MEDICO LEGAL

MAGAZINE

ISSUE 11

Presented by:

specialist info

MEDICO LEGAL

CONFERENCE 2019

16TH MAY 2019,
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WESTMINSTER, LONDON

specialist info

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The **Medico-Legal Conference** is set to be the UK's leading event bringing together medico-legal professionals & industry experts. Attend to experience our high-level programme of speakers, interactive exhibition zone and networking. The event takes place at London's prestigious Queen Elizabeth II Centre, Westminster on May 16th 2019.

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Welcome to Issue 11

Welcome to Issue 11 of the Medico-Legal Magazine, produced by SpecialistInfo and publishing partner Iconic Media Solutions Ltd.

This spring issue accompanies SpecialistInfo's Medico-Legal Conference, taking place on the 16 May 2019 at the prestigious Queen Elizabeth II Centre, Westminster, London. We have secured several high-profile speakers, including Sir Rupert Jackson as keynote speaker. Details of the programme and speakers can be found in this issue. I hope to meet you there!

Also in this issue, Barrister and our Master of Ceremonies at the Conference, Jonathan Godfrey, focusses on "scope of duty" in a landmark wrongful birth case report.

Enable Law Legal Director, Laurence Vick, comments on the recent first prosecution by the CQC of an NHS Trust for failing to meet its minimum "duty of candour" care standards.

Clare Chapman and colleagues from BLM, examine the Sentencing Council's new culpability levels to be applied in gross negligence manslaughter cases and consider how the GMC may interpret them in cases involving medical practitioners.

We are also pleased to include articles by Skin Camouflage and STEPS Rehabilitation.

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 is published on the Medico-Legal Section of the Specialistinfo.com website, and printed copies can be ordered from Iconic.

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, or share your news and experiences with us.

Lisa Cheyne

SpecialistInfo
Medico-Legal Magazine

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MEDICO -LEGAL COURSES:

By Lisa Cheyne, Medico-Legal Manager, SpecialistInfo

Training Courses for Expert Witnesses

The dates and locations for the confirmed ML courses that we are holding during 2019 are listed below with links to our booking page.

Medico-Legal Essentials Course (a general overview for anyone starting a medico-legal practice, focussing on personal injury):

- *17th September 2019* – London
- *20th November 2019* – Birmingham

£340 (plus VAT)

For further information about the Essentials course, please visit: www.specialistinfo.com/a_ml_standard.php

Clinical Negligence Medico-Legal Course
(for higher value medical negligence cases):

- *18th September 2019* – London
- *21st November 2019* – Birmingham

£365 (plus VAT)

For further information about the Clinical Negligence course, please visit: www.specialistinfo.com/a_ml_clinicalneg.php

Advanced Medico-Legal Course
(refresher for experts now including court-room skills):

- *19th June 2019* – London
- *19th September 2019* – London
- *6th December 2019* – London

£365 (plus VAT)

For further information about the Advanced course, please visit: www.specialistinfo.com/a_ml_advanced.php

Mediation Training Course

Workplace and Employment Mediation (2 days)

- *12th - 13th June 2019* – London

Foundation Training (5 days)

- *20th - 24th May 2019* – London
- *1st - 5th July 2019* – Manchester
- *15th - 19th July 2019* – London
- *9th - 13th September 2019* – London

2 day courses £550, 5 days £1,600 (No VAT)

For further information about the Mediation course please visit: www.specialistinfo.com/a_ml_mediation.php

To book your place on one of the above courses please complete the booking form on our website by clicking on one of the above links (discounts are available for multiple bookings – please call Lisa to discuss or to book over the phone).

Please contact me, Lisa Cheyne, on 01423 727 721 or email me at lisa@specialistInfo.com

Numbers are strictly limited so early booking is advised to make sure you do not miss out on these enjoyable and highly informative courses.

I look forward to hearing from you soon.

Kind regards

Lisa Cheyne
Medico-Legal Course Manager

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HOW NEW SENTENCING COUNCIL GUIDELINES AND THE GMC REVIEW COULD IMPACT HEALTHCARE PROFESSIONALS AND ORGANISATIONS CONVICTED OF GROSS NEGLIGENCE MANSLAUGHTER

Clare Chapman, Partner, Katie Costello, Partner and Jennifer Canavan, Trainee Solicitor, BLM Law

The Sentencing Council's advice on gross negligence manslaughter, announced last year, could result in lengthier prison sentences and increased fines for those found guilty of the offence. How might this impact healthcare organisations and professionals investigated for GNM, in light of the GMC Review?

The legal battles faced by Dr Bawa-Garba in recent years, which resulted in a GNM conviction in December 2015 (three years before sentencing advice was updated) left many in the medical community feeling that the junior doctor had been scapegoated for failings beyond her control. How might the sanctions against her have differed in light of the recent sentencing updates? What protections are in place for doctors who find themselves facing a GNM charge?

