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action against medical accidents

The charity for patient safety and justice

Lawyers Service Newsletter

November 2019

Contents

Editorial

Lisa O'Dwyer
Director, Medico-Legal Services

On 15th July, the Lord Chancellor announced an increase in the discount rate, up from minus 0.75% to minus 0.25%. According to the government, the increase was justified due to concerns that claimants were being ***"substantially over-compensated, increasing financial pressure on public services that have larger personal injury liabilities, particularly the NHS"*** https://www.gov.uk/government/news/lord-chancellor-announces-new-discount-rate-for-personal-injury-claims The rate will be reviewed in five years' time.

September saw NHS Resolution publish their ***"Early Notification scheme progress report:*** collaboration and improved experience for families" https://resolution.nhs.uk/wp-content/uploads/2019/09/NHS-Resolution-Early-Notification-report.pdf This report refers to 746 "qualifying cases" being included in the first year of the scheme (2017/18), 24 families have received admissions of liability within 18 months of the incident. The report compares this with the position pre ENS when ***"the average length of time between an incident occurring and an award for compensation being made was 11.5 years".***

The ENS report raises plenty of questions. Key concerns for AvMA include identifying what information, signposting and understanding families have about the ENS process when the investigation commences? The report says that families are told about AvMA, but it is far from clear, how and when that information is being communicated. A small number of families have found their way to us, not all of them as a result of being signposted by NHS Resolution. If there are only 24 admissions of liability, then most families are either still going through the process or have been advised that the care they received was of a reasonable standard. AvMA is exploring these concerns with NHS Resolution.

On a more positive note, **Helen Hammond and Emma Beeson**, both senior associates at **Pennington Manches Cooper** article ***"Future improvements in stillbirth rates anticipated with the adoption of the saving babies lives care bundle"*** looks at how outcomes can be improved. **Sophie Walmsley**, solicitor at **Tees Law** continues the optimism in her article ***"The dawn of a new era?"*** Sophie looks at whether NHS Resolution is at last demonstrating a willingness to take a more sensible, empathetic and fair approach to claims

by making admissions and settling cases early on. We can hope that this is a case of two steps forward. On the other hand, **Chris Hough** of **Doughty Street** reminds us that NHS Resolution's attempts to resurrect old challenges like "***Should a claimant deduct the costs of travelling to work?"*** serve only to detract from any positive changes, they are quite simply taking one step back.

October, saw the publication of the Civil Justice Council (CJC) report on fixed costs in lower value claims: **https://www.judiciary.uk/wp-content/uploads/2019/10/Fixed-recoverable-costs-in-lower-value-clinical-negligence-claims-report-141019.pdf** A more complete version of our position statement is available on our website and clearly sets out our concerns about these proposals **https://www.avma.org.uk/?download_protected_attachment=AvMA-Position-Statement-Redacted.pdf**

Staying with the subject of costs, many if not all claimant practitioners should read **Thomas Crockett's** article ***"Applications for Interim Payments of Costs: An Update".*** Thomas, is a barrister practising at **Hailsham Chambers**, he highlights how increasingly the courts are recognising that where liability is conceded but agreement on quantum is likely to be delayed, claimant solicitors can make an application for an interim costs order. **Kate Wilson** practises at **Park Square Barristers**, her focus is on the ***"Recovery of inquest costs in civil proceedings"*** with reference to the decision in *Fullick v Commissioner of the Police of the Metropolis [2019] EWHC 1941 (QB)* and Mrs Justice Slade's three stage approach to recoverability.

I highly recommend the article ***"Inquest disclosure: Can staff interviews given to other investigations really be withheld?"*** by **Cicely Haywood**, barrister at **5 Essex Court**. Cicely looks at the starting point for obtaining disclosure and the hurdles practitioners may face.

We are grateful to **Adam Copeland** and **Isobel Foenander**, both of **Tees Law** for sharing their case report on ***Claire Radcliffe v Cambridge University Hospitals NHS Trust.*** They remind us that despite NHS Resolutions general preference to buy off a client's claim for provisional damages, this can often be the answer to preserving a client's position, especially where prognosis is uncertain.

Whilst a defence of contributory negligence is rarely seen in clinical negligence litigation, **Patrick Limb QC** of **Ropewalk Chambers**, considers this further in his article ***"Contributory negligence post Montgomery"***. Patrick asks whether the judgment in *Montgomery v Lanarkshire Health Board [2015] UKSC 11. [2015] A C 1430* may invite a change of approach in the future.

The Inquest Service values its relationships with leading sets of chambers in inquest and healthcare law. The case report of the ***"Inquest touching the death of Henry James Maw"***, benefited from advocacy provided by **Jade Ferguson** of **Parklane Plowden Chambers**. Jade worked with AvMA's Dr Connor to provide representation to Henry's mother some 15 years after his birth and subsequent death.

In July, AvMA welcomed both Caroline Graham, a former consultant anaesthetist at St George's Hospital and Fleur Hallett, solicitor to AvMA's Medico Legal Team. Fleur recently worked with **Darragh Coffey**, barrister at **1 Crown Office Row** on the ***"Inquest touching the death of John Wells"***. Mr Wells was a 70-year-old gentleman with learning difficulties. Fleur and Darragh were able to draw the coroner's attention to several issues of concern which resulted in five Prevention Future Death (PFD) reports being issued.

AvMA is always looking for more helpline volunteers. If you are interested more information on the helpline volunteering service, including testimonials from current volunteers is included in the Newsletter.

The 8th Edition of ***"Lewis and Buchan: Clinical Negligence, a practical guide"*** is now available. **Ali Cloak** a senior associate at **Royds Withy King** has reviewed the book for us and says: ***"This comprehensive text will be a very useful resource for any clinical negligence practitioner, irrespective of seniority, given its breadth and well – considered coverage"***

We take this opportunity to congratulate **Janine Collier**, Executive Partner at Tees Law on being awarded the **Cambridge and District Law Society 2019 Woman Lawyer of the year award.** We have reproduced an interview with Janine and hope that her experiences will inspire and encourage others to persist with their ambitions. Janine reminds us that compromise, hard work and determination usually win through in the end. Last, but not least, AvMA's conference manager, Ed Maycock, shares some of the excellent feedback we received from delegates attending our 2019 annual conference. Our next annual conference will take place in **Bournemouth on Thursday and Friday 25th and 26th June – save the date!** More details to follow in 2020.

Best wishes

Future improvements in stillbirth rates anticipated with the adoption of the Saving Babies' Lives Care Bundle

HELEN HAMMOND, SENIOR ASSOCIATE
PENNINGTONS MANCHES COOPER

EMMA BEESON, SENIOR ASSOCIATE
PENNINGTON MANCHES COOPER

Improving stillbirth rates - a review of the Saving Babies' Lives Care Bundle and how this achieved a 20 percent reduction in stillbirths in early adopter trusts. The death of a baby is a devastating event for mothers, fathers and the wider family.

Penningtons Manches Cooper has represented numerous parents who have suffered the loss of a baby and members of the clinical negligence team know all too well how this loss can have a significant impact on both the parents of that baby and also the parents' friends and families. It affects people in a psychological, social and economic way.

The prevention of stillbirth remains a challenge to UK maternity services. Currently, the UK ranks 24th out of 49 high income countries in terms of stillbirth rates, with around one in 250 pregnancies ending in stillbirth after 24 weeks of pregnancy.

Recent statistics gathered by Penningtons Manches Cooper from local hospital trusts including Frimley Health NHS Foundation Trust, University Hospital Southampton NHS Foundation Trust, Hampshire Hospitals NHS Foundation Trust and Portsmouth Hospitals NHS Trust, do indicate that the rates of stillbirth and neonatal deaths across these trusts have declined over the past four years, in line with the UK trend. However, between 2015 and 2018 they still had a combined total of 665 stillbirths and neonatal deaths, including 111 stillbirths and 35 neonatal deaths in 2018 alone.

It is therefore clear that there is still work to be done.

How can stillbirth rates be improved?

There are two strategies that can be taken to reduce the rate of stillbirths. Firstly, identifying women that are at an increased risk of stillbirth and, secondly, identifying aspects of the maternal lifestyle, such as personal habits, that may increase the risk of stillbirth.

Some risk factors are well established. These include maternal medical issues; smoking; fetal growth restriction; and reduced fetal movements.

In order to tackle the high stillbirth rates in the UK there needs to be a multifactorial approach.

Although not all of the information requested from the trusts was complete, Frimley identified that out of the term stillbirths that occurred at 37 weeks gestation or later within their Trust between 2014 and 2018, 18 percent of these could have been avoided with alternate care.

The Saving Babies Lives Care Bundle (SBLCB) was launched by NHS England in 2015, in response to the Government's ambition to halve the stillbirth rate by 2025. It focuses on the effective implementation of best practice care. An evaluation of the implementation of the SBLCB in early adopter trusts in England, between April 2015 and April 2017, was undertaken in November 2018 and this article considers that report's findings.

The SLBCB sets out four different ways to potentially improve outcomes for babies and their parents:

- reducing smoking in pregnancy
- risk assessment and surveillance for fetal growth restriction
- raising awareness of reduced fetal movements
- promoting effective fetal monitoring in labour

Helen Hammond and Emma Beeson, senior associates in the clinical negligence team who often represent parents whose babies have been stillborn or pass away shortly after birth, comment: "It is the second, third and fourth issues identified in the Saving Babies' Lives Care Bundle that we see so often in the claims that we handle. A failure to properly identify and monitor fetal growth restriction, a failure of medical staff to heed a mother's reports of reduced fetal movements and ineffective fetal monitoring during labour."

The impact of the SBLCB

The trusts that indicated in the 2015 NHS England Tracker Survey that they were implementing SBLCB were deemed 'early adopters' and were eligible to take part in an evaluation of its implementation. The evaluation was conducted between May 2016 and December 2017 and took data from 19 NHS trusts (it should be noted that none of the trusts in the South contacted by Penningtons Manches Cooper for their statistics were included in this evaluation).

Over the five year period that the SBLCB was introduced, the total number of stillbirths across the 19 participating trusts declined from 4.2/1000 births to 3.4/1000 births. This equates to a 19.9 percent reduction in the rate of stillbirths in the trusts that implemented SBLCB.

It is estimated, based on the stillbirth rate before and after the launch of the SBLCB, that there were potentially 156 fewer stillbirths across the participating trusts between April 2015 and April 2017 and if it were implemented across the whole of the country, there would be 1,119 fewer stillbirths across the UK in that timeframe.

The evaluation also highlighted that alongside the reduction in stillbirths, the rates of scans, inductions to labour and emergency caesarean sections have progressively increased over the past five years. Although the evaluation of the implementation of the SBLCB could not prove that the SBLCB was the direct cause of those increases, given the nature of some of the interventions recommended in SBLCB, it is plausible that the improvement in early detection was due to the implementation.

Risk assessment and surveillance for fetal growth restriction

It is incredibly important that babies that are small for their gestational age (SGA) are identified during pregnancy. There is a higher risk that an SGA baby will develop hypoglycaemia (low blood sugar) and other conditions that can negatively impact their health and chances of survival. They are also at a higher risk of stillbirth.

The SBLCB recommended five interventions to identify SGA babies, including:

- using the SBLCB algorithm for risk classification
- for high risk women, using serial ultrasounds to assess fetal growth and plotting the estimated fetal weight on a chart
- for low-risk women, assessing fetal growth using symphysis fundal height
- an ongoing audit of SGA birth rates and antenatal detection rates
- an ongoing audit of 'missed' SGA cases

The evaluation found following the implementation of the SBLCB that antenatal detection of SGA babies increased significantly. This in turn has reduced the number of stillbirths as action can be taken to ensure that the baby is delivered at the right time to be born safely.

