find facts, not to assign blame. If behaviour of representatives for bereaved families is perceived to attempt the latter then it may be met with resistance. ■

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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!

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.

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.

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.

Annual Clinical Negligence Conference 2017

23-24 June 2017, Royal Armouries Museum, Leeds

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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). The programme this year will have an orthopaedics theme, whilst also covering many other key medico-legal topics at such an important time for clinical negligence practitioners. 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 full conference programme and registration brochure will be available in late March.

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23-24 June 2017, Royal Armouries Museum, Leeds

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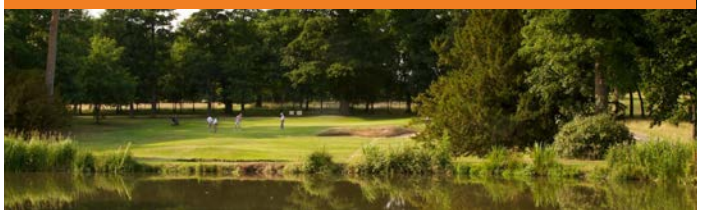

The thirteenth AvMA Charity Golf Day will take place on Thursday 22 June 2017 at the stunning Rudding Park in Harrogate. The Welcome Event for the Annual Clinical Negligence Conference will take place later that evening in Leeds (30 minutes' drive away) so the Golf Day offers the perfect start to the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

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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.

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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. Booking will open in March.

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