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Welcome to the Medico-Legal Magazine

Welcome to Issue 24 of the Medico-Legal Magazine, produced by SpecialistInfo and publishing partner Iconic Media Solutions Ltd.

This autumn issue of 2023 contains our new Expert Witness Directory, who are available for instruction, and includes the following articles:

Tim Deeming, Partner, Tees Law, Cambridge and Gareth Owens, Chair, Aortic Dissection Awareness UK & Ireland, discuss how to reduce misdiagnosis of acute aortic disease; and

Max Melsa, Deka Chambers, shares his insight on how a recent decision relating to group actions will influence future cases.

Also in this issue, Andrea Crisp, Senior Associate, Clyde & Co LLP, discusses claims brought under the Equality Act.

Once again, the magazine will be circulated to up to 40,000 people in the industry, including doctors, insurance companies, law firms and medico-legal agencies. It has a dedicated website www.medicolegalmagazine.co.uk and a page on the Medico-Legal Section of the Specialistinfo.com website, where all the back issues can be viewed. Printed copies can be ordered from Iconic Media.

Specialistinfo maintains a database of contact details for up to 90,000 UK consultants and GPs, including approximately 11,000 consultants and GPs who undertake medico-legal work. We also provide Medico-Legal courses for expert witnesses and promote the members of the Faculty of Expert Witnesses (the FEW).

We welcome feedback from our readers, so please contact us with any suggestions for areas you would like to see covered in future issues or share your news and experiences with us.

Lisa Cheyne

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NAVIGATING CLAIMS UNDER THE EQUALITY ACT: A GUIDE FOR MEDICAL PROFESSIONALS

By Andrea Crisp, Senior Associate, Clyde & Co LLP, Manchester - Andrea.Crisp@clydeco.com

Claims under the Equality Act 2010[1] arising out of clinical care are increasing in frequency and are often made wholly without merit. Such claims are novel and whilst not of high value, they can run the risk of reputational damage to the defendant healthcare provider. They tend to be by their very nature headline grabbing.

Dealing with claims that lack merit is a challenge that medical professionals might encounter. It is important to understand the legal basis for such claims and have a strategy for their management to ensure a just and fair resolution.

The legal framework

The Equality Act 2010 ("the Act") legally protects people from discrimination in the workplace and in wider society including healthcare providers. It is against the law to discriminate against anyone because of:

- age
- disability
- gender reassignment
- being married or in a civil partnership
- being pregnant or on maternity leave
- race
- religion or belief
- sex
- sexual orientation

These are known as "protected characteristics".

Types of claims

Unlawful discrimination can take various forms including:

Direct discrimination (s13)	treating someone with a protected characteristic less favourably than others. In a medical context, this could manifest as unequal treatment of patients based on their gender, race or disability.
Discrimination arising from disability (s15)	treating someone unfavourably because of something arising in consequence of their disability
Indirect discrimination (s19)	putting rules or arrangements in place that apply to everyone, but that put someone with a protected characteristic at an unfair disadvantage.
Failure to make reasonable adjustments (s20/21)	to rules or arrangements to avoid a disabled person suffering a substantial disadvantage
Harassment (s26)	unwanted behaviour linked to a protected characteristic that violates someone's dignity or creates an offensive environment for them
Victimisation (s27)	treating someone unfairly because they have complained about discrimination or harassment

Management of such claims

Review the claim thoroughly to understand the specifics and the basis on which it is made. Determine whether the claim falls within the scope of the Equality Act and if it pertains to a protected characteristic. In order to successfully bring a claim for damages under the Act, the person bringing the claim must prove that they have suffered unlawful discrimination as a result of a protected characteristic which caused them to suffer injury to feelings. Sometimes, claims without merit might not even meet the basic criteria for protection under the Act.

All relevant documentation and evidence related to the alleged incident should be gathered. This could include medical records, communications with the patient, witness statements and relevant policies or guidelines. This evidence will be essential in assessing the credibility of the claim.

Medical defence organisations and/or specialist lawyers can assist in assessing the situation objectively and provide guidance on the appropriate next steps to address the claim. Unlike clinical negligence claims, expert evidence is not always required in order to successfully defend claims under the Equality Act. Often, claims are successfully defended based on the contemporaneous records and factual evidence. This should be carefully considered on a case-by-case basis.

Time limits

There is no Pre-Action Protocol for discrimination claims. A defendant should respond to a Letter of Claim within a reasonable time, up to 3 months.
Of note, the limitation period is 6 months, irrespective of whether the claimant is a minor. Courts adopt a stricter approach to limitation in these types of claims so as to not burden public bodies with claims of this nature. It is important to carefully check the dates on receipt of a new claim to ensure that it is not already statute barred.

Examples of claims under the Act

Case example 1

Clyde & Co LLP represented a GP practice in a claim that concerned allegations of indirect disability discrimination by requiring all patients to wear a face covering during the Covid-19 pandemic when attending a GP appointment. The Claimant alleged that she was disabled because she suffered from claustrophobia.

No evidence was provided to support the assertion that the Claimant was disabled within meaning of the Act, so the Act was not engaged. In addition, throughout the relevant period, Covid-19 restrictions were in place at the GP practice. It was a legal requirement for face masks and coverings to be worn by staff and patients in all clinical and non-clinical areas unless they were unable to do so. This was required to prevent the transmission of Covid-19 and minimise disruption to health and care services. If a patient was unable to wear a face covering, it would then be a matter for the treating clinician to decide whether they felt comfortable proceeding with an appointment in those circumstances. If not, an appointment would be re-arranged with an alternative clinician. The care provided was reasonable and there was no unlawful discrimination. The claim was successfully repudiated.