Raising awareness of reduced fetal movements

A large proportion of women who experience a stillbirth report recognising reduced fetal movement (RFM) prior to the birth. RFM can be a key warning sign that a baby is in distress. If the baby is being deprived of oxygen, their movements will slow to conserve energy, but this has to be recognised and action taken to ensure a baby is born before it is too late.

Various studies, such as the *Confidential Enquiry into Term Antepartum Stillbirth*, published in 2017, have found that the lack of prompt management of RFM was a contributing factor to stillbirths that could be avoided.

From the local trusts that Penningtons Manches Cooper contacted when conducting investigations, Frimley's statistics alone demonstrated that of the neonatal deaths that occurred there between 2014 and 2018, 17 percent of those delivered at 37 weeks gestation or later reported a maternal appreciation of reduced fetal movement during pregnancy.

The SBLCB focused on raising awareness among pregnant women of the importance of detecting and reporting RFM during pregnancy, and ensuring that healthcare providers have protocols in place to manage RFM.

Raising awareness about the importance of monitoring fetal movements and recognising RFM is a very high profile initiative, with charities such as **Kicks Count** and **Tommy's** focusing significantly on this and the impact that raising awareness may have on reducing stillbirths.

The recommendations on tackling RFM by the SBLCB were relatively low cost and included providing women with an information leaflet on RFM and discussing the importance of reporting RFM at every antenatal appointment.

Following the implementation of the SBLCB, virtually all women reported monitoring their baby's movements. A large proportion of women who experienced RFM attended their maternity unit and, of those women, 74 percent received fetal heart monitoring and 65 percent received an ultrasound scan. In addition, around 55 percent of women reporting RFM were induced.

This demonstrates that there is still room for improvement, but taking the necessary steps to raise awareness and having protocols in place to react to women reporting RFM can have a significant impact on stillbirth rates.

Promoting effective fetal monitoring during labour

Monitoring the baby during labour is one way of checking on the baby's wellbeing. Recording the baby's heartbeat can help to identify distress and shortage of oxygen, thereby reducing the chances of stillbirth.

Monitoring can ensure that if a baby becomes distressed, a mother can be offered an assisted instrumental delivery (usually a ventouse or forceps) or a caesarean section so that the baby is delivered safely.

The SBLCB recommended specific actions to help improve effective fetal monitoring during labour. These recommendations included annual training for all staff and a buddy system for reviewing cardiotocography (CTG) results, with protocols for escalation if concerns are raised about the baby's wellbeing.

Unfortunately, the report on the SBLCB stated that CTG training for staff across trusts was poor and there was not adequate data for analysis. Nonetheless, the buddy system was utilised quite highly, and even through trusts were not completely compliant with the system, escalation protocols were well utilised.

What are the challenges of implementing these initiatives?

The initiatives recommended by the SBLCB come with increased costs. It is estimated that the cost of implementing the SBLCB between April 2015 and April 2017 in the early adopter trusts was £26 million. This figure includes purchasing new equipment, the increase in the number of scans conducted, investment in training and the increase in intervention such as induction of labour and caesarean sections.

There may also be other costs associated with implementing the SBLCB which are more difficult to monitor, for example, the impact on staff, as they would be required to complete additional tasks within the same appointment time.

Although these costs may seem high, it is possible that by investing in the recommendations made by the SBLCB, there will be a reduction in expenditure elsewhere. An example of this would be that costs will be saved on testing and **post-mortem examinations conducted as a result of a stillbirth**, something which may become more significant with the implementation of inquests for stillbirths at term. Additionally, a reduction in the rate of stillbirths that are easily preventable will lead to less money being spent on litigation, which can be incredibly expensive for the NHS. In 2016/17 obstetric claims made up 50 percent of all claims that the NHS Litigation Authority handled and cost around £4,370 million Furthermore, intangible costs that are incurred as a result of parents suffering a stillbirth, such as unemployment, adverse psychological consequences and social isolation will be prevented and reduced, which is invaluable.

Conclusion

When evaluating the implementation of the SBLCB in early adopter trusts, it is clear that there have been significant changes in outcomes for women and their babies. There is a national aim to reduce the amount of stillbirths in England and the results from this study are in line with what would be required to achieve those targets.

By following the fairly simple, yet effective, recommendations made in the SBLCB in the future, ensuring that SGA babies are identified and monitored, that women are made aware of RFM and that there is effective fetal monitoring during labour, there could be a drastic reduction in the high level of stillbirths.

The Dawn of a New Era?

SOPHIE WALMSLEY, SOLICITOR
TEES

Is there a glimmer of hope in the way that the NHS is dealing with new claims? Over the last 6 months or so, we have seen signs that in some cases, NHS R is taking a more sensible, empathetic and fair approach much earlier on, leading to costs savings and earlier resolution.

We summarise three cases beneath:

Case A

Client A suffered and was admitted to hospital for a chest infection which had not responded to treatment in the community. He was treated with gentamicin and suffered gentamicin toxicity, leading to acute kidney injury. Client A required a period of treatment in ICU.

A SI report was very critical of the failure to monitor Client A's gentamicin levels and of the dosage prescribed.

We sent a Letter of Notification, inviting early admissions, so as to avoid the cost of liability investigations.

One month after service of the Letter of Notification, having received no response, we instructed a Respiratory Physician, Pharmacologist and Nephrologist.

In the event, four months after the Letter of Notification, the Defendant served a Letter of Response, admitting liability, at the same time, making a not unsensible offer to settle. We responded by way of a Part 36 Offer to Settle, which the Defendant accepted.

Comment: It was unfortunate that the admission was not forthcoming just a few months earlier as significant expert fees could and would have been avoided. However, an admission four months after service of the Letter of Notification and prior to service of formal Pre-action Protocol Letter of Claim is a marked improvement on the NHS LA's historic approach. However, once the admission was made, the Defendant's Part 36 offer was well pitched – it was not an unreasonable offer, placed the Claimant under significant pressure (as the case had not, at that stage, been fully quantified) and led to settlement just a few weeks later. It is a shame that NHS R have not been willing to engage in costs negotiations without referral to Acumension as this has incurred significant additional costs of costs proceedings.

Case B – full admission of liability within one month of service of Letter of Notification

Client B suffered a delayed diagnosis of a fracture – the client had made a complaint about her treatment and received a letter apologising for the error.

We requested medical records, the complaints file and policies and protocols and, having considered these (in an effort to minimise costs) without obtaining liability expert evidence, served a Letter of Notification inviting an admission of liability.

Less than one month after receipt of the Letter of Notification, NHS Resolution served a Letter of Response with a full admission in respect of breach and causation and a letter of apology for the client.

One month later, we received a Part 36 Offer to settle. The offer was low and has not placed Client B at risk. We are now fully quantifying the case.

Comment: The costs of liability investigations have been saved with the early admission. It is regrettable that the Defendant's Part 36 offer was so low that it cannot have sensibly been intended to resolve the case at that stage and the case has yet to conclude.

Case C – full admission of liability, compensation and costs settled in less than three months!

This case involved a young lady (Client C) and the still birth of her child.

Following an initial conversation with Client C, we had concerns that there was a failure to manage Client C's diabetes, a failure to follow the guidelines about reduced

fetal movements, delays in intervention and delays in delivering the baby.

We requested medical records, the complaints file, the SUI report and any relevant policies and protocols. The Trust responded a month later providing the documentation required.

Four days later we received a letter from NHS Resolution confirming that liability was admitted. Along with this letter was a, not unreasonable, offer to settle.

Following sensible negotiation, the case was settled within the following few weeks, with costs also being settled within a few weeks, without the need for a formal bill to be drawn, served, or the involvement of Acumension.

The entire case from Client C's initial call to costs settlement took less than three months.

Comment: This is the exemplar, the Nirvana – the best outcome for our clients, for clinicians and of course, taxpayers.

Commentary

Whilst still the exception, rather than the norm, these cases show that there may be a developing trend towards earlier admissions and earlier resolution, at least in certain cases.

There were a number of commonalities in all three claims:

- Admissions in a SI / complaints correspondence
- Cases valued at < £50k
- Sensible Case Handlers, with no involvement of Defendant Panel solicitors

The numerous benefits to all Parties of early resolution cannot be under-estimated:

- the client avoids years of litigation-induced stress, emotion and uncertainty, achieves closure and has the necessary funds to be able to access appropriate treatment and support sooner rather than later
- the clinicians involved in the care avoid years of litigation
- the taxpayer saves £10,000s, if not £100,000s in legal fees as well as significant management time costs.

Whilst early admissions and resolution sadly remain the exception to the rule, we dare to dream that the future may look brighter for our clients, the clinicians and the taxpayer.

Should a Claimant deduct the costs of travelling to work?

CHRISTOPHER HOUGH
DOUGHTY STREET CHAMBERS

Where a Claimant makes a claim for past and future loss of earnings, should they give credit for the costs of working (usually travel expenses)?

For a great many years, the answer was thought to be no. More recently, the NHSR and those they instruct have revived an old argument that such costs should be deducted.

At first, I thought it was just one of the delights of being against some of the old dinosaurs still found in place like 2TG. It is becoming more of an epidemic: everybody now wants a deduction - usually pitched in the Counter Schedule at 15-20% (presumably on the basis that Claimant will concede 10%).

Resist!

In 1988, the case of Dews v National Coal Board 1988 AC 1 was heard in the House of Lords, Lord Griffiths held:

> "Where ever a man lives he is likely to incur some travelling expenses to work which will be saved during his period of incapacity, and they are strictly expenses necessarily incurred for the purpose of earning his living. It would, however, be intolerable in every personal injury action to have an inquiry into travelling expenses to determine that part necessarily attributable to earning the wage and that part attributable to a chosen life-style. I know of no case in which travelling expenses to work have been deducted from a weekly wage, and although the point does not fall for decision, I do not encourage any insurer or employer to seek to do so. I can, however, envisage a case where travelling expenses loom as so large an element in the damage that further consideration of the question would be justified as, for example, in the case of a wealthy man who commuted daily by helicopter from the Channel Islands to London. I have only touched on the question of travelling expenses to show that in the field of damages for personal injury, principles must sometimes yield to common sense."

Whilst obiter, this could hardly be expressed more forcibly.

The case that Defendants rely upon is Eagle v Chambers 2004 EWCA Civ 1033. This litigation followed a serious RTA which occurred in June 1989. At her trial in 2003, the judge, Mr Justice Cooke, deducted 15% from Ms Eagle's past earnings as representing her travelling expenses for work. He made no such deduction in respect of future earnings – for the very good reason that the Defendant's legal team did not ask him to do so.

Unfortunately, the judge was not referred to the recent HL authority which described such a deduction, even if limited to past losses, as "intolerable".

This case went to the CA where, in a short passage the CA refused to interfere with the 15% deduction. It was said that the decision in Dews did not lay down a rule of law. Lord Justice Waller interpreted the passage in Dews as follows:

> "What the passage seeks to prevent is inordinate time being spent on not very significant items in the context of an exercise which is attempting to assess damages in a broad way. I would not disturb the judge's finding."

Putting these decisions together, it seems highly unlikely that the court would, save for those claimants who travel to work by helicopter, make a deduction for the costs of going to work.

My experience is that, faced with the passage from Dews, defendants back down. I encourage others to remember Dews.

Applications for Interim Payments of Costs: An Update

THOMAS CROCKETT
HAILSHAM CHAMBERS

hailshamchambers

It is a feature of modern clinical negligence and personal injury litigation that there often can be substantial delay between securing judgment giving rise to the entitlement to damages and the payment of the same. Such delays are frequently due to uncertainties as to the quantification of damages and can be particularly prevalent in higher value cases concerning children and/or the most complex injuries. Claimant parties can thus experience significant 'cash flow' issues which may affect inter-litigation decisions, such as the procurement of evidence or choice of expert. It could be said that there may be an access to justice point to be made too: as smaller, specialist, firms of solicitors may be unable to compete against those who are more readily able to wait sometimes many years for payment. Conversely, defendant parties are likely to be resistant to having to pay out for costs which may never be ordered where uncertainties remain as to the likely outcome of any final determination of quantum issues.