On 1 November 2018 sentencing guidelines were introduced in relation to convictions for Gross Negligence Manslaughter (GNM).

The aim of these guidelines is to provide consistency in relation to sentencing and also to increase the sentencing of offenders, which brings GNM in line with most other criminal offences (sentencing for GNM having previously been based on the common law by reference to previous cases rather than any guideline for custodial terms). Justice Minister Rory Steward said that *"Manslaughter is an extremely serious offence," "so it is vital our courts have clear, consistent guidance in these often complex cases" and "these guidelines will make sure sentences reflect the severity of the crime."*

Under the new guidelines, once an individual has been convicted of GNM, the courts follow a number of steps in determining sentencing. Some of the more significant points arising for members of the healthcare professions are as follows;

The court will determine the culpability of the offender. The new guidelines have introduced four levels of culpability, from low to very high, ranging from 1-18 years custodial sentence respectively. For example, a factor which indicate lower culpability could be a single lapse in the offender's otherwise satisfactory care. Factors which could indicate a higher culpability could be where there is one or more of following (not exclusive): an offender showing blatant disregard for a very high risk of death resulting from their negligent conduct; or an offender continuing to repeat the negligent conduct in the face of the obvious suffering caused.

The court is to apply a sentencing range which will be the starting point for all offenders regardless of any pleas or previous convictions. For example, for very high culpability, the range is 10-18 years in custody, whereas even for lower culpability the range is 1-4 years with a starting point of 2 years. There is no reference in the guideline to a sentence being suspended, which suggests that it is only in the rarest of circumstances, with the most significant mitigation, where that would be appropriate. Dr Bawa-Garba's sentence may well have been decided differently under the new guidelines.

The court will then take into account aggravating factors such as previous convictions, history of violence, or actions after the event including covering up and concealing evidence.

The court is now required also to look at factors which may assist in reducing sentencing including remorse, self-reporting, reasons beyond the offenders control including lack of equipment, support or training and stress and pressure. These factors are particularly relevant for healthcare professionals. The final steps for the court to consider are; to consider any factors which indicate a reduction for assistance to the prosecution, a reduction for a guilty plea, dangerousness, totality in principle, compensation and ancillary orders, reasons and consideration for time spent on bail.

The new guidelines provide more clarity for both the court and the defendant, but with that clarity comes greater stringency. Historically, as previously cases of GNM are relatively rare, there was a wide variation in sentencing between courts, and the highest sentence recorded in recent years for a healthcare professional was in 2013 when a GP diagnosed depression in a middle-aged patient who died shortly afterwards from diabetic ketoacidosis. The doctor pled guilty to manslaughter and received a two-and-a-half-year custodial sentence.

For healthcare organisations and professionals, the new guidelines are inevitably going to cause concern given the significant increase in custodial ranges from sentences imposed historically. By way of example; in 2004 a surgeon was given a 21 month suspended custodial sentence after pleading guilty to manslaughter when his patient suffered catastrophic blood loss during an operation to remove a liver tumour. In 2007 a GP was given a two-year suspended sentence after admitting manslaughter when a he gave a patient a lethal overdose of diamorphine for migraine. However, in 2012 a urologist was sentenced to two years imprisonment, after pleading guilty, when a patient died of sepsis following surgery. In 2013, before the conviction was overturned, a surgeon was given a two-and-a-half year custodial sentence after the patient underwent a knee replacement and developed abdominal symptoms. The surgeon preformed a laparotomy for a perforated bowel, and it was found that there was an inappropriate delay in the diagnosis and treatment. The real impact of the Guidelines is yet to be determined.

The guidelines of course will not affect the number of prosecutions within healthcare, as the factors detailed apply only to sentencing and not to prospects of conviction. However, of greater impact in this area will be the outcome of the GMC's review of how the law on GNM (and culpable homicide in Scotland) is applied to medical practitioners. Whilst the GMC recommendations will not be binding on the CPS or police, it is to be hoped that their review and recommendations will influence the way in which cases are investigated. The terms of reference for the review were announced in March 2018. The Chair, Dr Hamilton, has stated that *"if a doctor intends deliberately to harm a patient or seriously violates accepted codes of practice, the criminal justice system should be applied. Doctors are not above the law."* However, Dr Hamilton also accepted that post Dr Bawa-Garba there is a climate of fear amongst medical professionals.

The review is expected to report in spring 2019 and is considering the following issues:

1. Post incident, pre-criminal investigation – this will include the quality of investigations, the distinction between errors and 'truly and exceptionally bad' failings and the lack of corporate manslaughter prosecutions being brought.
2. Inquiries by the coroner – including learning points, avoidable delays in the process and the role of medical experts.
3. Police investigations and decisions to prosecute – whether there is the necessary support to enable fully informed choices, whether there are any factors which may need

to be taken into account and the proportionality and appropriateness of cases being referred to the criminal justice system.