Case example 2

Clyde & Co LLP represented a dental practice in a claim brought by the Claimant who was an NHS patient of the practice. At its heart, the Claimant's claim was one of alleged unlawful disability discrimination, specifically a purported failure to make reasonable adjustments. It was alleged that the dental practice unlawfully discriminated against the Claimant by failing to accommodate their mobility needs by failing to ensure all of their appointments took place in the downstairs clinic and failing to accommodate their communication needs by failing to communicate by email (their preferred method of communication) and accommodating their difficulties with organisation.

Clyde & Co LLP applied to the court for summary judgment because the claim was without merit. The Judge held that the Claimant's complaints in respect of the alleged delay or failure to respond to emails, to re-arrange appointments and failing to arrange them in a downstairs clinic were errors on behalf of the dental practice that were no more than administrative failings or one off events, and did not amount to unlawful discrimination.

In respect of the dental practice's late cancellation policy, no action was taken by the dental practice as a result of the Claimant's late cancellations and therefore there was no disadvantage to the Claimant in that policy. Consequently, any argument would be speculative and even if that isn't correct, what reasonable adjustment could one put in place? The Judge could not see how the claim could succeed.

The Claimant alleged that the claim was actually concerned primarily with the policy of phone calls taking precedence over emails. The Judge held that that is not a policy but rather just inherent in the nature of the technology itself. The use of telephone is instantaneous whereas text communication is inherently delayed. Complaining that text-based communication is slower than direct verbal communication is like the argument that "water is too wet". The Judge held that such a claim was speculative and would be difficult to prove. To require all communication be done by email is not a reasonable adjustment.

The Judge held that the claim had no prospects of success, dismissed the claim and ordered summary judgment for the dental practice.

Conclusion

Cases under the Equality Act 2010 are increasing in frequency and like the above examples, are invariably wholly defensible. Clyde & Co's healthcare team have significant experience in supporting healthcare professionals and providers throughout these difficult cases and achieving a discontinuance/dismissal. In fact, Clyde & Co continue to have a 100% success rate in rebutting these novel claims brought under the Act arising out of clinical care.

References:

[1] https://www.legislation.gov.uk/ukpga/2010/15/contents

ALL ABOARD THE NIHL OMNIBUS

By Max Melsa, Barrister, Deka Chambers, London - mmelsa@dekachambers.com

Prior to being called to the Bar in 2015, Max Melsa worked with Gerard McDermott KC on all aspects of high-value cases arising from catastrophic personal injury, in particular involving travel and cross border claims of significant value and complexity. He now maintains a mixed practice of civil and family work, alongside representing interested parties at inquests.

The appeal in *Abbott and others v Ministry of Defence* [2023] EWHC 1475 (KB) concerned the claims of about 3,500 Claimants (for context, the average attendance at Fleetwood Town or Colchester United home games last season) and whether each of those Claimants required their own Claim Forms to be issued.

The Claimants were military personal who claim to have suffered noise induced hearing loss (NIHL). There were key traits within each claim that were common between them. The parties had agreed that there should be trials for lead cases and common issues by the time the case came to Master Davison in July 2022. At that CMC however, the Master questioned whether separate Claim Forms needed to be issued for each Claimant, and in finding that this was the case, directed for each of the Claimants to issue their own Claim Forms within 6 months or be struck out.

In the appeal, the Court considered the wording of CPR 7.3:

A claimant may use a single claim form to start all claims which can be conveniently disposed of in the same proceedings.

In granting the appeal, three determinations were made:

1. It was not disputed by the parties that being "disposed of" means the claims finally determined, not just case managed [51];
2. The test of convenience is only that common disposal be convenient; it does not require common disposal to be the only possible or reasonable way of determining the set of claims in question, or that separate disposal would be inconvenient [52]; and
3. "Convenient" is an ordinary word which means possible and helpful or useful, nothing more [53].

The Master's error was to equate 'the same proceedings' with 'a single trial' which is not what CPR 7.3 requires [55].

In concluding, Baker J set out at [71]:

"The governing principle, therefore, is not whether there is a large number of claimants and / or causes of action. Rather, it is the convenience of disposing of the issues arising between the parties in a single set of proceedings. The degree of commonality between the causes of action, including as part of that the significance for each individual claim of any common issues of fact or law, will generally be the most important factor in determining whether it would, or would not, be convenient to dispose of them all in a single set of proceedings."

The reality of what was set in motion from the Master's judgment was the Claimants' firm being required, within 6 months, to ask each Claimant to provide a Help with Fees Form if appropriate; submit any returned forms to the Fees Office; file a signed Claim Form; and then pay any issue fee required. It was as if Fleetwood Town or Colchester United had to provide season tickets to each person attending a home game, but also pay for them to attend.

Significant issues arose with Claimants being charged incorrect issue fees, the difference needing to be covered by the Claimants' firm. The Court Office was also understandably overwhelmed.

The appeal judgment is therefore of great assistance to any firm dealing with large numbers of Claimants, reduces pressure upon the Court system, and is a victory for access to justice.

This article was first published as a "Dekagram" by Deka Chambers on 26 June 2023

BOOK REVIEW

HOW TO EXPECT THE UNEXPECTED *BY* KIT YATES

The science of making predictions and the art of knowing when not to -
Published by Quercus Editions Ltd 2023

By Lisa Cheyne

Kit Yates is a Senior Lecturer in the Department of Mathematical Sciences and Co-director of the Centre for Mathematical Biology at the University of Bath.