Applications for interim payments on account of costs have been made by claimant parties seeking to mitigate this situation for some time. Since *Giambrone v JMC Holidays Ltd* [2002] EWHC 2932 (QB), payments on account of liability costs have been readily ordered, where there has been an admission or judgment on liability. Indeed, very recently (23 October 2019) the Court of Appeal in *Global Assets Advisory Services Ltd & Anor v Grandlane Developments Ltd & Ors* [2019] EWCA Civ 174, held that the court had the power to make such an order in circumstances where a claimant party has accepted a Part 36 offer within time. However, applications for payment on account of costs incurred in respect of quantum made before the quantum trial has taken place have not been the subject of (at least publicised) reasoned judicial decision until this year.

Earlier this year, His Honour Judge Robinson sitting in the County Court at Sheffield heard an appeal from a district judge's refusal to grant a claimant in an obstetric negligence case such an interim payment on account of costs in *HI (a Minor by his Litigation Friend) v Hull & East Yorkshire Hospitals NHS Trust* (unreported, 25 February 2019, County Court at Sheffield).

The circuit judge held that CPR 44.2(1) and (2) were sufficiently wide to allow the court to order such an interim payment in principle, that such an entitlement could be triggered by an order for an interim payment in respect of damages and that, taking into account the presence or absence of Part 36 Offers, any likely delay between determination of liability and determination of quantum (as would be common in many cases, particularly those concerning children) was a *"very significant fact"*. It is important to note that the circuit judge made an order in respect of quantum costs before making an order for payment on account of those costs.

The Defendant sought the permission of the Court of Appeal for a second appeal on this point. This was refused with Lord Justice Irwin holding that it was *"entirely proper... to order interim costs payments with a view to the cash flow of solicitors in very long-lasting litigation where very significant liability has been conceded"*.

In *RXK v Hampshire Hospitals NHS Foundation Trust* [2019] EWHC 2751 (QB), judgment had been entered for damages to be assessed along with liability costs to be assessed if not agreed. The Defendant Trust has been ordered to make interim payments on account of damages in the sum of £100,000 and of costs in the sum of £50,000.

The claimant sought interim payments on account of damages and costs, but only an order in respect of the latter proceeded for determination before Master Cook on 3 October 2019. The Master noted that *"this sort of application has become common in high value clinical negligence and personal injury claims where there is likely to be substantial delay before quantum can be determined by the court"* (para.3).

He was critical of the way the Claimant's application had been presented and said that he *"would give a short written judgment in the hope that such applications would be better prepared in future"* (para.3).

The Master's judgment is indeed pithy and worthy of consideration by any Party seeking to make or respond to such an application.

Surveying CPR 44.2 and the judgment in HI (supra), the Master held that the *"discretion conferred by section 51 of Senior Courts Act 1981 and expressed in CPR 44 (2) is a very wide one"* and could include the making of *"a 'prospective' or 'anticipatory' costs order, ...made before the conclusion of the proceedings"* (paras.10-12).

The Claimant's further application for another interim payment of costs was supported by one paragraph in a witness statement of his solicitor. This dealt very briefly with the matter and maintained that the £100,000 sought would not exceed what the claimant expected to be awarded in costs, and referred to the delay before final judgment. A schedule of costs was exhibited to the witness statement in short summary form which did not apportion any figures between liability and quantum costs.

On the question of the principle of the existence of a power of the court to make such an order, Master Cook rejected the relevance of *"any kind of exceptionality test"*, and held it was *"clear that the court will wish to take into account the factors listed in CPR 44.2 (4) and (5) and will normally expect to be presented with sufficient information to enable it to carry out that exercise"* (para.14).

He held at paragraph 15 that a *"relevant consideration will be to preserve security for a Defendant and to ensure that there is a limited risk of such costs having to be repaid although ... a defendant who has overpaid costs to a claimant's solicitor may seek to set off such costs against damages.*

He continued to hold that *"[w]ithout being prescriptive relevant considerations may include: i) the type of funding agreement and details of any payments made under that agreement, ii) whether any Part 36 or other admissible offer has been made, and if so, full details of the offer, iii) details of any payments on account of damages made to date, iv) a realistic valuation of the likely damages to be awarded at trial, v) a realistic estimate of the quantum costs incurred to the date of the application, vi) any other factor relevant to the final incidence of costs, such as the possibility of an issue-based costs order, arguments over rates or relevant conduct[, and] vii) the likely date of trial or trial window."*

As the Master held that the Claimant's solicitor's witness statement failed to address the issues he considered pertinent to the exercise of the Court's discretion when faced with such an application, he granted permission for the service of one further statement from each party. The judgment closes with the salutary remark (para.16) that *"I hope that those who make such applications in future will ensure that all relevant material is put before the court in support of the application".*

Given the existence now of such guidance it is likely that a party not substantiating their application for such an interim payment of costs as suggested in RXK may find the court is inclined to dismiss it or adjourn it for further evidence, in either case very likely accompanied by an adverse costs order.

By way of a postscript, it is clear that development of the law in this area has far from run its course. There is no higher authority (other than the paper refusal by Irwin LJ) as to the principle of whether there is indeed a power or discretion to allow such interim payments, nor as to the circumstances in which the same should be allowed.

Defendant parties are likely to advance the powerful argument that it cannot be determined who is the *"successful party"* for the purposes of the exercise of the discretion afforded to judges per CPR 44.2 in making an award of costs in the context of a quantum claim until the final determination of that claim. Until such a final determination, it may well be argued for the purposes of the routine presumption for an award, that there is no 'event' for 'costs to follow'.

The exceptionality argument dismissed by the circuit judge and QB Master could also find higher judicial favour, encompassing arguments pertaining to the inherent risk of such awards being found to eventually constitute overpayments or acting as a fetter upon the discretion of a trial judge. This argument indeed found favour in an unreported decision by way of a written reserved judgment of District Judge Thomas sitting in the County Court at Middlesbrough in the case of HH (a Child by his Litigation Friend) v South Tees Hospital NHS Trust (unreported, 4 September 2019), which distinguished HI on the facts and where an application for an interim payment of costs was refused.

Key Points:

- For now at least (though all parties should probably 'watch this space') the law appears settled that the Court has a discretion to order the payment of interim payments of costs pursuant to CPR 44.2 and section 51 of Senior Courts Act 1981
- Applications for interim payments of costs are likely to continue to become more commonplace

- Parties seeking such an order would be well-advised to ensure that their applications deal with all likely relevant considerations of the court when exercising its discretion and substantiating the reasonableness of the size of the interim payment sought

The author is grateful for the kind assistance and insight of his colleague Dan Stacey of Hailsham Chambers in writing this article.

Recovery of Inquest Costs in Civil Proceedings

KATE WILSON
PARK SQUARE BARRISTERS

PARK SQUARE BARRISTERS

Kate Wilson, barrister at Park Square Barristers, examines the recent decision in the case of **Fullick v Commissioner of the Police of the Metropolis [2019] EWHC 1941 (QB)**

Introduction

Coroners have no power to award costs of legal advice or representation at inquests. Where a successful civil claim follows, parties will naturally wish to recover the costs of the inquests as well as the costs of the civil proceedings from the losing party. The starting point is Section 51 of the Supreme Court Act 1981 which enables the court to award costs "of and incidental to" civil proceedings.

Although fact-specific, this recent case considered the application of the remit of discretion in determining when, and the extent to which, legal costs incurred by families attending inquests will be recoverable as part of civil proceedings. The central issue raised on appeal before Mrs Justice Slade was whether the costs judge at first instance had erred in awarding the costs of attending two pre-inquest reviews, preparatory work (including conference with counsel) and attendance at the inquest.

The Facts

The Claimants were family members of Ms Jones who became ill whilst attending a police station voluntarily as a witness to a crime, and subsequently died. An inquest was held in 2015 which included two pre-inquest reviews and a seven-day inquest before a jury. The jury delivered a narrative conclusion that the death had been contributed to by inadequate police policies, procedures and training.

A civil claim for damages for breach of Article 2 of the European Convention on Human Rights, negligence and misfeasance in public office was issued in March 2016 and stayed pending the outcome of the inquest. Without service of a letter of claim or particulars of claim, the claim was settled for just over £18,000.

The First Instance costs order

Notwithstanding the modest settlement, a bill of costs was presented by the Claimants for £122,000 (excluding VAT) which included the costs of attending two pre-inquest review hearings, the inquest and £36,000 for civil claim documents work. At first instance, Deputy Master Keens stated that *"proportionate costs does not necessarily, in my mind, mean the lowest amount"* and further that pre-inquest review hearings *"were instrumental in a number of ways in getting [the Claimant's] own pathology evidence heard at the Inquest, in compelling certain police witnesses to attend"*. Further, he held that the inquest went a lot further than evidence gathering: *"it was very largely determining the issues and that is why settlement was capable of being reached without the civil proceedings having really needing to be progressed"*. In this particular case, the Master found that the Claimant was active in ensuring that the evidence was before the coroner and jury and it was artificial to say that the work done and preparation for the inquest was not part of the civil claim. Costs of £88,356.22 were ordered.

The Appeal

The Defendant appealed, raising two grounds:

> (1) The amount ordered of £88,356.22 was not proportionate, having regard to the settlement of the claim at £18,798. The Defendant argued that the Judge failed to apply CPR r 44.3 correctly in particular by proceeding on the basis that it was reasonable and proportionate for the vast majority of the inquest costs to be recoverable in the civil claim.
>
> (2) The Judge erred in treating the inquest as "the battleground" and effectively the trial of the civil claim.

The Defendant contended that she should only have to pay for the costs of attendance at the inquest *"which were for evidence gathering for the civil claim and which were reasonable and proportionate"*. This ought therefore

to exclude the attendance at the two pre-inquests reviews and any preparation, including conferences with counsel. Pursuant to Rule 13 of the Coroners (Inquest) Rules 2013, an interested person could obtain disclosure of documents held by the Coroner and this provided a reasonable and proportionate way of obtaining evidence rather than attendance (often by both solicitor and counsel) at the various preparatory hearings.

The court noted and emphasised the different purpose and functions of an inquest and a civil claim. The first is inquisitorial and the second determines civil liability. If the steps in the inquest are necessary to advance a civil claim, they can be recovered unless they are disproportionate.

The authorities setting out the tests to be applied on this issue were reviewed and notwithstanding the reforms to civil procedure, remain binding.

Summary of earlier case law

In Re Gibson's Settlement Trusts [1981] Ch 179 it was held that pre-action costs were, in principle, "incidental" to the proceedings however a threefold test had to be satisfied to recover the costs: (1) proven use and service in the civil action; (2) bear relevance to an issue in the proceedings; and (3) be attributable to the paying party's conduct.

In Roach v Home Office [2009] EWGC 312 (QB), the Home Office's arguments that the costs of one set of proceedings were never recoverable as costs of and incidental to, another set of proceedings, was rejected. The extent of the recoverability of those costs depends on the specific facts of each case. Mr Justice Davis in Roach therefore refused to lay down any general guidelines in light of this.

At first instance, Master Hurst allowed the Claimant to recover only 50% of the costs of attending the inquest as, whilst some of those costs were for questioning witnesses and obtaining evidence for the subsequent civil claim, there was also a dual purpose to the inquest to assist the coroner. This approach was rejected on appeal by Mr Justice Davis as the purpose of the inquest was a relevant consideration but not decisive. In cases where the inquests costs are significant in comparison to the amount at stake or the direct costs of the civil proceedings, then proportionality will be a central consideration.