4. The use of medical experts in criminal investigations and proceedings
5. The professional regulatory process, including the meaning of public confidence, whether there should be more clarity in relation to GMC guidance and the extent of support available for medical practitioners.
6. Employment and support – including how to encourage a learning culture and the availability to continue working whilst there are criminal and regulatory matters outstanding as well as the provision for supervision and training.

Coupling the terms of reference for the review and the factors to be considered when sentencing under the new guidelines it is clear that the focus is shifting to consider the 'seriousness' of clinical errors and the need to explore the context within which such errors occur. Those who are the subject of investigations, or are being prosecuted for offences, should therefore ensure that evidence is obtained as to the context and circumstances within which the alleged crime arose and should commence reflection and work on remediation at the earliest possible stage.

Therefore, when a prosecution is successful, the sentencing guidelines are more stringent, but it remains to be seen whether the outcome of the GMC review will result in fewer decisions to charge and matters instead being dealt with by the regulator.

About BLM

BLM is the leading insurance and commercial risk law specialist in the UK and Ireland. With a turnover of over £100million, we advise insurers, Lloyd's syndicates, MGAs, brokers, corporate policyholders, professional indemnifiers and other market organisations

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DOCTORS' SCOPE OF DUTY FOR WRONGFUL BIRTH: AN ANALYSIS OF DR HAFSHAH KHAN V MNX [2018] EWCA CIV 2069

Jonathan Godfrey, Barrister, Parklane Plowden Chambers, Leeds and Newcastle

On 23rd November, 2018 the Court of Appeal handed down judgment overturning the decision of Mrs Justice Yip in MNX v Dr Hafshah Khan [2017] EWHC 2990 (QB).

The Facts

The Respondent's nephew had been born in January 2006 and was subsequently diagnosed with haemophilia. The Respondent wished to avoid having a child with that condition and so consulted her GP in August 2006 to ascertain whether she carried the haemophilia gene. Blood tests were arranged. The tests were to confirm whether the Respondent had the condition and not if she was a carrier of the gene. In order to determine her position, the Respondent would have had to be referred to a haematologist for genetic testing. On 25th August 2006, the Respondent saw the Appellant to discuss blood tests and was told that the results were normal. As a result, she was left to believe that any child she had would not have had haemophilia.

The Respondent became pregnant with FGN in 2010 and shortly after birth he was diagnosed with haemophilia. The Respondent was referred for genetic testing which confirmed she was a carrier of the haemophilia gene. Had the Respondent been referred for genetic testing in 2006 she would have known she was a carrier of the gene before she became pregnant and she would have undergone foetal testing for haemophilia, which

would have revealed that the foetus was affected. In these circumstances, the Respondent would have terminated the pregnancy and FGN would not have been born.

In December 2015 FGN was diagnosed with autism. The fact that FGN had haemophilia did not cause his autism or make it more likely that he would have autism.

The Appellant admitted that, but for her negligence, FGN would not have been born as his mother would have properly discovered during her pregnancy that he was afflicted by haemophilia and she would have undergone a termination of the pregnancy. The issue at trial before Mrs Justice Yip was whether, as a matter of law, the Appellant's liability was limited to the additional losses associated with FGN's haemophilia or whether she was liable for the additional losses associated with both his haemophilia and autism.

By an order dated 8th February 2017 the Appellant consented to judgment being entered on the basis of the allegations of breach of duty and causation as set out in the Particulars of Claim. Prior to trial the parties reached agreement in relation to quantum on the basis that:

1. If the court determined that the Appellant was liable for the additional losses associated with FGN's haemophilia and rejected the Respondent's claim that the Appellant was also liable to the additional losses associated with FGN's autism, quantum was agreed in the sum of £1,400,000. These losses would have applied for wrongful birth due to disability having regard to Parkinson v St James' & Seacroft University Hospital NHS Trust [2002] QB 266 and Groom v Selby [2002] PIQR P18.
2. If the court determined that Appellant was liable for the additional losses associated with FGN's haemophilia and autism, quantum was agreed in the sum of £9,000,000.

Mrs Justice Yip found that the Respondent was entitled to damages in respect of bringing up FGN due to his haemophilia and that she was also entitled to the additional costs in relation to FGN's autism, albeit that it was an unrelated condition. On a simple application of the "but for" test of causation the costs flowed from the negligence, as FGN would not have been born. Damages, therefore followed in the sum of £9,000,000 as per the agreement reached as between the parties.