This is Kit's second book after his first entitled The *Maths of Life and Death*, which was a Sunday Times Science Book of the Year.

I first became aware of Kit Yates during the Covid lockdowns, when a group of concerned scientists set up *Independent Sage*, which became a useful and trusted source of information on the progress of the (still ongoing) pandemic for my family, especially as my husband was clinically vulnerable.

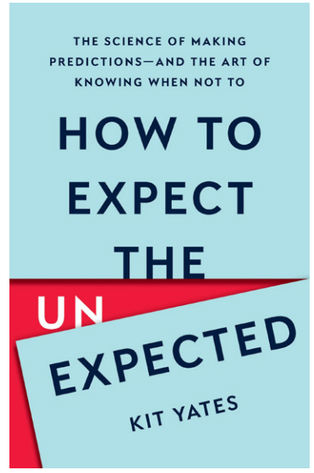
I am a scientist by training, but maths, and especially statistics, was always a necessary evil that had to be battled through. This book makes maths accessible and even "fun". My 14-year-old daughter was a willing test subject for the many challenges throughout the book, which nicely illustrated that our brains are hard wired in certain ways, meaning that "logical" decisions are often plain wrong, and can at worst allow us to be the victims of disaster or fraudsters.

There are many mathematical pitfalls for even highly trained scientists to fall into, and expert witnesses, who know they must always be non-partisan and not stray from their own area of expertise, would do well to take note of Kit's warnings.

There are plenty of scientific examples of the use (and misuse) of predictive maths in science, from climate change to pandemics to drug trials, and Kit gets the balance right between delving into the science but keeping the level accessible. There is a comprehensive reference section, for those wanting to find out more.

There are plenty of amusing stories and hints and tips, for example, how the makers of the iPod had to change their shuffle feature to be non-random to reduce the number of complaints about strings of songs "proving" that shuffle was not "random enough"; or how seemingly improbably coincidences are more common that you think; and how to improve your chances of winning the lottery.

If you want to be more mindful of how you approach probability or bias in your work, or just read some interesting anecdotes about common misunderstandings of how real-world maths works, this book is for you.



AORTIC DISSECTION AND INQUESTS

By Tim Deeming, Partner, Tees Law, Medical Negligence, Cambridge and Gareth Owens, Chair, Aortic Dissection Awareness UK & Ireland

Following any tragic death there will be many questions which arise and many potential areas which need to be considered and explored, one of which may be that of an inquest.

We hope that this article provides some support to help anyone who may be affected by such circumstances. We are of course able to support any bereaved individual/family and provide education for clinicians and information for legal professionals: info@thinkaorta.net

Aortic Dissection

The aorta is the largest artery in the body and carries oxygen-rich blood from the heart to the brain, limbs and vital organs. Aortic dissection (AD) is a rare but life-threatening condition, where there is a tear in the inner wall of the aorta.

As the tear extends, blood may flow between the layers of the wall of the aorta, forcing the layers apart and creating a false passage or 'lumen'. This can lead to reduced blood flow to organs and limbs, or to catastrophic rupture of the aorta.

In 2018, data from national patient charity Aortic Dissection Awareness UK & Ireland showed that Aortic Dissection causes more deaths in the UK than road traffic accidents. The condition is not as rare as was once thought. The charity expressed concern that many of these deaths occur unnecessarily due to misdiagnosis and delay and created the patient-led THINK AORTA campaign and diagnostic strategy in partnership with the Royal College of Emergency Medicine (RCEM).

In 2020 the UK Government's HealthCare Safety Investigation Branch (HSIB) published an investigation report[2] confirming that delayed recognition of aortic dissection is a national patient safety issue, citing THINK AORTA as a diagnostic strategy and requesting action by the Royal College of Emergency Medicine and the Royal College of Radiologists (RCR). The two Royal Colleges worked collaboratively on their response and in 2021 published their first-ever joint guidance for medical professionals, "Diagnosing aortic dissection in the emergency setting"[3].

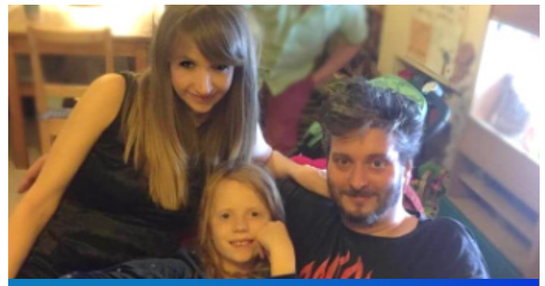


Figure 1: Paul Sartori, 38, was one of an estimated 1,000 people a year in the UK who lose their lives to misdiagnosed acute aortic dissection. His death was reviewed at an inquest by the NE London Coroner, who highlighted a 'systemic' lack of education among healthcare professionals about the condition [1]

Figure 2: Emergency Department staff at Wishaw General Hospital in Lanarkshire were among the first to roll-out the life-saving THINK AORTA campaign in 2018