More recently, in the case of Lynch and Others v Chief Constable of Warwickshire Police and Others (2014) SCCO 14 November 2014 costs of attending pre-inquests reviews and a ten-week inquest (attending by leading and junior counsel, senior solicitor and junior fee earner) were sought. The Defendant argued that this approach had been unnecessary and disproportionate. Further, it was argued that, as a result of extensive pre-inquest disclosure, it was not necessary for the Claimants to attend the inquest in order to plead their civil case (therefore the costs of attendance did not meet the first limb of the Gibson test). Master Rowley stated: *"cases involving long running inquests invariably stand the evidence gathering approach in Roach on its head. Instead of it being a cost-effective method of gathering evidence, it becomes a disproportionate expensive way of doing so"*. Master Rowley preferred the Defendant's approach which advocated a forensic analysis of the costs to determine if the time spent was incidental to the civil claim. Allowable profit costs included time spent when certain witnesses were given evidence (whether asked questions or not by the Claimant) and a note taker at other times. However, the costs of the following were not allowed: attendance on procedural matters relating to the inquest (e.g. summing up, jury questions, pre-inquest review); time during which witness statements were being read; costs of leading counsel; costs relating to client care.

The Appeal Decision

Mrs Justice Slade emphasised that each case must turn on its own facts, applying the test identified in Re Gibson and that the factor of *"relevance"* was highly important.

Mrs Justice Slade set down a three-stage approach to determine the recoverability of inquest costs in civil proceedings [paragraph 46]

> (1) Identify the issues raised in the civil claim and the relevance of matters raised in the inquest or other proceedings, to determine whether in principle those costs can be claimed. This should include an assessment of what it was in that participation that would assist with the civil claim [70]
>
> (2) Were those costs proportionate to the matters in issue in the civil proceedings? The value of the assistance should be weighed against the cost of pursuing this during the inquest.
>
> (3) Those costs which are disproportionate may be disallowed or reduced even if they were reasonably and necessarily incurred.

Mrs Justice Slade, in refusing the appeal save for the assessment of costs in relation to work done on civil documents, made the following observations:

- Although the claim is modest, CPR 44.4 provides that when assessing the costs on the standard basis one of the factors to be taken into account when

considering reasonableness and proportionality is the importance of the matter to all parties. Although the claim is small, the claim was not solely about money. The Deputy Master did not err when taking into account that the issues raised were not only financial but were of importance to the deceased's family. The inquest held the police to account in some way for the death. The issues raised during the inquest not only led to settlement, but to an agreement to revise policies. The issues were of wider public importance.

- Of central importance in this case was that the cause of death and recommendations for changes in police procedure were relevant to the civil claim. Evidence as to cause of death and actions and procedures of the police given in the inquest and the verdict reached were relevant to issues in a civil claim. The Defendant had not conceded the cause of death or defects in their procedures prior to the inquest.
- It was noted that in some cases, such as this, inquests in practice seem to cause civil proceedings to be compromised with relative speed.

Regarding the pre-inquest reviews, Mrs Justice Slade held that the costs judge did not err in allowing those costs to be recovered. In performing an exercise assessing the relevance of issues raised during the participation of aspects of the inquest and the value of that weighed against the cost of pursuing that particular point, this is necessarily an onerous task however one which Slade J regarded as necessary. Further, after that forensic approach, *"it may be necessary and would be prudent to stand back to consider whether the total costs of participation in the inquest are proportionate to its utility and relevance to outstanding issues in the civil claim"* [71]

It was held that the first pre-inquest review was relevant and the costs proportionate as this was the first opportunity for the Claimants to *"engage"* with the issues of concern. This included seeking expert evidence to be considered by the coroner and jury, which was ultimately relevant to their conclusion and the matters raised in the civil claim.

At the second pre-inquest review, it was held that this was recoverable as the Claimant's representatives had raised questions and their concerns with the Coroner that they wished to be raised with a particular witness. This was ultimately relevant to the civil claim.

Commentary

The courts will consider the relevance of the issues and participation by the Claimant and/or their representatives at each stage of the inquest process in detail, applying the three-stage test set out above.

It seems likely that a proportion of inquests costs will be awarded, particularly in Article 2 compliant inquests, even where the financial value of the claim is modest. It seems more likely that representatives of families will recover costs if the issues raised and explored are consistent between the inquest and the subsequent civil proceedings. Early consideration of the framing of the civil claim, including the extent to which any conduct is likely to be found to be attributable to the death is wise. A prospective claimant's legal representatives should, as far as possible, ensure that the work done for the inquest is relevant to any contemplated civil proceedings and proportionate.

These matters are relevant even where families have been represented wholly or partly Pro Bono, as the Court can make pro bono costs orders pursuant to s194 of the Legal Services Act 2007, whereby the court orders the losing party to pay an amount equivalent to legal costs to the Access to Justice Foundation (which in turn is used to support legal advice charities).

Prospective defendants can minimise or potentially avoid liability for costs of inquests by making early admissions of liability in appropriate cases.

Inquest disclosure: can staff interviews given to other investigations really be withheld?

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The question of whether written accounts or notes or transcripts of staff interviews ("contributions") given to investigations following a serious incident and resulting death should be disclosed in coronial proceedings comes up time and time again. Different stances are taken all over the country; sometimes such material is disclosed without dispute, and other times arguments of confidentiality and public interest immunity are raised, with mixed results.

The short answer to the question posed in the title of this article is "it depends". But it should depend on what sort of investigation has been conducted, whether there is any statutory prohibition on disclosure, if so whether any exception to the prohibition applies and, perhaps most importantly, on the relevance of the contributions to the matters within the scope of the inquest, rather than the stance of any particular Coroner or Trust.

HSIB investigations

Investigations carried out by the Healthcare Safety Investigation Branch (who presently conduct up to 30 investigations a year, which will be determined with reference to their criteria – essentially cases engaging particularly serious, impactful patient safety issues) are conducted pursuant to the 'safe space' principle defined in regulation 6 of The National Health Service Trust Development Authority (Healthcare Safety Investigation Branch) Directions 2016 ("the HSIB Directions").

Under the 'safe space' principle, material gathered in the course of the investigation, including contributions made by people whose actions come under consideration in the course of an investigation, will not be disclosed for purposes other than for making recommendations unless there is an overriding public interest in disclosure or a legal compulsion. However, the HSIB Directions do not require third parties seeking disclosure to apply to a particular court, and do not amend or modify the application of existing legislation which allows public bodies (including Coroners) to compel disclosure of material. Thus, at present if such material was potentially relevant a Coroner could order 'first stage' disclosure of the material underlying an investigation by the HSIB to be made, and then assess it for relevance and hear arguments on onward disclosure to interested persons (which would have to engage with the safe space principle).

That may soon change. The Health Service Safety Investigations Bill, currently in its second reading at the House of Lords, introduces a statutory prohibition on disclosure of any information, document, equipment or item held by the Health Safety Service Investigations Body (which will replace the HSIB) unless certain specified exceptions apply, which include disclosure being necessary for the investigation of a criminal offence, necessary to address a serious and continuing safety risk, or pursuant to an order of the High Court. Under the draft legislation, the High Court may only order disclosure if it determines that the interests of justice in disclosure outweigh any adverse impact on current or future investigations by deterring participation, or any adverse impact of the Secretary of State to secure the improvement of the safety of NHS services.

It is likely that an application of that nature would face the same sort of difficulties as those faced in applications for Air Accidents Investigation Branch ("AAIB") material. In R (on the application of Secretary of State for Transport) v HM Senior Coroner for Norfolk (Defendant) [2016] EWHC 2279 (Admin) the Divisional Court held that the Coroner had no power to make a Sch.5 order for disclosure of AAIB material. Lord Thomas further held that "in the absence of credible evidence that the investigation into an accident is incomplete, flawed or deficient, a Coroner conducting an inquest into a death which occurred in an aircraft accident, should not consider it necessary to investigate again the matters covered or to be covered by the independent investigation of the AAIB".

Investigations governed by the Serious Incident ('SI') Framework

Local investigations carried out pursuant to the Serious Incident Framework are not currently subject to the safe space principle. The Department of Health's consultation on whether the safe space principle should be applied to local investigations concluded (in April 2017) that it was premature for this to happen, and it should be reconsidered when the principles had been tried and tested at a national level through the HSIB investigations.

Therefore the starting point is that contributions to local investigations can be disclosed into other proceedings, including coronial proceedings, where a court so orders. Disclosure will be made to the Coroner in the first instance to assist with the investigation and be considered for relevance.

Although the decision in *Worcestershire County Council and Worcestershire Safeguarding Children Board v HM Coroner for the County of Worcestershire* [2013] EWHC 1711 (QB) related to local safeguarding reports, rather than the material underpinning the reports, the logic of the ratio in that case would seem to apply equally to contributions as to the report itself; the public interest in the interests of justice require disclosure to the Coroner in the first instance.

If the Coroner considers the contributions are relevant, then they should be disclosed to interested persons, subject to considering any submissions from the disclosing party. Given the confidential nature of the contributions (to which some limited expectation of confidentiality probably attaches), and the fact that they are likely to be personal data for the purposes of the GDPR, it will be important that relevance is given careful scrutiny by the Coroner. If, for example, the relevant content of the contributions has been or can be covered in a witness statement, then that may form a proper basis for the Coroner to withhold disclosure. If the content is relevant, it should be disclosed unless the disclosing party makes a successful public interest immunity application. In reality, it is hard to envisage a PII application succeeding in respect of staff contributions to local investigations; if they are truly relevant, and the relevant content is not or cannot be adduced by some other means then, in light of the decision not to adopt safe space principles to local investigations, the public interest in disclosure is likely to outweigh the public interest in maintaining participation.

HSIB investigations in respect of Maternity Cases.

Pursuant to the National Health Service Trust Development Authority (Healthcare Safety Investigation Branch) (Additional Investigatory Functions in respect of Maternity Cases) Directions 2018 ("the HSIB Maternity Directions"), which came into force in April 2018, HSIB took over certain types of maternity investigations from NHS Trusts. These Directions specifically exclude the safe space provisions in the HSIB Directions, and therefore issues of disclosure of contributions should be dealt with in the same way as they would be for SI investigations.

In conclusion

For the time being there is no proper basis in the healthcare context to refuse disclosure to the Coroner of contributions to SI investigations, HSIB maternity investigations, or indeed any other local investigation.

Having received first stage disclosure it is incumbent on the Coroner to consider relevance carefully. Where interested persons are concerned about a particular issue, such as the credibility or reliability of a witness, they would do well to raise the issue at an early stage with the Coroner, to ensure that the relevance assessment is conducted in the knowledge of issues that are or might be of concern. If the contributions are relevant they should be disclosed, and it is unlikely that a PII application would succeed.

The position in respect of contributions to other HSIB investigations is less clear-cut, because whilst at present there is no statutory prohibition on disclosure, it is in contemplation. However, for now it would at least be open to a Coroner to order first stage disclosure. If the documents were relevant but disclosure was objected to it would then be necessary for the Coroner to consider the operation of the safe space principle.

Time will tell how the safe space principle works in practice in the HSIB / HSSIB investigation context, and whether it might in future be rolled out to local investigations.

Claire Radcliffe v Cambridge University Hospitals NHS Foundation Trust
Delay in diagnosis of cancer; provisional damages

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Adam Copeland acted for the Claimant, Claire Radcliffe, in a clinical negligence claim against Cambridge University Hospital NHS Foundation Trust arising out of a failure to diagnose and treat the claimant's breast cancer in a timely fashion.

The facts of the case are as follows. Claire Radcliffe, who was 22 years old, attended her GP on 15 October 2012 with a 4 day history of a lump in the right breast. On 26 October 2012, she was seen at the breast clinic at Addenbrooke's hospital where a discrete lump was palpated. Ultrasound suggested a 10mm solid lesion consistent with a fibroadenoma with no suspicious features. She was reassured and discharged. In fact, the ultrasound was wrongly interpreted /reported and should have led to the diagnosis that the claimant had breast cancer.