The Court of Appeal

The Appellant appealed with permission granted by Mrs Justice Yip on the basis that in finding that she was liable for damages associated with both FGN's haemophilia and autism, Mrs Justice Yip had misapplied the scope of duty test set down by Lord Hoffman in South Australia Asset Management Corpn v York Montague Ltd [1997] AC 191 (Hereinafter "SAAMCO"). The reasoning behind the test is that in order to protect a defendant from liability for every foreseeable factual consequence of their negligence the courts have placed an additional test on the consequences of a breach that are considered to be within the appropriate scope of the defendant's liability, namely the requirement that the particular loss claimed must be within the "scope of duty". The Appellant had not undertaken to provide any information or advice about the risks of autism, and the negligence had not contributed to the autism.

The leading judgment was given by LJ Nicola Davies DBE.

The Court of Appeal determined that the SAAMCO "scope of duty" test was relevant and determinative of the issues in the case. Given the limits of the advice sought by the Respondent and the appropriate testing, Mr Maskrey QC on behalf of the Appellant, identified three questions that it was for the court to address:

1. The purpose of the procedure and/or information that was alleged to have been negligent;
2. The appropriate apportionment of risk taking into account the nature of the advice, procedure and information; and
3. The losses which would in any event have occurred had the correct information been given or the procedure performed?

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Davies LJ found that:

1. In the Respondent's case the purpose behind the consultation was to allow her to make an informed decision in respect of any child that she may subsequently conceive and who was carrying the haemophilia gene. The specific enquiry was related to whether any future child would carry the haemophilia gene, therefore it would be inappropriate and unnecessary for any doctor to volunteer any other additional information about the risks of pregnancy, including that of autism.
2. In terms of the apportionment of risk that would be split as between the risks of the Respondent giving birth to a child with haemophilia due to no foetal testing and thereby no termination of pregnancy, as against the risks to her of all other potential difficulties of the pregnancy and birth both as to herself and the child
3. The loss that would have been sustained had the correct information and testing been given and performed is that FGN would have been born with autism.

The scope of the Appellant's duty did not extend to all the risks of pregnancy and the continuation with pregnancy. The Appellant had no duty to prevent FGN's birth. This was a decision that could only be made by the Respondent taking into account a multiplicity of factors, such as her ethical views, her willingness to accept the risks associated with pregnancy and was outside the limits of any advice/treatment sought from the Appellant. It had not been part of the Respondent's case that the Appellant had a duty to advise more generally in relation to the risks of any future pregnancy. The risk of autism was not increased by the Appellant's advice, "the purpose and scope of her duty was to advise and investigate in relation to haemophilia in order to allow the Respondent the opportunity to avoid the risk of a child being born with haemophilia".

In reaching the conclusion that she did namely that the Appellant should be liable for a type of loss that did not fall within the scope of the Appellant's duty to protect the Respondent against, Mrs Justice Yip was said to have reverted the "but for" causation test and not the appropriate SAAMCO "scope of duty test". The SAAMCO test required there to be an adequate link between the actual breach of duty and the loss claimed. In this context, Davies LJ stated that "It is insufficient for the court to find that there is a link between the breach and the stage in the chain in causation, in this case the pregnancy itself, and thereafter to conclude that the Appellant is liable for all the reasonably foreseeable consequences of the pregnancy". In finding that the Respondent was deprived of the opportunity to terminate the pregnancy, reference was had to one of the chains of causation, whereas SAAMCO required that the link had to be between the scope of duty and the damage sustained. "In the context of this case the development of autism was a coincidental injury and not one within the scope of the Appellant's duty".

The most appropriate analogy of the co-incidental injury and not one within the scope of the Appellant's duty is that identified by Lord Walker in Chester v Afshar [2005] 1 AC 134 where he stated:

"If a taxi driver drives too fast and the cab is hit by a falling tree, injuring the passenger, it is a sheer coincidence. The driver might equally well have avoided the tree by driving too fast, and the passenger might have been injured if the driver was observing the speed limit…".

Comment

Mrs Justice Yip had reverted to the "but for" test of causation when in fact she ought more properly to have applied the "scope of duty" test applied in SAAMCO. The scope of the duty was narrow. It was limited to whether the Respondent was a carrier of the haemophilia gene and did not extend beyond that. The distinction as between this case and Parkinson and Groom was that there was no duty to prevent the pregnancy. The case has important ramifications as to the scope of duty to be applied in wrongful birth cases.

CQC BARES ITS TEETH: A REVIEW OF THE DUTY OF CANDOUR 4 YEARS ON

Laurence Vick, Legal Director, Enable Law, Laurence.vick@enablelaw.com, @LaurenceVick

In January 2019 the CQC announced that Bradford Teaching Hospitals NHS Foundation Trust had become the first NHS Trust in England and Wales it had prosecuted for failing in its duty of candour. The case related to a baby who died after being admitted to Bradford Royal Infirmary in July 2016. Although the Trust had recorded the baby's care as a Notifiable Safety Incident – triggering the operation of the duty of candour – the family were not informed of this and did not receive an apology or explanation until October of that year.