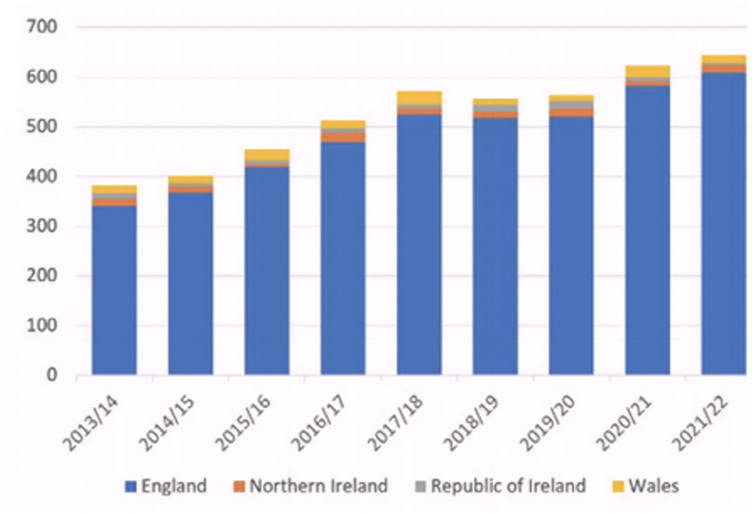


Figure 3: Data from the UK 2023 National Adult Cardiac Surgery Audit (NACSA) shows the positive impact of THINK AORTA [4]

In 2023, the UK National Adult Cardiac Surgery Audit highlighted that, as a result of increased awareness and THINK AORTA, more patients are receiving emergency Aortic surgery, with a **68% increase** in cases (250 more patients a year) since 2014[4]. The national action and education prompted by THINK AORTA are transforming diagnosis of this disease.

Inquest Investigations

Following any death, the treating clinicians and independent medical examiners will consider whether the death was natural or not, and whether a death certificate can be provided at that stage.

A Coroner has a duty to investigate a death if they have reason to suspect that one of the following circumstances applies:

a) The deceased died a violent or unnatural death;
b) The cause of death is unknown;
c) The deceased died while in custody (e.g. in prison) or in state detention

As a result if the treating clinicians or medical examiner have concerns then they will refer the matter to the Coroner to consider. This does not automatically result in there being an inquest though, as a Coroner can make preliminary enquiries and then decide as a result of those enquiries that no inquest is required, because the duty to investigate further has not in fact arisen. One example of this might be where further evidence confirms that the death was due to natural causes, such as a post mortem.

Post Mortem

A post-mortem is an examination of the body by a qualified pathologist to assist in determining the cause of death and is arranged primarily by the Coroner, whilst of course bearing in mind the sensitivities of the family and any religious/cultural needs.

Most post-mortems are invasive, but there are increasing numbers being undertaken non-invasively, through imaging, although these are not available in many areas of the country, and may not exclude the need for potential samples to be taken to test for histology or toxicology. It must also be remembered that scanning techniques may not avoid the need for a more invasive post-mortem if, following receipt of the scan results, the Coroner decides that the more invasive type of post-mortem is required after all.

The Coroner will appoint a pathologist to conduct the post-mortem, who will be independent and they have the authority, if approved by the Coroner, to conduct tests and remove material that has a bearing upon the cause of death.

After the pathologist has completed their investigation the Coroner will usually authorise the release of the body to funeral directors so that arrangements can be made, if the Coroner is satisfied that the body is no longer required for the investigation. The pathologist will have provided a post-mortem report to the Coroner which should contain a detailed analysis of their findings and provide conclusions about the cause of death, so far as they are able.

If the family or another interested person is not content with the post mortem result then they can seek the Coroners authority for a second post mortem to be undertaken, at the requesting parties cost. This though is more usual where the death relates to a potential homicide. There is no absolute right or entitlement for a second post mortem as the Coroner has judicial discretion to take account of the reasons in support of a request and any competing considerations.

If, following their preliminary enquiries a Coroner decides that they are satisfied that the duty to investigate does arise then an inquest is likely to follow. The numbers of inquests vary across the country and Coroners are supported by their Local Authority, but nationally inquests occur in around 5% of all deaths. Following such preliminary enquiries then a Coroner may issue an interim or final death certificate, depending on the investigations and whether an inquest is required.

Inquest

The Coroner is not allowed or expected to make any finding relating to liability or negligence as a Coroner's Court is not to allocate blame, or to establish civil/criminal liability, it is a fact finding investigation and will usually involve obtaining statements from the treating clinicians and family, as well as considering other available evidence which may well include the post mortem and toxicology results, and potentially independent expert evidence.

Often a Coroner will arrange for preliminary statements to be obtained from the family, the treating clinicians and for these to be shared and they may then arrange a pre-inquest review hearing. This can be held in person or remotely so as to ensure that a clear route is set out for the investigation through to the inquest so that the family are front and centre.

Where an inquest is being arranged it is often the case that the Hospital/GP/Interested persons will have legal representation and support and so families should likewise consider the same given the impact that this can have upon the investigation, as well as the emotional impact that any inquest will understandably have.

The areas which are often addressed at this hearing will be:

- Identity of Interested Persons
- Scope of the inquest
- Whether Article 2 engaged
- Whether jury required
- Matters for further investigation
- Provisional list of witnesses
- Disclosure
- Jury bundle
- Date of next PIR hearing
- Date of inquest; length of inquest
- Venue for hearings

And more infrequently it will include:

- Anonymity of witnesses
- Special measures for witnesses (including video links and screens)

- Public to be excluded for part of inquest (national security)
- Public interest immunity
- Apparent bias
- Need for an interpreter
- CCTV evidence
- View of the scene
- Other matters

At the inquest, which may also be held remotely or in person depending on the Coroners determination, it will usually be that once the Coroner has opened the hearing, witness evidence will either be read in by the Coroner where it is agreed, or witnesses will be called to give their evidence and understanding of the situation as they recall it. Questions can then be put to them by the Coroner, family and other interested persons but this is not cross examination, as it is not a trial. All persons should be assisting the Coroner in enabling the investigation to be full, frank and fearless.