On 31 March 2014, when she was 23 years old, the claimant represented to her GP with inversion of her right nipple and associated breast swelling. She was referred back to Addenbrooke's Hospital and she was seen there on 31 March 2014. Imaging confirmed a large mass in the breast and the likelihood of involvement of four axillary lymph nodes. Biopsy revealed moderately differentiated invasive ductal carcinoma. The tumour was oestrogen receptor positive and HER2 negative and was not associated with the BRAC1 or BRAC2 familial breast cancer genes. Staging investigations showed no evidence of distant disease. At the time of diagnosis, the Claimant was working as a carer in a nursing home.

The Claimant was treated with third-generation neo-adjuvant chemotherapy followed by bilateral mastectomy and right axillary clearance and adjuvant hormone therapy with ovarian suppression with Zoladex and a planned 10 years treatment with Tamoxifen. She was also referred for psychological support.

The Claimant instructed Tees solicitors in January 2015. Expert evidence was obtained from an expert breast surgeon, oncologist, fertility expert, psychiatrist and care expert. Particulars of Claim served as a Letter of Claim were served in January 2017, together with a provisional schedule of loss and condition and prognosis reports.

It was alleged that there was an error in reporting the ultrasound scan which led to the failure to identify potential malignancy and refer the Claimant for a biopsy. Had she been referred for a biopsy on 26 October 2012, it is likely that the cancer would have been demonstrated. It would have been of a grade 2 moderately differentiated and oestrogen receptor positive 1 cm tumour, stage T1 and without spread to the lymph nodes [T1,N0]. Treatment would have been with wide local excision and sentinel node biopsy followed by likely second generation adjuvant chemotherapy and hormone therapy.

Using the Predict tool at that time, with prompt diagnosis in 2012, she would have been advised that her 10-year survival would have been in the region of 95.9 %. She would have had a much less than 50% chance of already having metastatic disease and would have been reassured that she was likely cured of her breast cancer and likely to go on to lead a normal life expectancy.

Had she been diagnosed in October/November 2012, our expert evidence was that she would also have avoided the following:

1. Bilateral mastectomy, breast reconstruction and subsequent implant change surgeries;
2. Axillary node clearance, shoulder stiffness and weakness in her right arm and a 20% risk of lymphedema;
3. Total nodal irradiation;

4. Hormonal treatment with Zoladex in addition to Tamoxifen for 10 years

5. Third generation chemotherapy. She would have avoided chemotherapy altogether or would have received less toxic second generation chemotherapy;

6. Psychiatric damage;

It was also alleged that she was likely to suffer a loss of life expectancy of about 14 years but on the balance of probabilities, she was likely to survive beyond 10 years (50.4%) according to Predict 2015.

In May 2017, the Defendant apologized to the Claimant for the failure to diagnose her malignancy and served its letter of Response in which it indicated that liability would not be contested. The extent of any injury, damage or loss and was subject to quantum and expert condition and prognosis evidence in the usual way. It was also admitted that she would have undergone WLE with sentinel node biopsy and that axillary node clearance and lymphedema would have been avoided.

The Claimant had indicated her wish to start a family with her partner and had been reassured that this would be possible by taking a break from her hormonal therapy, to be discussed with her treating oncologists. However, I was concerned to protect her and her children's position should she succumb to cancer notwithstanding the Predict tool's prognosis that her survival beyond 10 years was 50.4% i.e. that she would survive on the balance of probabilities. I raised the question with the experts as to her long term survivability i.e. beyond 10 or 15 years.

The Predict tool is a mathematical model which can be used to give a likely prognosis for an individual patient at diagnosis. The Predict tool was updated in 2018 with additional clinical data and the later statistics provide prediction of both 10 and 15 year survival. The Claimant's oncology expert advised that it was arguable, based on the 2015 data, that the Claimant's survivability would in fact be less than 50% beyond 10 years and that the updated 2018 Predict tool gave a far bleaker outlook. The experts also agreed that this was in line with clinical experience with a person such as the Claimant who was 11 node positive with a tumour of over 10 cm at the time of diagnosis.

The problem was that the Claimant had been reassured by her treating clinicians as to the good progress she had made and had advised her that she was "in the 60% lane" for survival. She had carried out a great deal of psychological therapy and counselling and had arrived at a positive attitude toward the future. She did not want to know her prognosis in any detail nor did she have any appetite to hear argument about her future prognosis at a trial. After discussion with the Claimant, it was decided that the solution was to put forward a claim for provisional damages.

A claim for provisional damages was pleaded in November 2017 in the event of a recurrence of the cancer on the basis that this would amount to the development of a serious disease and / or will give rise to a serious deterioration in the Claimant's physical or mental condition and will result in death or a substantial reduction in life expectancy. The Defence went on to formally admit liability in December 2017 with quantum to be assessed. In relation to the provisional damages claim, it noted that one had been made, reserved its position in relation to it, and put the Claimant to proof as to any causative link between any future recurrence and the Defendant's admitted breach of duty. Judgement was subsequently entered for the Claimant, with the extent of her injuries and damages to be assessed.

The claim was resolved after exchange of quantum evidence at an RTM in November 2018 for £450,000 on a provisional damages basis. The advantage for the Claimant was that she would be compensated in full for her injury at the time of settlement but would have the opportunity to come back to the Court in the event of recurrence. The Defendant, if correct in their assumption and she survives without recurrence or relapse, would have nothing further to pay. If she was unfortunate enough to suffer a recurrence and had started her family, it would be for the Court to deal with her actual situation rather than be involved in speculation now. It would also allow closure of the litigation whilst having the insurance of being able to come back to court if needed. It also meant that the Claimant's legal team could deal with issues of prognosis and life expectancy sensitively whilst preserving fairness for all parties.

An estimated breakdown was 100K for general damages, 100k for past loss, including care and loss of earnings and 250k for future loss, to include future care; future loss of earnings; future surgery for replacement breast implants and future therapies.

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Contributory Negligence post-Montgomery

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Travel back seven decades: the Law Reform (Contributory Negligence) Act 1945 was given Royal Assent on 15th June 1945; three years later, on 5th July 1948, the NHS was founded.

At the level of principle, the statute effected a radical change in the law by abolishing the position at common law by which any negligence of the Claimant, however slight, afforded a complete defence if it was part, even a small part, of the cause of the damage. Instead, to use the wording of section 1: *"Where any person suffers damage as a result partly of his own fault ... the damages recoverable shall be reduced to such extent as the court thinks just and equitable having regard to the claimant's share in the responsibility for the damage".*

In practice though, as regards clinical negligence claims over the last 70 years, the defence of contributory negligence has been raised more in faint hope than any real expectation of success. Indeed, to date, there remains only one clinical negligence case in the jurisdiction of England and Wales where a Judge has made [1] a deduction for contributory negligence, namely His Honour Judge Bullimore in Pidgeon v Doncaster HA [2002] Lloyd's Rep Med 130. Is that now at risk of changing and, if so, why and how does one guard against it on behalf of claimants?

Some commentators have suggested that the seminal case of Montgomery v Lanarkshire Health Board [2015] UKSC 11, [2015] A.C. 1430, which swung the pendulum in favour of claimants on the issue of consent, may have the effect of also breathing new life into the partial defence of contributory negligence. At Para 81 of the Judgments of Lord Kerr and Lord Reed (with who the other Justices agreed, including Lady Hale who produced one of her own) in Montgomery stated this:

> *"The social and legal developments which we have mentioned point away from a model of the relationship between the doctor and the patient based upon medical paternalism. They also point away from a model based upon a view of the patient as being entirely dependent on information provided by the doctor. What they point towards is an approach to the law which, instead of treating patients as placing themselves in the hands of their doctors (and then being prone to sue their doctors in the event of a disappointing outcome), treats them so far as possible as adults who are capable of understanding that medical treatment is uncertain of success and may involve risks, accepting responsibility for the taking of risks affecting their own lives, and living with the consequences of their choices"*

The argument goes that, by the Supreme Court insisting on a collaborative doctor-patient relationship, and thereby calling time on (in effect) a 'Doctor Knows best' culture, the concomitant reluctance to blame the patient if anything goes awry which that form of medical paternalism entailed, is and was also lessened. In short, the door is part-opened to arguments for contributory negligence getting through.

In the context of clinical negligence claims, allegations of contributory negligence may take different forms, such as failing to give a full history; or failing to re-attend when symptoms persist; or failing to undergo treatment or testing. It though instructive to view such allegation through the prism of "Good Medical Practice" ["GMP"] as published by the GMC, which came into effect now over 6 years ago.

Take, for example, history taking and, on the other side of that coin, failing to give a full history, which may necessarily assume the patient has a true grasp of what is and is not relevant. Paragraph 15 (a) of the GMP requires that: *"adequately assess the patient's conditions, taking account of their history (including the symptoms and psychological, spiritual, social and cultural factors), their views and values; where necessary, examine the patient"*. To the extent that the patient explains the alleged failure to give a full history as a function of his or her *"symptoms*

1 *Mrs Justice Whipple would have made a deduction of 25 % in PPX (A Protected Party by his Brother and Litigation Friend BLF v Dr Ravinder Aulakh [2019] EWHC 717 where regrettably the Claimant suffered a serious neurological injury as a consequence of an attempted suicide by hanging if the Clamant had established primary liability*

and psychological, spiritual, social and cultural factors" this rebounds, in the first instance, on the doctor.

Next, as potentially relevant both to meeting allegations of failure to provide a full history and failing to re-attend, note for example paragraph 21 of the GMP, which requires that:

"Clinical records should include:

a. relevant clinical findings

b. the decisions made and actions agreed, and who is making the decisions and agreeing the actions

c. the information given to patients

d. any drugs prescribed or other investigation or treatment

e. who is making the record and when"

Given that sometimes meeting these exacting requirements is honoured in the partial breach, they surely assist patients faced with such allegations of contributory negligence, given that the Court is ever likely to first scrutinize what the doctor said and did (and conversely what he or she did not say or did not do). In this regard, paragraphs 27 and 32 of the GMP should also be noted because they respectively make clear that doctors need to have regard to - and so first assess – the patient's level of vulnerability and the ability to gauge information, both of which may provide an answer to why the patient acted (or omitted to act) in the ways challenged by allegations of contributory negligence.

Paragraph 49 of the GMP sets out quite the list of responsibilities (as to which see also para 44 of the GMP), including to ensure the proper exchange of information not only as between doctor and patients but between medical practitioners:

"You must work in partnership with patients, sharing with them the information they will need to make decisions about their care, including:

a. their condition, its likely progression and the options for treatment, including associated risks and uncertainties

b. the progress of their care, and your role and responsibilities in the team

c. who is responsible for each aspect of patient care, and how information is shared within teams and among those who will be providing their care"

In short, reliance on these first principles of good medical practice is the way to keep the focus resolutely on the doctor, who after all, in raising any allegations of contributory negligence bears the burden of proof in seeking to establish them.

Lastly, go back (as ever) the words of the 1945 Act: they include *"...suffered as the result partly of his own fault..."*. This means that in order for any given Claimant's acts or omissions to entitle the Court to make a reduction those acts or omission must have been part of the cause of the damage. The Claimant's carelessness or unlawful behaviour, however reckless, which does not actually cause the damage claimed for cannot be the basis for a reduction in his damages. Holding fast to that proposition will provide the answer to allegations of contributory negligence based on, say, lifestyle.