The CQC guidance document 'Regulation 20: Duty of Candour March 2015' clarifies that the duty of candour applies to all 'unintended or unexpected incidents' if they result in the requisite level of harm, even if they are a recognised (and consented) complications of the treatment. There doesn't have to be a failing in the care provided.

This prosecution is a sign that the CQC is beginning to flex its muscles to ensure compliance with certain minimum standards – standards below which care must never fall - and serves as a reminder that healthcare providers must be open and transparent with patients and their families when something goes wrong and they must do so in a timely manner. The fixed penalty notice of £1250 was equivalent to 50% of the maximum fine of £2500 a court could have imposed under the CQC's powers granted in 2015 to prosecute breaches of the Fundamental Standards including the duty of candour introduced after the Mid Staffordshire scandal.

The CQC's chief inspector of hospitals, Professor Ted Baker, said: "The action that we have taken against Bradford Teaching Hospitals does not relate to the care provided to this baby, but to the fact that the Trust was slow to inform the family that there had been delays and missed opportunities in the treatment of their child. Patients or their families are entitled to the truth and to an apology as soon as practical after the incident, which didn't happen in this case."

A reminder that candour is derived from the Latin candor, meaning dazzling whiteness or brilliance, with connotations of honesty purity innocence and a current meaning of frankness and openness.

So how is the duty of candour working and being applied in practice now that we have passed the fourth anniversary of its application to all healthcare providers?

The CQC has faced criticism in a number of recent reports over how it is policing compliance.

CQC duty of candour inspections 'inconsistent' and 'often superficial'.

A 2016 study carried out by Action against Medical Accidents (AvMA) published on the National Health Executive website on 8 August 2016 found that CQC duty of candour inspections were "inconsistent" and "often superficial." A quarter of CQC inspection reports included little or no evidence to show that the regulator was taking steps to ensure that NHS Trusts improved compliance, and 7% of reports did not refer to duty of candour at all. AvMA's research, which analysed 90 CQC reports of inspections of NHS trusts in 2015, revealed that nearly two-fifths of CQC reports contained criticism of how a Trust was implementing the duty, but only 14 of these went on to make a recommendation to improve. Where recommendations had been made to improve implementation the CQC was unable to "provide a single example" of a Trust having responded with details of the action they would take.

AvMA chief executive Peter Walsh said: "Having fought so hard to get a statutory duty of candour, we are deeply disappointed about how the CQC has regulated this so far. We still believe the duty of candour is potentially the biggest breakthrough in patient safety and patient rights in modern times, but we have always said that its success will depend to a large extent not only on the goodwill of providers, but on robust regulation by the CQC."

Responding on behalf of the CQC Professor Ted Baker said AvMA's review had looked at CQC's assessment of the duty of candour requirement placed on NHS Trusts during (only) the first year of the regulation coming into force. Over this period the CQC had focused on Trusts' awareness of the new duty and the systems and processes they were putting in place to support its implementation. From these early inspections the CQC had identified the need for a more systematic approach to inspecting how well organisations were embedding the duty as part of their broader approach to learning from incidents and supporting people who use services and their families. The CQC had since developed their methodology - with input from AvMA - and this was now allowing them to follow a more robust and consistent approach in assessing compliance with the regulation as part of their hospital inspections http://www.nationalhealthexecutive.com/Health-Care-News/cqc-duty-of-candour-inspections-inconsistent-and-often-superficial (8.8.16)

CQC Review: Failings in the way the NHS reports and investigates patient deaths

Later in 2016, the CQC published a report following a large scale review of deaths of patients in acute community and mental health care at NHS Trusts. Although the report centres around deaths of the elderly with acute mental health needs, the findings were relevant throughout the NHS. The CQC found that families were often left in the dark when a patient dies; unsure of where to find answers and have a poor experience of reviews and investigations; they are not always treated with sensitivity and feel overwhelmingly that the Trust is trying to 'delay, deny, defend'. The quality of investigations was criticised – those appointed to lead them were often untrained, the communication is poor and there was often confusion about timelines and guidance.

The report called for Trusts to make full and honest apologies and to listen to the concerns of families who should be 'meaningfully involved' in investigations. Trusts need to learn from their mistakes, clinically and administratively. Training should be cascaded throughout agencies, allowing a seamless multi-disciplinary approach. Changing the culture is imperative.