Having heard all of the evidence the Coroner, or jury where required, will then determine the history of events as they find it and then look to complete the record of inquest which sets out the findings. We cannot set out all of the potential inclusions and impacts within this article, but the record will include:

1. The name of the deceased
2. The medical cause of death
3. How, when and where the deceased came by their death – which is usually a factual summary
4. The conclusion of the Coroner/jury – which may include any of the prescribed short form conclusions, a narrative conclusion, or an Article 2 inclusion
5. The deceased's details for the final death certificate for the Registrar, so that a final death certificate can be provided

Learnings

One potential outcome from an inquest is that where the Coroner/jury believe that there were failings, and that sufficient improvements have not been made such that there remains a risk for other individuals, then a Coroner can issues a Regulation 28 request, more commonly referred to as a Prevention of Future Deaths report. A Coroner cannot compel that action is taken, but can highlight areas of concern and Trusts will then have a duty to consider and respond to this. An example of such a request by the Coroner[1] investigating the death of Paul Sartori was:

During the course of the inquest the evidence revealed matters giving rise to concern. In my opinion there is a risk that future deaths could occur unless action is taken. In the circumstances it is my statutory duty to report to you.

*The **MATTERS OF CONCERN** are as follows. –*

1. *The Inquest heard evidence that the streaming guidance in place for A & E staff had not been updated to take into account the learning from the death and to take into account the guidance from the THINK AORTA Campaign (launched in 2016).*
2. *The nurse making the decision to re-direct the deceased from A&E did not record a full set of observations, to include a pain score, prior to diverting the deceased from the A & E department. The nurse did not document her decision-making process and rationale for redirecting the deceased from A&E.*
3. *A junior sister who provided evidence at the Inquest was not aware of the THINK AORTA campaign. The Inquest heard that the senior leadership team had recently agreed to embed the THINK AORTA learning into practice at all levels within the emergency department. This learning had not been embedded at the time of the Inquest hearing.*

It is vital for all that learning is embedded to prevent/reduce risks arising again, especially by the time of the inquest, as everyone present will want to ensure that every practicable step has been taken.

Next Steps

The 2023 NACSA data shows that, to date, THINK AORTA has addressed roughly 25% of the estimated UK deaths due to misdiagnosed aortic dissection. As a diagnostic strategy, THINK AORTA has professional endorsement from the Royal College of Emergency Medicine, the Royal College of Radiologists, the Society for Cardiothoracic Surgery, the Vascular Society, the Healthcare Safety Investigation Branch and Heart Research UK.

What we know is that with prompt diagnosis and rapid transfer to a specialist Aortic centre, modern medicine can deliver excellent outcomes for a patient with acute Aortic Dissection. THINK AORTA has ushered in a new standard of diagnosis and care. The old clinical thinking, that this is an incredibly rare disease and patients do not do well, even if diagnosed, needs to be updated to reflect 21st century medicine and the new standard of care.

Clinicians should seek to educate themselves and their colleagues about THINK AORTA, using the RCEM/RCR professional guidance[3] and the free educational resources available from THINK AORTA. In Emergency Medicine, acute aortic dissection needs to be included in differential diagnosis more frequently, especially for chest pain. In Radiology, the barriers to obtaining an urgent CT scan of the Aorta (the only definitive way of diagnosing an aortic dissection) need to be removed.

Legal professionals should also familiarise themselves with the current standard of diagnostic care in acute aortic dissection, so that they are best-placed to support individuals and families who turn to them for help when affected by this condition. Where a complaint may be required, we have attached a guide to assist[5].

Aortic Dissection is an emergency that is often fatal when missed. Early diagnosis is vital to successful treatment and improved survival of patients, however the signs and symptoms are variable, which can make diagnosis difficult. Typical symptoms include sudden, severe chest pain, which can be mistaken for a heart attack or pulmonary embolism. This, in addition to a general lack of awareness of aortic dissection among non-specialist clinicians, can lead to delayed or missed misdiagnosis. A study by the Mayo clinic found that 38% of patients with an AD are initially misdiagnosed and that in 28% of patients, the correct diagnosis was not made before post mortem examination[6].

Our accredited THINK AORTA learning resources are available as a free download for any healthcare professional who wants to use them and we know they have saved lives.

Resources:

THINK AORTA
www.thinkaorta.net

Aortic Dissection Awareness UK & Ireland
www.aorticdissectionawareness.org

RCEM Learning resources
www.rcemlearning.co.uk/foamed/aortic-dissection/

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[2] Delayed recognition of acute aortic dissection, HSIB Investigation Report, January 2020
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[6] Spittell PC, Spittell Jr JA, Joyce JW. et al. Clinical features and differential diagnosis of aortic dissection: experience with 236 cases (1980 through 1990). Mayo Clin.Proc.1993;68:642-651.
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David Simon Costain is a Podiatric Consultant and Gait Specialist, based in Harley Street, London. He has over 45 years of experience in Podiatry and is the CEO of the Gait & Posture Centre.

He specialises in the analysis of gait related musculo-skeletal problems relating to foot and leg malfunction, dividing his time between his private practice and expert witness work. He focuses on Personal Injury cases where approximately 75% of his work is for the claimant, and 25% for the defendant.