For example, in Bryant St George v Home Office [2007] EWHC 2774 the Claimant entered prison addicted to drugs and alcohol, and had suffered withdrawal seizures and epileptic fits in the past. A few days later, he fell from his bunk, suffered a head injury, had a prolonged epileptic fit, and was left with brain damage. He successfully contended that the prison, having been informed of his condition and history, had been in breach of their duty of care in allocating him a top bunk; and were also in breach as a result of a number of delays in treating him after his fall and by failing to clear his airway and administer oxygen leading to his brain damage. At first instance, Mackay J. made though a deduction of 15% for contributory negligence finding that:

> *"... the claimant must be taken to have foreseen a risk of harm to himself from his drug taking habits. It is not necessary to make this claim of contributory negligence good that the claimant should have foreseen the precise way in which the harm to him might come about. It is enough if he is aware that taking drugs was something that gave rise to a risk to his health. That is plainly something of which he must have been aware."* (para 51)

This was though reversed by the Court of Appeal at [2008] EWCA Civ 1068, which held that the claimant's *"fault"* (as the appellate court agreed it to be) in becoming addicted to drugs and alcohol in his mid-teens was not a potent cause of the status and the consequent brain damage that was triggered by his fall. It was too remote in time, place and circumstance and was not sufficiently connected with the negligence of the prison staff to be properly regarded as a cause of the injury. Moreover, the Court of Appeal held that even if the Claimant's injury had been partly the result of his fault in becoming addicted

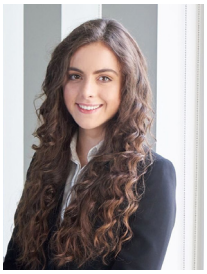
to drugs and alcohol, it would not have been just and equitable to reduce his damages having regard to his share in the responsibility for his injuries. He had told prison staff about his addiction and previous seizures.

His position was analogous to that of a patient admitted to a rehabilitation clinic for the express purpose of being weaned off his addiction to drugs. If the same thing had happened to such a patient, his damages would not be reduced for contributory negligence.

Nothing was actually said in express terms about contributory negligence in Montgomery. Of course, the absence of a body of case-law in this jurisdiction supportive of arguments for contributory negligence may be a function of shrewd settlements where the potential sting in that issue has been drawn by sensible compromise before it reaches any trial judge. However, for the reasons given above, it is still to be doubted that this will change soon. "Good Medical Practice" is likely to provide a good answer to allegations of contributory negligence.

Inquest touching on the death of Master Henry James Maw

JADE FERGUSON
PARKLANE PLOWDEN CHAMBERS



Intro

Henry James Maw died on 22 August 2005 at the Friarage Hospital in Northallerton at age 53 minutes. Henry's family waited 14 years before receiving answers with regards to his unexpected death. After Henry's birth, two members of staff stated that Henry had shown signs of life. Despite this, Henry was referred to as a stillbirth throughout the medical records and his death was not reported to the Coroner until 2016.

Background

Upon falling pregnant with Henry, Henry's mother ("JH") was identified as a high risk patient due to her medical history. JH had previously given birth to two healthy children. In 1992, her first child was a breach delivery by elective caesarean section. In 1996, she gave birth to her second child by vaginal delivery however she later suffered a post-partum haemorrhage. Between 1996 and 2004, JH suffered five miscarriages including an ectopic pregnancy.

JH underwent fortnightly scans throughout her first trimester with Henry. At 12 weeks gestation, she was advised that the pregnancy was progressing without any cause for concern and subsequently did not require another scan until 20 weeks gestation. Until JH's admission on 21 August 2005, the pregnancy was uneventful. Although JH did not have any recollection of such discussions, it was noted in the medical notes that she was aiming for a vaginal delivery.

It is of importance to note that JH was a "VBAC" (vaginal birth after caesarean section) patient due to her previous caesarean section during the birth of her first child. One of the most serious risks for VBAC patients is a uterine rupture during vaginal delivery. This occurs when the scar along the uterus from the previous caesarean section ruptures which can consequently lead to both fetal and maternal death.

On 21 August 2005, JH was 12 days overdue and was admitted to Friarage Hospital in Northallerton in order to induce labour. At 06:20am on 22 August, JH was induced by the administration of Prostin. At 09:10, she was reviewed by an Obstetrics Consultant and Specialist Registrar who noted that a second dose of Prostin should be given in 6 hours' time. The early progress of the induction was satisfactory in terms of care; however the midwives were not advised to withhold Prostin if uterine activity was noted as this would significantly increase the risk of uterine rupture. There was also no instruction that a continuous CTG should be started once JH was contracting regularly in order to watch out for anomalies given her VBAC status.

No further medical notes were made until 16:40 however Henry's father noted down JH's contractions which became frequent from 13:10. At 15:04, JH began to suffer sudden acute abdominal pain. At this point, Henry's father stopped recording the contractions in order to assist her. JH's pain became so excruciating that she was screaming with pain. Henry's father went searching for a midwife however a midwife did not attend JH until 16:40.

At 16:40, Midwife LB undertook a vaginal examination and noted that JH was not dilated. She noted in the records that JH was very distressed and asking for pain relief. Midwife LB called the labour ward in order to transfer JH. After some disagreement between the labour and maternity ward, JH was eventually transferred to the labour ward at 17:10. At 17:35 a further vaginal examination was undertaken and it was noted that there was still no dilation despite JH suffering from continuous acute abdominal pain above her previous caesarean section scar.

At 18:40, an Obstetric Consultant reviewed JH and was immediately concerned that JH was showing symptoms of an imminent uterine rupture. He recorded in the notes that upon reviewing JH he was convinced that a caesarean section was necessary. The medical notes suggest that knife to skin did not take place until 19:35.

During the caesarean section, it was noted that JH had suffered an extensive uterine rupture which extended to the dome of her bladder. Henry was delivered in a poor condition and was described as "floppy and pale". A nurse and an SHO present at Henry's birth noted that they had heard a noise consistent with a heartbeat; however this was very slow and stopped after 2 or 3 sounds. The emergency paediatric team were called in. Prompt, effective and caring efforts were made to resuscitate Henry however they were sadly unsuccessful.

A blood gas analysis was conducted on samples drawn from the blood in Henry's umbilical cord. The cord blood pH was noted to be 6.49. This showed that Henry had suffered significant metabolic acidosis, indicating that he had been deprived of oxygen for some time before birth.

The Inquest

In 2016, HM Senior Coroner Michael Oakley was made aware of Henry's death and subsequently referred the matter to North Yorkshire Police. After a police investigation, no charges were brought. As Henry's body had been buried, there was the difficulty that there was no body lying within the jurisdiction. On 31 October 2018, Chief Coroner Mark Lucraft QC made an order permitting an investigation to be held by the Coroner in the absence of Henry's body.

The inquest was heard in Northallerton Coroner's Court before Assistant Coroner John Broadbridge over 3 days. Evidence was heard from the family, the hospital Trust's staff and management, the clinicians involved with Henry's and his mother's care, and independent Obstetric and Neonatal experts.

The Coroner was to make a finding on whether Henry was a stillbirth or a live birth. At the time of Henry's birth, this question was treated with imprecision and was recorded inconsistently throughout the medical records. Birth and death certificates had been issued however the clinicians had since asserted that Henry was a stillbirth and recorded this in the medical records. In light of this, the Coroner decided to start afresh and make his findings based on the evidence he had heard over the course of the inquest.

Evidence

It quickly transpired during the inquest that none of the midwives involved with JH's care had dealt with a uterine rupture before. In evidence, the Midwife LB stated that she had intended to transfer JH to the labour ward immediately as she had begun to suspect that JH may be suffering from the start of a uterine rupture. Despite her suspicions, she did not escalate her concerns to other members of staff which subsequently led to delays in other staff recognising the urgency of the situation and life saving treatment being withheld.

The independent Obstetrics expert stated that it ought to have been obvious to the staff by 16:40 that JH was showing signs of an impending uterine rupture and agreed if JH had been properly escalated at that time then Henry would likely have survived as a healthy baby. By 16:40, the margin for error was shrinking rapidly and every decision by staff had a potentially life threatening consequence for Henry. By the time JH was reviewed by the Obstetric Consultant at 18:40, Henry's fate had already been sealed.

The Coroner heard evidence from an independent Neonatology expert who provided an opinion on whether it was likely in the circumstances that Henry was born alive. Particular weight was given to the cord blood analysis results. The Neonatology expert stated that it was very unlikely that a baby with a cord blood pH as acidic as Henry's would have been born alive, and therefore on balance she was of the opinion that Henry was most likely to have been a stillbirth.

Present at Henry's birth was Nurse HB and an SHO. Nurse HB provided a written statement in which she confirmed she had heard a heartbeat. In oral evidence, the SHO accepted that although there was medical evidence to suggest it was unlikely Henry was alive at birth, she was still confident that she did hear a heartbeat and, in her own words, she "could not unhear the sounds". The Neonatologist expert and the Histopathologist both deferred to the SHO's account. It was agreed that although acidosis at such a level would mean that a live birth would be very unlikely, they had to defer to the SHO if she was sure that she had heard signs of life.

The Verdict

The Coroner found that both Nurse HB and the SHO had heard 3 heartbeats which were unequivocal signs of life. He found that Henry was born alive.

The Coroner was critical of Henry's mother's obstetric care during the induction process. In his findings of fact, the Coroner commented that on JH's admission there ought to have been a discussion with JH as to whether to proceed with caesarean section given the increased risk of uterine rupture for VBAC patients who are being induced with Prostin. He was also critical of the failure of Midwife LB to properly communicate her concerns

so that early lifesaving intervention could take place. He went on to state that even when the urgency of the situation was recognised by staff, delays occurred which further compromised Henry's survival.

Comment

The inquest demonstrated the utility of such proceedings in allowing the family to explore their concerns surrounding a loved one's death. Although the Coroner did not find that there had been gross negligence or a breach of Article 2, he was critical of the obstetric care JH received. By law, the Coroner could not make a finding that established civil liability; however he did draw a clear causal link between the staff's failure to recognise the uterine rupture and Henry's death. This was of the upmost significance to the family who have been fighting for answers since 2005.

Inquest touching the death of John Wells

FLEUR HALLETT, MEDICO-LEGAL ADVISOR
AVMA

Background

John Wells was 73 years old and had been living alone in sheltered housing in Worthing for over ten years. He was a vulnerable individual who had been diagnosed with learning difficulties and more recently dementia and Alzheimer's disease. Despite this he enjoyed being a part of his local community and took pleasure tending to his neighbours' gardens.

In the early hours of 29 January 2019 John activated his careline and described blood flowing from a vein in his ankle. He stated that he had been unable to stop the bleeding. He sounded confused and distressed. The careline call handler from Appello proceeded to call 999 and was transferred through to an Emergency Medical Advisor who used the NHS Pathways system to triage the call. The disposition was a Category 3 response which required an ambulance to be on scene within two hours. By the time the crew arrived over an hour later John was in cardiac arrest and was subsequently pronounced dead. His family's main concern was that John died alone and frightened, awaiting the arrival of medical help.

Worthing Homes were the housing provider of the flat John lived in. Redassure are an arm of Worthing Homes which provides the equipment for a careline to be present in their properties, a warden service in working hours and a responder service out of hours. Appello answer calls and seek help for residents who activate their careline.

AvMA instructed Darragh Coffey of 1 Crown Office Row Chambers to represent John's family.

Key issues in the case:

1. Whether the Appello call handler followed the correct procedure?

2. Whether the 999 call was correctly triaged by South East Coast Ambulance service?

The Inquest

The inquest was heard over two days at West Sussex Coroner's Court before Assistant Coroner Robert Simpson.

We heard evidence from John's niece that his learning difficulties affected his ability to communicate. He found it difficult to articulate his needs and how he was feeling, he would try his best to explain a situation, but he couldn't converse in depth. He would not have known how to stem the bleeding or thought to chase the ambulance service himself once he was told there were on their way. His friend gave evidence stating that anyone dealing with John would be acutely aware of his learning difficulties.