Deborah Coles, Director of INQUEST and member of the expert advisory group to the CQC Review, said: "This report must be a wakeup call and result in concrete action. It ratifies what INQUEST and families have been saying for years. There is a defensive wall surrounding NHS investigations, an unwillingness to allow meaningful family involvement in the process and a refusal to accept accountability for NHS failings in the care of its most vulnerable patients.
https://www.cqc.org.uk/news/releases/cqc-calls-action-end-missed-opportunities-learn-patient-deaths (13.12.16)

CQC 'cannot be relied on' to enforce the duty of candour.

More recently, a further analysis carried out by AvMA, reported on by Shaun Lintern in the Health Services Journal on 2 October 2018, concluded that the CQC 'cannot be relied on' to enforce the duty of candour. Although they felt that auditing the process for compliance with the duty should be relatively simple AvMA found there was a problem with regard to checking the factual accuracy of statements made to patients and families; the CQC having said they do not investigate individual cases it was difficult to see how they could be in a position to verify this.

The trend towards further prosecutions

New CQC chief executive, Ian Trenholm, confirmed in November 2018 that his organisation would be taking a tough stance on bringing prosecutions where Trusts breach the Fundamental Standards. The CQC would be carrying out more criminal investigations and had hired experienced staff to review evidence in 31 prosecutions under consideration. This reflects an increasing trend to prosecute providers where they have failed to provide safe care and treatment resulting in avoidable harm, or a significant risk of exposure to avoidable harm to a service user.

The first criminal prosecution of Mid Staffs NHS Foundation Trust (by the HSE under the Health and Safety at Work Act 1974) over events at Stafford between 2005 and 2008 was announced in 2013 regarding the death of a patient with diabetes who fell into a coma after staff failed to give her insulin.

In October 2017 the CQC prosecuted Southern Health Trust for failing to provide safe care to a patient who suffered serious injuries falling from a roof. The Trust had taken "no effective action" to prevent patients accessing the roof, despite previous safety incidents, and were fined £125,000 and ordered to pay £36,000 costs. The same Trust was fined £2m in March 2018 after an HSE prosecution over the 'entirely preventable' deaths of Connor Sparrowhawk and Teresa Colvin

In March 2019 the CQC prosecuted Sussex Partnership NHS FT in a case involving a 19-year-old man found dead from hanging in his cell in the healthcare unit of HM Prison Lewes, East Sussex.

Background to the duty of candour: seeking the truth after the Bristol heart scandal

In 2001, the report of the Public Inquiry into children's heart surgery at Bristol at which I jointly represented the parents of children who died or survived but suffered neurological and other injuries after undergoing operations in the 1990s, found serious, systemic failures at a unit that had clothed itself in a 'club culture' of wilful blindness to safety concerns and poor practice, with staff closing ranks to protect their colleagues.

Then as now, patients and families seek information and explanations if treatment has failed. This is not 'hospital complaint' territory. It should not have been left for lawyers, with the benefit of expensive expert reports - as it was when we pursued these cases through the courts – to have to explain to grieving parents what really happened to their child. Sadly it is only through the expensive, often long-winded litigation process that patients and their families learn the truth.

Unique in my 30 years' experience of handling clinical negligence claims was the fact that a number of parents hoped that our experts would not be able to find negligence and that their claims would fail. Those who sought explanations after their children died had received limited explanations from the surgeons. In most cases, parents only came forward in response to the news reports around the time of the GMC hearings in 1998 and the Public Inquiry that began a year later. Letters to parents from the Trust's new Chief Executive were written in sympathetic, compassionate tones but, as he was relying on medical and surgical staff still at the hospital for his information, they were of little benefit. The hospital sought to explain that the surgeons had encountered unexpected presentations of the children's particular defects or abnormal anatomies that could not have been foreseen. The letters attempted to deflect blame from the surgeons, cardiologists and other members of the team.

Parents were given no insight into the experience of the surgeons and their medical support team. Before surgery, they had been given optimistic success rates in the various procedures, which reflected national but not local experience. They were not given the choice of a second opinion or a referral to another centre with a superior safety record. None of the 25-30 sets of parents of children who had suffered brain damage over the 10-year time span covered by the Inquiry were, to my knowledge, offered any explanation, even though they had to return to Bristol for their children's continuing cardiology care. We referred to these unfortunate parents and children as the 'forgotten families'.

The need for a duty of candour became obvious after Bristol: a duty on doctors and hospitals to report untoward incidents and to raise concerns. The Kennedy report recommended that doctors should also, if necessary, blow the whistle on failings and incompetence of colleagues or if they are aware of safety concerns within their hospitals, with proper legal safeguards to protect them from dismissal or victimisation if they have cause to take action.

Following publication of the Kennedy report, the Chief Medical Officer at the time, Sir Liam Donaldson, demanded that doctors should admit to patients when an error in their surgery had occurred. Recommendation 12 of his 2003 Making Amends consultation report stated:

"A duty of candour should be introduced together with exemption from disciplinary action when reporting incidents with a view to improving patient safety."