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THE GAIT AND POSTURE CENTRE

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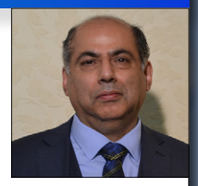

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Mr Khanna is a substantive NHS Consultant in Plastic, Reconstructive and Hand Surgery at The Sandwell and West Birmingham NHS Trust and has been involved in medical legal work since 1998. In this period he has provided over 3800 medical reports. He has prepared a chapter for the Encyclopedia of Forensic & Legal Medicine entitled "Medical malpractice in Cosmetic and Plastic Surgery".

Areas of expertise:

- Hand surgery: Sequelae of hand injuries and surgery
- Soft tissue injury:
- Burns management: Sequelae of disability following burns injury, scarring and surgery
- Medical negligence in Cosmetic Surgery

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Professor Mitra is a key opinion leader in Nephrology and Acute Medicine practising as a Full-time substantive Consultant for 20 yrs. He has been a Senior Consultant at The University Hospitals of Manchester, Manchester Royal Infirmary (NHS practice) and Spire Hospitals (Private practice) and has been involved in medical legal work since 2008. In this period, he has provided over 180 medical reports. He also serves as a CQC specialist advisor.

Areas of expertise:

- Chronic kidney disease
- Acute Kidney Injury
- Electrolyte disorders
- Dialysis Medicine
- Kidney Transplantation Hypertension
- Multimorbidity and Complex Medical Care
- Medical technology usability and complications
- Safety breach and Quality Assurance
- Clinical Governance and Risk Mitigation
- Adherence to Guidance and specifications

EMAIL ME

Dr Ana Phelps

MD, PhD, FRCP, RCPathME

Substantive Consultant Geriatrician

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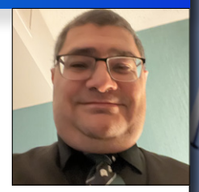
Dr Phelps is a substantive Consultant Geriatrician at Buckighamshire Healthcare NHS Trust. She is a Medical Examiner, regularly reviewing hospital mortality cases and advising doctors on medical certification of cause of death and when to refer to a Coroner. Her expertise include Orthogeriatrics, Frailty, Dementia, Peri-operative Medicine and complex cases in patients >65y.

Her medico-legal practice includes medical negligence, second opinions, decisions on escalation and resuscitation, ethical situations, inappropriate/harmful testing and treatments, and breeches in communication. She is able to provide comprehensive case reviews and expert opinion on the quality of the care provided at the different stages of care.

EMAIL ME

Professor Panayiotis (Panos) Kyzas



Edge Hill University

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Consultant OMFS H&N Surgeon

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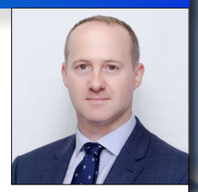
My name is Professor Panayiotis (Panos) Kyzas. I am a consultant in OMFS/Head and Neck Surgery with a clinical specialty interest in ablation and reconstruction of head and neck cancer and facial skin cancer. I am the Regional Specialty Advisor (RSPA) for OMFS. I am the deputy editor of the main UK scientific journal for my specialty, and I am elected to become Editor-in-Chief in 2024, for 5 years. I am the chair for the OMFS Specialty Training Committee and the regional research advisor. I am the national OMFS representative on the TIG H&N fellowship committee and the Quality Assurance Lead. I have recently graduated my law degree with honours. I currently hold a Bronze National Clinical Excellence Award for my services to the NHS. I am the Chief Investigator of the MANTRA trial, a with multimillion pounds NIHR funding. In August 2023 I have been appointed as a visiting Professor in OMFS H&N Surgery at Edge Hill University.

EMAIL ME

Philip McCann



Philip McCann

Consultant Orthopaedic and Trauma Surgeon

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w: www.shouldersurgeonbristol.co.uk

Mr McCann is a full time Trauma and Orthopaedic surgeon at University Hospitals Bristol and Southmead Hospital Bristol. He has a Specialist interest in:

- Fractures of the clavicle, shoulder, humerus and elbow
- Arthroscopic (keyhole) surgery for shoulder problems including tendon tears, impingement, stiffness, instability and arthritis
- Primary and Revision Shoulder replacement surgery
- Management of post traumatic, degenerative and sports-related
- conditions of the upper limb

With his modern tertiary referral practice and extensive research portfolio, Mr McCann is able to provide comprehensive medicolegal reports (full reports and desktop screening reports) for both personal injury and clinical negligence cases.

VISIT WESBITE

P N Plowman

MA MD FRCP FRCR

Senior Clinical Oncologist

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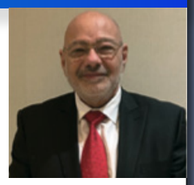
Dr P N Plowman is senior clinical oncologist to St Bartholomew's Hospital, London and has a paediatric interest and on the staff of Great Ormond Street Hospital. He has a long history of medicolegal work with around 50 new instructions each year. He has been an expert in the Tobacco Litigation and the class action of 22,000 USA women claiming breast cancer caused by HRT. Most of his instructions are to do with delay to diagnosis of cancer or causation aspects of cancer treatments' complications.

EMAIL ME

Mr Sarwat Sadek

MBBCh FRCSI FRCS (ORL-HNS) FRCS



Consultant Otolaryngologist and Head & Nech Surgeon

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e: sarwatsadek@doctors.org.uk

Mr Sarwat Sadek has been practising as an ENT Consultant for nearly 40 years and is currently Consultant Otolaryngologist and Head & Neck Surgeon at Musgrove Park Hospital and the Nuffield Hospital, Taunton.