During the course of the evidence it became clear that the Appello call handler did not follow the correct procedure. Consequently, the responder, trained in first aid, was not called and did not have the opportunity to attend and assist John.

The evidence given by the Trust's two witnesses confirmed that John's presentation ought to have been classified as a Category 2 call, whereby a response is required within 18 minutes, not the Category 3, 120 minutes response allocated by the EMA. We heard that an audit of this call took place and it was found to be non-compliant. It is of note that at the time of John's death the Trust were in special measures, having faced heavy criticism from the CQC in a recent inspection.

Having heard all the evidence the family felt John's death was entirely avoidable and that he had been let down by three different organisations.

Coroner's findings

The Coroner returned a short form conclusion of accident.

When considering the conclusions open to him, the Coroner contemplated whether a rider of neglect was appropriate. He observed there was no doubt John was

anything other than someone in a dependant position who required basic medical attention. He found that the combination of a lack of information gathered by Worthing Homes in relation to Mr John's medical history (which was therefore not passed on to Appello) and the incorrect triaging of the 999 call, leading to a delay in dispatching an ambulance, together formed the basis of a gross failure. However, when considering whether the paramedics could have saved John's life, on the balance of probabilities, if they had attended within 18 minutes, the Coroner was not satisfied on the evidence before him. In the absence of establishing a causal link, the Coroner felt it unsafe to return a conclusion which included a rider of neglect.

The coroner looked in detail at what had been done by Worthing Homes, Appello and SECAMB since John's death. Despite assurances that changes were underway, they were yet to be implemented. The Coroner therefore chose to issue Prevention of Future Death reports to ensure that changes were enacted and as swiftly as possible. The Coroner also commented that issuing these reports affords other organisations the opportunity to learn lessons, an approach which the family and AvMA wholeheartedly support.

The Coroner indicated he intends to write five Prevention of Future Death Reports raising the following matters of concern:

1. **Worthing homes**

   The collection of medical background of residents. He was not satisfied that sufficient information was currently being obtained and relayed to Appello.

2. **Appello**

   The Telephone numbers for responders are not on the contact list screen with other contact numbers and there is no direct link from the alert box showing the call is a Redassure PRS call to the corresponding policy and that is of concern as it gives opportunity for errors to arise where they need not.

3. **Appello**

   Call handlers are not medically trained in any way, the computer system does not flag risk factors that need to be flagged to ambulance service, such as if a patient is bleeding and anticoagulated.

4. **SECAMB/ NHS Pathways**

   After one missed call from an EMA to a patient who was the subject of a third party call, the call is now escalated to a clinician rather than after three missed calls as is the current practice.

5. **Association of ambulance chief executives/ Technology Enabled Care Services Association 'TSA'**

   Suggesting a conference calling function, currently already in discussion, to be implemented, so that EMAs can speak to patients via the Careline audio system when residents are unable to answer their phone.

Helpline Volunteering Opportunities - Remote working or from our Croydon office. Can you help?

GILLIAN SAVAGE, HELPLINE DEVELOPMENT OFFICER
AVMA

We are always looking to recruit volunteers to join our Helpline and we would love to hear from you or a member of your team if you can spare some time to help us staff this core service.

The helpline is open Monday-Friday 10am-3.30pm. Volunteer sessions can be staffed remotely or from our office in Croydon.

The sessions are on a rota system and each volunteer has an allocated 1 ½ or 2-hour session either once a week, fortnightly or once every 4 weeks. Opportunities to volunteer for a full or half day rather than short sessions will also be considered. We ask that volunteers commit to a minimum of 6 months and give 6 weeks' notice if possible if they are no longer able to volunteer.

Volunteering for the helpline is a chance to use your legal knowledge, gain greater awareness of the complaints system and a clearer understanding of the clients' perspective. A training program will be tailored to meet the volunteers' needs which would include a one-day intensive training day and follow up training if needed. Training can also be done remotely.

This is what some of our Helpline volunteers have to say about volunteering:

"I have been assisting on the AvMA helpline for approximately 18 months and have found it very beneficial in developing my skills as a paralegal. Since working on the AvMA helpline, I have developed my confidence and expertise in relation to advising clients and explaining to them how a clinical negligence claim works. The skills I have developed will stand me in good stead as I progress in my career" **Kathryn**.

As a lawyer, volunteering for the AvMA helpline is a rewarding experience. It is an opportunity to use and develop important skills, such as building rapport quickly with someone in distress, or identifying the key issues in a complicated situation. It is a chance to speak with people from different walks of life and to provide constructive steps to help them to deal with the circumstances in which they find themselves. it is great to know that your time and experience has made a difference to someone at a difficult point in their life" **Laura**

"Volunteering for the AvMA helpline is a great opportunity to use my knowledge and skills from my work as a solicitor in a more holistic way to help injured and bereaved people, rather than just considering the narrow question of whether they would be eligible to make a claim. They often don't know which path they want to take or even what their options are, and the AvMA helpline is one of the best places they can go to find out. It's really satisfying to know that you're helping people in a constructive and much-needed way at a very difficult time in their lives" **Caroline**.

"AvMA is a fantastic organisation that helps individuals and their families who have suffered from medical negligence. The work is varied and interesting and you are provided with a real opportunity to help people with their questions, queries and concerns. The team at AvMA are very helpful and friendly. I look forward to my monthly session and it is an absolute privilege to volunteer for such a worthy cause" **Laura B**

"We are very supportive for any member of our team to volunteer on the helpline, we have found it to be an invaluable grounding for the work we do. It enables team members to develop client care skills in a supportive environment while being exposed to a range of issues experienced by those who use the helpline for support - all of which is good training for the future." **Kay**

If you are a qualified Solicitor, trainee solicitor, paralegal, Barrister or medically qualified we would like to hear from you.

You can download an application form the Get Involved section of our website: **https://www.avma.org.uk/get-involved/**

Or contact Gillian Savage, Helpline Development Officer.

Email: **support@avma.org.uk** or DD: 020 3096 1112 for further information.

Book Review

Lewis and Buchan: Clinical Negligence A Practical Guide

ALI CLOAK, SENIOR ASSOCIATE
ROYDS WITHY KING

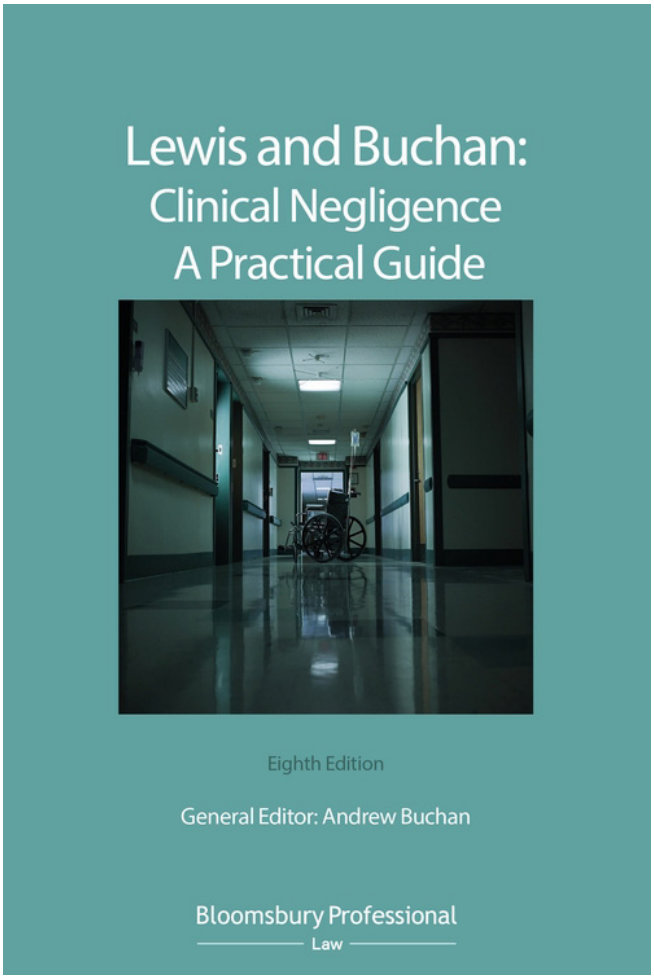
Now in its 8th incarnation, this book is a fully updated version of a popular and established text for clinical negligence practitioners. As the title suggests, it has a practical focus which is consistent throughout - no mean feat given the variety of authors. An impressive list of contributors includes specialist counsel, solicitors and experts, as well as AvMA's Lisa O'Dwyer.

The book runs to over 800 pages and is broken down into 5 main parts. There is a selection of key reference documents in the appendix, including selected statutes, medical abbreviations and hieroglyphs, protocol documents, model court directions and precedents for instructing experts.

As someone regularly involved in inquests I was glad to see extensive coverage of this area, with the latest issues and cases included. There is thorough consideration of costs recovery for work done in relation to inquests, as well as applications for funding through the Legal Aid Agency. Human Rights is covered in its own chapter, which is well tailored to clinical negligence claims. While there is no standalone section for fatal claims, the key elements are covered in other chapters.

In addition to the more traditional topics, I found a number of less frequently covered topics of much interest, including chapters on claims in Wales, product liability, Court of Protection and a detailed consideration of the structure of the NHS and other healthcare bodies.

This comprehensive text is a very useful resource for any clinical negligence practitioner, irrespective of seniority, given its breadth and well-considered coverage.



An Interview with the Cambridge & District Law Society 2019 Woman Lawyer of the Year, Janine Collier

Janine Collier, Executive Partner, Head of the Tier 1 Medical Negligence and Personal Injury team and Co-Head of Tees Law's Cambridge office, recently won the 2019 Cambridge and District Law Society Woman Lawyer of the Year award.

A mother of two, her career has long demonstrated to future generations of female lawyers that it is possible to balance family life with success at work.

When did you decide on a career in the law?

I thought I might be a lawyer from quite a young age - From childhood I enjoyed problem-solving and logical puzzles, so intellectually the law was a natural fit. It also appealed to the values of fairness and what's right or wrong, which are dear to me – as my parents will likely recall of their then argumentative teenage daughter!

Even before University, I always had a heart for medical negligence work. I found medicine interesting and, when I was 17, required surgery for an arm injury. I experienced first- hand how things can go wrong, despite best intentions and the effect that this can have on patients. My interest was cemented at university when I studied a Medical Law module and wrote my final year dissertation in Medical Ethics.

What was your first job?

My first paid job was packing bags of lettuce at a lettuce factory during the summer holidays. It was a 4am start, hard work, and not very stimulating, but it was a means for me to be able to do the things I wanted to do!

My first full time legal job was at FieldFisher - I was delighted to secure a Training contract there and to spend most of my Training contract working for Paul McNeil (aka my "Godfather" of all things Medical Negligence). I spent many happy years at FieldFisher and was sad to leave when I moved out of London to raise my family.

What are the best things about your role?

I wear many "hats", but first and foremost, I love helping people!

As all medical negligence lawyers know, our clients have been through highly stressful and often life-altering experience. Helping them understand what happened during their treatment, and bringing hope, optimism and financial security for their future, has always been my biggest motivator. We genuinely make a difference to people's lives and this is both a privilege and an honour.

I also very much enjoy the team approach that we have at Tees and that I have the opportunity to reach and shape the next generation of lawyers and create an environment that enables my colleagues flourish and be the best they can be.

What one thing you would change about the environment you work in?

My biggest frustration is the way that cases can drag on for such a long time, running up huge costs. This undermines natural justice for our clients and turns public opinion against the legal profession when we are just as frustrated as every other taxpayer who hates public sector waste. I would like to work with all sides to see how we can improve the system for everyone's benefit.

What are the biggest challenges that you have faced in your career?

That is a difficult one to answer.

From the beginning, demographically, you might say I was an unlikely candidate for a legal career. I am female, was born into a Council Estate in South East London and none of my family had been to University. However, my parents were amazing and always raised me to believe that with hard work, and dedication, you can achieve your dreams.