The appalling scandal that then emerged at Mid Staffs demonstrated that the lessons of Bristol had not been learned. The report of 2013 following the public inquiry chaired by Robert Francis QC was the fifth official report and Francis's second into the failings at Stafford. There had been major problems at all levels, including a culture of bullying and a lack of governance on the part of the Trust. Worryingly high mortality data had not been made available to patients and their families before they received treatment. Reminiscent of the Kennedy Bristol recommendations was Francis's call for a statutory duty of candour, placing a legal obligation on professionals and organisations to be honest with patients and their families regarding incidents which have resulted in medical harm.

The post-Francis review 'A promise to learn – a commitment to act', led by Professor Donald Berwick published in August 2013 included a number of recommendations for the NHS: embracing a culture of learning, placing quality at the top of priorities and making sure that patients are present, powerful and involved.

Then Health Secretary, Jeremy Hunt, commissioned the Dalton-Williams 'Building a Culture of Candour' review. The report published in March 2014 proposed that 'when things do go wrong, patients and their families expect three things: to be told honestly what happened, what can be done to deal with any harm caused, and to know what will be done to prevent a recurrence to someone else. Health and care organisations have a responsibility to ensure that all of these are reliably undertaken'.

Addressing how a duty of candour should be framed Professor Williams recommended that: 'A willingness to be open with patients must also include honesty about organisational problems that may have contributed to harm, such as losing notes, problems with discharging patients or poor management of resources'.

The reaction to this report was seen as the first indication that the push towards a duty of candour could be jeopardised by the Government's desire to prevent what they feared would be a deluge of litigation from patients who, armed with evidence that they might have suffered avoidable harm, would now grasp the opportunity to sue for compensation. AvMA's Peter Walsh responded: "(this is) misconceived and grossly unfair. You get to know the truth but you can't do anything with it".

Some commentators argued that introducing a statutory duty of candour was unnecessary as doctors have always had an ethical duty to be candid with patients when things go wrong. For over 50 years the MDU has advised members to tell patients when things go wrong, to put things right and to apologise. The ethical duty is set out in unambiguous terms in GMC guidance. Clearly, however it was thought that more needed to be done to ensure compliance.

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A contractual duty of candour as a service condition of the NHS standard contract was introduced in April 2013, by which all NHS and non NHS providers of services to NHS patients under the NHS standard contract must disclose cases of 'moderate' and 'severe' harm or death. Francis, however, had called for a direct obligation to patients and their families and not just to NHS Commissioners in the form of a statutory duty of candour.

The statutory duty of candour and the 'fit and proper person's requirement' for directors were introduced for NHS bodies on 27 November 2014. This was extended on 1 April 2015 to cover all other health and social care providers registered with the CQC including GPs and independent healthcare providers to the NHS.

A generation later, how has the duty of candour affected the position in children's heart surgery?

There have been improvements and cardiac units across the country continue to achieve incredible outcomes for young children with life-threatening conditions, but in some ways little has changed in since the 1990s. Parents of a child with a certain complex defect may not be informed as part of the consenting process that another unit is well known as having significantly greater expertise in the corrective surgery for that lesion and achieve better outcomes in terms of lower mortality rates and a lower incidence of, and ability to deal with, post-operative complications.

What can parents expect from the duty of candour if their child has undergone surgery at a unit that lacked expertise in this procedure? They may be given a frank explanation of why their child died, or why he or she suffered complications, but in the same way that they should have been informed of the facts and options before surgery, shouldn't they be informed that there may have been a quite different outcome if their child had been operated on at another centre with a superior safety record?

The failure to disclose this kind of information after a child has died, or survived with neurological damage, whether or not avoidable, is not going to satisfy a parent's understanding of what they can expect from the duty of candour. Families choosing a cardiac centre often struggle to interpret the data to make properly informed decisions about units and surgeons. The availability of readily understandable data to enable parents to make an informed choice is surely a facet of a wider duty of candour across the wider NHS. Although research is being undertaken on non-fatal outcomes and how morbidity information can be collected and made available to rectify this, it is unsatisfactory that the only data available is limited to 30 day mortality.

Whilst being open and honest is second nature to the vast majority of doctors, there are pressures which may have the (unintended) consequence of making doctors reluctant to admit that errors have taken place. If the duty of candour is to have its full meaning, I believe a patient must be informed of the part that the known incompetence of a surgeon or lack of essential resources and appropriate specialist experience has played in the adverse outcome? But can doctors employed by a Trust be as frank as they would wish if the Trust may risk censure or a negligence claim if it is found to have provided inadequate care?

What should the duty entail if harm has been suffered against a background of a pending investigation into concerns over a particular doctor or surgeon or where a whistleblower has raised concerns over lack of resources or systemic problems at the unit where the treatment was carried out or where the surgeon lacked experience in the operation performed? Any of these factors individually or collectively might have played a part in causing a notifiable safety incident.