Areas of interest:

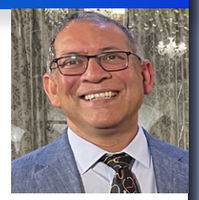
- Noise induced hearing loss
- Occupational rhinitis
- Facial & neck trauma
- Traumatic loss of sense of smell and taste
- Deafness, tinnitus and vertigo as a result of road traffic accidents

EMAIL ME

EXPERT WITNESS DIRECTORY

Mr Aruni Sen

MS, FRCS, FRCEM, DipMedEd.



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Medico Legal Expert since 1996
Experience as independent expert for claimant, defence & SJE.

Areas of interest:

- Clinical Negligence
- Personal Injury
- Hand Injury
- Resuscitation
- Trauma, Burns, Sedation & Acute Pain
- Musculoskeletal injuries
- CPR Part35 trained
- MEDCO accredited
- Up to date medico-legal CPD portfolio
- Reports vetted by solicitors
- Consultation Venues at: Chester (Cheshire, Northwest & North Wales), Guernsey & Jersey
- Happy to provide pro-bono opinion

Member of EWI, APIL, Law Society.

EMAIL ME

The Therapy Company

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Membership of the FEW has two grades:

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- Have undertaken appropriate Medico-Legal training and agreed to undertake refresher training every 3 years so that they are consistently up to date with all the latest rules and procedures.
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- Have satisfied SpecialistInfo's Lawyers as to the quality of his or her reports by submitting an anonymised sample report for review*, including presentation and compliance with Civil Procedure Rules
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- Have undertaken appropriate Medico-Legal training and agreed to undertake refresher training every 3 years so that they are consistently up to date with all the latest rules and procedures.
- Have their Medico-Legal CV listed on SpecialistInfo

Unlike other panels, membership is FREE for Doctors.

Both grades are expected to adhere to specified standards of good practice covering compliance, availability and service by conforming to a Code of Good Practice.

Non-Members appearing on the SpecialistInfo directory are Consultants and GPs who have indicated their willingness to undertake Medico-Legal work but have not yet qualified for FEW membership.

If you are a medical expert interested in joining our panel or you are a company looking for a quality expert, please contact Lisa Cheyne lisa@specialistinfo.com 01423 787 984

MEDICO -LEGAL NEWS:

By Lisa Cheyne, Medico-Legal Manager, SpecialistInfo

A round-up of news in the industry of the Third quarter of 2023

NEWS

Judicial Review issued in relation to Fixed Recoverable Costs

In August, The Association of Personal Injury Lawyers (APIL) issued Judicial Review (JR) proceedings against the Lord Chancellor.

The JR is based on several challenges to the MoJ plans to extend fixed costs to most civil claims worth up to £100,000.

There are 4 key grounds, one of which relates to Clinical negligence and the failure of the Government to properly consult on the new rules. APIL is also challenging provisions relating to vulnerable people which leave solicitors having to cover part of the additional costs incurred.

The other challenges are based on fixed costs for representation at inquests, and a possible reversal of Court of Appeal case law, which allows parties to contract out of fixed costs in disputed settlement agreements.

The JR proceedings were paused until the Government responded to the latest FRC consultation, which closed on 8th September. At the time of going to press, the Government had just affirmed its intention to go ahead with fixed costs on 1st October and announced fixed costs for clinical negligence cases up to £25,000 from April 2024.

APIL can apply to amend the grounds once they have seen the Government's response to this consultation.

Read more: https://www.apil.org.uk/statement/Fixed-recoverable-costs-judicial-review

New Rules for Expert Reports come into Effect this October

There will be a 20-page limit for all reports on the new intermediate track (those cases ranging in value from £25k-£100k). This intermediate track has been introduced to help provide greater certainty over legal costs.

All expert witnesses are required to meet their obligations under the Civil Procedure Rules.

Rule 28.14 (3) now states that: "...any expert report shall not exceed 20 pages, excluding any necessary photographs, plans and academic or technical articles attached to the report."

There are concerns in the industry that the new page limit could compromise the quality of expert evidence in more complex cases.

Industry bodies are seeking urgent clarification on what must be included in the 20-page limit.

Read more: https://www.justice.gov.uk/courts/procedure-rules/civil/rules/part28

The Scandal of Private Patient "Dumping" in A&E

In the month that saw Patient Safety Day, more than 500 patients a month were still routinely transferred to NHS hospitals from private clinics because of lack of proper overnight cover and intensive care in many private hospitals.

Delays in ambulance transfers have inevitably led to deaths in some cases, such as an elderly patient who died after waiting several hours for an ambulance from the Spire to Norfolk and Norwich Hospital less than a mile away. He had deteriorated during recovery from routine hip surgery.

Following a three-day inquest into his death, the county's senior coroner, Jacqueline Lake, raised serious concerns about the incident.

"This is on the face of it a natural cause of death," she said. "However, this is not a case where this adequately reflects all the evidence I have heard."

She said she would be sending a Prevent Future Deaths (PFD) report to both the East of England Ambulance Service Trust and Spire Healthcare, and also contacting the secretary of state for health.

Under an agreement reached during the pandemic, the private hospital treats many NHS patients, to help clear health service waiting lists.

Shockingly this has been the third such death at the Spire, after routine surgery and delay in transfer to NNUH, since 2020.

Read more: https://www.judiciary.uk/prevention-of-future-death-reports/christina-ruse-prevention-of-future-deaths-report/

The GMC Medical Practitioners Tribunal for Controversial Mesh Surgery

Surgeon Mr Anthony Dixon, who was dismissed in 2019, pioneered the use of artificial mesh to lift prolapsed bowels, often caused by childbirth, a technique known as laparoscopic ventral mesh rectopexy (LVMR). A GMC assessment in 2018 found "the standard of his professional performance and his performance was found to be unacceptable in the areas of assessment of pelvic floor patients, clinical management of pelvic floor patients, and working with colleagues."