The next "challenge" I faced was a personal one. I learned that I may not be able to have children and so the decision that I wanted to at least try was accelerated. I was delighted to find out I was pregnant with my first son, but this came much earlier in my career than was, at that time, expected in the industry (2 years PQE) (in fact, I recall someone asking me if it was an accident!) and I had to make some decisions on balancing work and a family. My husband travelled abroad a lot with his work and so I chose to work part-time and to put my career path "on hold" until the children were older.

The final major challenge was that I suffered a cycling accident in 2011, needed multiple surgeries and some months off work. Tees were hugely supportive during this time and, in retrospect, it was a real turning point in my career – the time "off" enabled me to reflect, re-prioritise and I came back renewed, with a much greater sense of direction and purpose.

Who do you look up to in business? who is your inspiration?

When I'm faced with a particularly tough case, I often ask myself, what would Paul McNeil do? Paul was my first boss at FieldFisher and is very much an industry leader and role model.

Every day I learn something new about managing and growing a business from Ashton Hunt, David Redfern and Andy Swarbrick, the Managing Director, Senior Partner and NED respectively at Tees.

My parents are my other inspiration. They have chosen to look after my seriously disabled sister and her children for more than 20 years, lately as almost full-time carers. Rather than complain about the hand that life dealt them, they take each day positively and are a source of love, compassion and wisdom to our whole family.

What do you do outside "work"?

I really enjoy helping the local community and volunteer with some charities such as Pos+Ability, a Cambridgeshire-based organisation which offers a chair-based exercise programme to people with long-term conditions such as Parkinsons, MS and strokes.

I also play a bit of tennis, have been known to run a marathon or two, and to do some Mud Obstacle Races.

My faith is also important to me.

What is the best piece of advice would you give to someone starting out in their career?

There's many a sporting analogy in the world of work, and for me it's really important to put in the hard yards when you're starting out, whether at school, university or in your job. Learn the skills, the tactics and the commitment to team above individual when you're young, and the "muscle memory" will kick in as you go through your career and open up so many opportunities as you get older.

AvMA Annual Clinical Negligence Conference 2019 a huge success

ED MAYCOCK, CONFERENCE MANAGER, AVMA

The 32nd AvMA Annual Clinical Negligence Conference took place at the Royal Armouries Museum in Leeds on 28-29 June, bringing together 520 clinical negligence lawyers, medico-legal experts and service providers to network, learn and discuss the latest issues, developments and policies in clinical negligence and medical law. It was a record number of attendees for the event.

The conference programme had a focus on acute medicine, whilst also covering many other key medico-legal topics at such an important time for clinical negligence practitioners. Dr Roderick Mackenzie of Addenbrooke's Hospital, Cambridge, delivered the opening plenary address on Emergency Medicine. One delegate reviewed the presentation as "A useful through-the-keyhole view on emergency medicine and the difficulties faced when attempting to obtain pertinent information so as to follow the correct protocol and right steps to take to treat the patient".

Dr Mackenzie was followed by Dr Gillian Sare, Consultant Neurologist, Queen's Medical Centre, Nottingham, and Dr Norman McConachie, Consultant Interventional Neuroradiologist, Queen's Medical Centre presenting 'Stroke Medicine – the importance of a timely diagnosis'. 100% of delegates rated the presentation as either "excellent" or "good". Among the other plenary session speakers who received particularly excellent feedback from delegates were Dr Emma Ferriman, Consultant Obstetrician & Fetal Medicine Specialist at The Jessop Wing, Sheffield, who spoke on 'Obstetric Emergencies in the Labour Room'; Dr Kenneth Power, Consultant in Anaesthesia and Intensive Care at Poole Hospital NHS Trust, who presented 'Medico-Legal Issues in Sepsis'; and Professor Catherine Nelson-Piercy, Professor of Obstetric Medicine, Guy's and St Thomas' Hospitals Trust, covering 'Obstetric Emergencies During Pregnancy'.

To mark 100 years of women in law, Dana Denis-Smith, Founder of the First 100 Years Project, opened the Friday afternoon session 'Celebrating the past to shape the future for women in law', reviewed by one delegate as "A fascinating talk about the history of women in law". Nigel Poole QC of Kings Chambers delivered the 2019 Legal Update.

When asked what they found most useful about the conference, one delegate answered "The speakers, because they focus your mind on the issues. Very useful for potential experts. I have already approached a couple based on the quality of their lectures". Another replied "The lectures struck a good balance between the medical information and how it applies to the work that we do as lawyers". 100% of delegates said that they would use the learning gained from the conference in their everyday work, and 92% scored the event between 8-10 out of 10. One first time ACNC delegate commented "It was my first ACNC and it was brilliant", and a regular attendee described the event as "One of the best ACNCs I can remember".

There was a real buzz on social media about the event. To see a selection of some of the delegates' tweets please go to **https://wakelet.com/wake/5e4a4dd7-0224-4921-8001-35a71577c6f3.**

The 2020 Annual Clinical Negligence Conference will be held on Thursday 25th – Friday 26th June at the Bournemouth International Centre. Early bird booking will open in the new year, with the full programme available in March.

Forthcoming conferences and events from AvMA

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

AvMA Specialist Clinical Negligence Panel Meeting

Afternoon of Thursday 5th December 2019, RSA House, London

The annual meeting for AvMA Specialist Clinical Negligence Panel members provides the opportunity to meet, network and discuss the latest key developments and issues facing clinical negligence law. This year's meeting will take place on the afternoon of Thursday 5th December. Registration and a networking lunch will commence at 12.15, with the meeting starting at 13.15 and closing at 17.00.

AvMA Christmas Drinks Reception

Evening of Thursday 5th December 2019, RSA House, London

AvMA's Christmas Drinks Reception will this year take place at the at the beautiful, award-winning RSA House, just off The Strand in central London (https://www.thersa.org/hire-rsa-house). The event will start from 17.00, immediately after the meeting, and provides an excellent opportunity to catch up with friends, contacts and colleagues for some festive cheer!

Medico-Legal Issues in Cardiology, Cardiac and Vascular Surgery

11 December 2019, Irwin Mitchell Solicitors, London

An estimated 7.4 million people are living with heart and circulatory disease in the UK and more than 100,000

hospital admissions each year are due to heart attacks (British Heart Foundation, 2019). Failure to assess, diagnose and treat appropriately, followed by issues related to consent and procedure complications, are the common causes of cardiovascular claims. Therefore, it is essential that as clinical negligence practitioners you develop your knowledge in cardiology, cardiac and vascular surgery, to represent your clients as effectively as possible. Leading experts will navigate critical areas and the latest advances in cardiology, cardiac and vascular surgery including congenital heart disease, the role of angioplasty in the treatment of myocardial infarction,

Cardiac surgery, Abdominal Aortic Aneurysms and Cardiac arrhythmias.

Clinical Negligence: Law Practice & Procedure

30-31 January 2020, Anthony Collins Solicitors, Birmingham

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

Court of Protection conference

26 March 2020, Hilton Leeds City Hotel

Since its inception in 2007, the Court of Protection has made crucial decisions to try to protect the well-being of vulnerable individuals. In a rapidly-evolving legal environment, AvMA's third annual Court of Protection conference will examine the current state of litigation and the challenges and responsibilities facing those who work in this important area. The conference programme will be available and booking will open in December. For details on sponsorship and exhibition opportunities please contact conferences@avma.org.uk.

AvMA Annual Clinical Negligence Conference

25-26 June 2020, Bournemouth International Centre

We are delighted to announce that #ACNC2020 will take place on Thursday 25 – Friday 26 June at the Bournemouth International Centre. The Welcome Event will take place on the evening of Wednesday 24 June at Level8ight The Sky Bar the Hilton Bournemouth. Sponsorship and exhibition package details are available now, early bird delegate booking will open in early 2020 and the full conference programme will be available in March. Look out for further details soon and please e-mail conferences@avma.org.uk should you have any queries in the meantime.

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- The New Electronic Bill Of Costs
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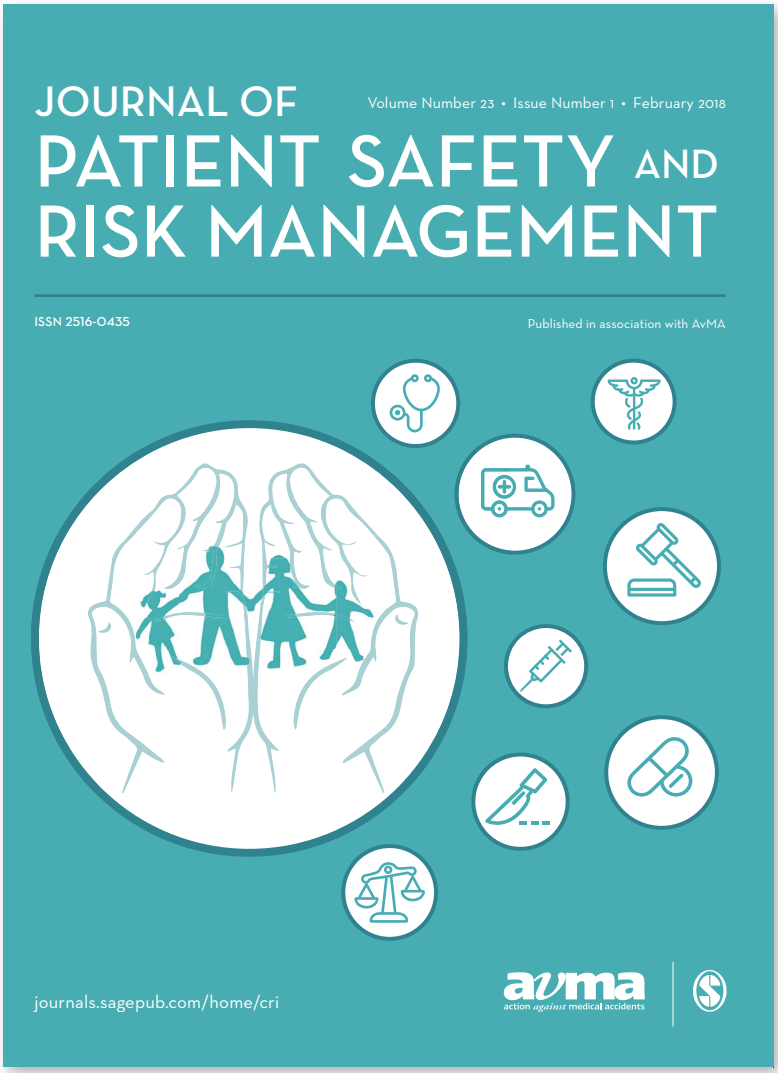

The Journal of Patient Safety and Risk Management, published in association with AvMA, is an international journal considering patient safety and risk at all levels of the healthcare system, starting with the patient and including practitioners, managers, organisations and policy makers. It publishes peer-reviewed research papers on topics including innovative ideas and interventions, strategies and policies for improving safety in healthcare, commentaries on patient safety issues and articles on current medico-legal issues and recently settled clinical negligence cases from around the world.

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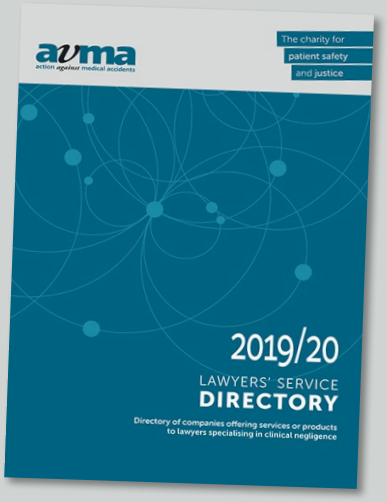

- Costs consultants
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1 MARCH 2020

Entry fee £46; Fundraising target £300

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