More than 200 patients underwent mesh bowel operations in Bristol they might not have needed, and many have been left with life-changing issues as a result, such as incontinence and chronic pain.

The tribunal, which commenced on 11 September 2023 and is due to run until November will "inquire into the allegation that between 2010 and 2016 Dr Dixon failed to provide adequate clinical care to six patients in a number of areas including: ensuring procedures for some of the patients were clinically indicated; adequately advising some of the patients regarding options for treatment; obtaining informed consent before performing clinical procedures; adequately performing a procedure for one patient; providing adequate post-operative care for some of the patients; and communicating appropriately with some of the patients and their family members."

Read more: https://www.mpts-uk.org/hearings-and-decisions/medical-practitioners-tribunals/dr-anthony-dixon-sep-23

ACSO Launches Campaign to Reduce Civil Justice Logjams

The Association of Consumer Support Organisations (ACSO), which represents the interests of consumers in the civil justice system, has launched a campaign urging ministers to tackle ongoing delays in the civil courts.

The Ministry of Justice's own Civil Justice Statistics show that in 2019, the mean time for multi/fast track claims to go to trial was 59.4 weeks. The latest data found that the average time is now 79.9 weeks.

Matthew Maxwell Scott, ACSO's executive director, said that its own research conducted with Express Solicitors found that on average it takes 353 days to wait for the court to hear a case.

He said the ACSO campaign will urge ministers to make the delays a priority. "Most people want the civil courts to hear their cases quickly and effectively."

ACSO now urges:

- More government focus on civil justice, including appropriate levels of new funding where necessary and new impetus behind the courts-reform programme;
- The adoption of a range of models of dispute resolution, including new technologies where appropriate, working with the MoJ, Master of the Rolls, service providers and others to build public awareness of and trust in new methods;
- More transparency on waiting times, court and tribunal processes and the implications of delays, cancellations and arcane processes;
- Ministers to set clear targets for getting delays down; and
- Working with stakeholders across the legal and claims sector to achieve a coordinated, consensual approach.

Read more: https://acso.org.uk/news

Government Consultation Launched into Unregulated Cosmetic Procedures

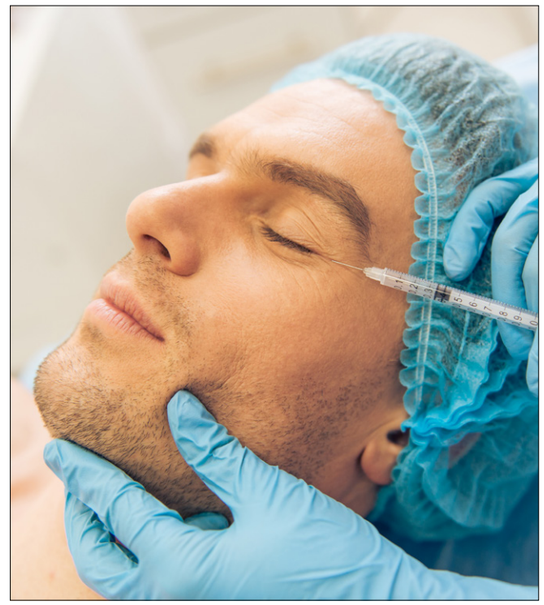
The public and businesses are being invited to share their views on how to make non-surgical cosmetic procedures, including Botox, laser hair removal and dermal fillers, safer.

The consultation will run for 8 weeks and will close on Saturday 28 October 2023.

It follows the passing of the Health and Care Act in April 2022, which gave the Health and Social Care Secretary the power to introduce a licensing regime. Professor David Sines CBE, Chair of the Joint Council for Cosmetic Practitioners, welcomed the consultation, saying:

"It will help to ensure that people who undergo non-surgical cosmetic procedures receive treatment from practitioners who are properly trained and qualified, have the necessary insurance cover and operate from premises that are safe and hygienic."

Read more: https://www.gov.uk/government/news/consultation-launched-into-unregulated-cosmetic-procedures



can be relied upon to give patients the care they need, when they need it. We have received feedback that this may not be the case at the moment.

"The services we will be looking at are private companies, which have a sometimes arms-length relationship with the NHS. We are looking at how they are governed, managed, and how standards are enforced. We will also examine transparency and accountability – someone has to take responsibility for getting this right."

One company under the spotlight is "Sciensus", after a patient recently died and three more are critically ill as a result of receiving unlicensed versions of cabazitaxel, a chemotherapy used to treat prostate cancer, which Sciensus was authorised by the Medicines and Healthcare products Regulatory Agency (MHRA) to manufacture.

Read more: https://committees.parliament.uk/work/7739/homecare-medicines-services/

House of Lords Public Services Committee Investigation into Private Homecare Medicines Services

Homecare Medicines Services are under investigation this September by the Lords with DHSC Minister, Will Quince. They want to know how much the Government is involved in overseeing the provision and regulation of these services.

Estelle Morris, the chair of the committee, said: "There are reports of missed deliveries, delays, and potentially significant health impacts for patients. Our inquiry will seek to examine how far these problems are occurring and the impact of these problems – both for individuals and the wider NHS."

Announcing details of the inquiry earlier this year, Lady Morris added: "The government is increasingly focused on how to treat more people out of hospital and look after them in the community. Homecare medicine services could form part of the answer to this, and it is crucial that they – and the system –

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