Although there has been a significant improvement in the culture within the NHS since Bristol, scandals continue to occur. Blowing the whistle still appears to be regarded as career suicide and whistleblowing doctors continue to be suppressed and victimised, yet the suspicion is that the human misery and financial cost of the scandals that continue to emerge could have been avoided if warnings had been heeded.

Much of the guidance from professional bodies when the duty of candour was introduced appeared to focus on the 'say sorry but don't admit blame or acknowledge fault' mantra and the fear was that compliance would become a box ticking exercise, with the use of template letters providing formulaic responses. My concern after representing patients and seeing many who have had to pursue endless journeys of discovery to establish 'the truth' was that they would not be content with explanations that satisfy the wording of the duty but would not deliver what they expect in accordance with what I believe was the intended spirit of the duty. We are in a post-Montgomery era of increased patient autonomy and greater degree of transparency is expected. The quality and extent of the information that is required to be given before treatment is not matched by the information received by the patient after he has undergone treatment that may have resulted in harm.

The position of the healthcare provider

For their part, healthcare providers have complained of an inconsistent approach by the CQC and uncertainty over the regulations and the requirements of the duty. The Bradford case may have been a particularly egregious example of a failure to comply. We don't know all the details. If this case does represent an increasing trend on the part of the CQC to crack down on non-compliance, it remains to be seen whether providers will seek to rely on any lack of certainty - a requirement of the 'rule of law' - to defend further Regulation 20 prosecutions.

Some have questioned what a financial penalty on an NHS body can achieve. The maximum fine of £2,500 is comparatively small but the reputational damage is something Trusts and other providers will wish to avoid and in the future we may even see the CQC revoking a provider's registration.

SKIN CAMOUFLAGE SERVICES®
Independent Private Practice

IN CONVERSATION
WITH **VANESSA JANE DAVIES** OF SKIN CAMOUFLAGE SERVICES

Tell us your background and why you decided to set up Skin Camouflage Services?

I was invited to be part of a funding venture at a GP Practice in Yorkshire back in 1993 which involved managing and setting up the first skin camouflage clinic in North Yorkshire. Over the years this led to many rewarding experiences that supported patients who had encountered Scarring, Vitiligo, Rosacea and Melasma.

Parallel to this I introduced Skin Camouflage as a Higher Education degree module which in turn led to the development of teaching materials for both FE and HE education. As my educational career developed, I had the privilege of performing the role as examiner both in the UK and overseas culminating as a Higher Education Module Writer in skin camouflage for Edexcel.

In 1995 I joined the Skin Camouflage Network and became a committee member in 1997. This position offered the opportunity to be part of the accredited skin camouflage qualification with University of Hertfordshire and to offer support with study days and updates with SCN members.

My skin camouflage training for the British Army has been a great experience and my work continues to this day supporting Army referrals. Our 'clinic wrap around service' which originally began with our rehabilitation patients now extends across all our clinical practices.

Skin Camouflage Services achieved the Harley Street licence to practice in 2007. No actual 'services' existed other than skin camouflage alone, so it was a natural step to create a business name that encompasses my background and our range of services...in the categories of Expert Witness Services, Rehabilitation Assessments and Clinical Consultancy. The name Skin Camouflage Services has remained the focus of my business and is respected and recognized both in private and NHS practice.

Skin Camouflage Services have since opened four additional clinics with three BMI Healthcare Hospitals playing a pivotal role in the expansion of my company. My work in this profession has now spanned over 25 years and I have earned the position of vetted Expert Witness and Skin Camouflage Consultant which I hope reflects my journey from my humble beginnings all those years ago.

In 2019 we are delighted to be working with a number of great charities, collaborating with the University of Sussex and connecting with Business Innovation to improve access to Skin Camouflage treatment and products across the UK. Exciting times ahead!

What is skin camouflage and what conditions can it help?

Skin camouflage is the skilled application of highly pigmented creams to areas of skin discolouration or scaring to even out skin tones and improve the aesthetic appearance of a person's skin.

Skin camouflage can be of help to men and women and children of all ethnicity, enabling individuals manage their appearance where there is a visible skin difference whether congenital, dermatological or as a result of trauma. This is often a major step forward, both physically and psychologically.

Do clients need a referral?

Patients can self-refer via our website or they can request a private referral via their GP, surgeon or psychologist as part of their treatment choice.

Tell us more about your work with UKTI to introduce Skin Camouflage?

Our work with UK Trade & Investment (OMIS) was to introduce skin camouflage to the burns units in hospitals in Perth Western Australia. This was a turning point when we were selected as a UKTI business case study. International referrals particularly from London embassies began and we became recognised for our clinical expertise with burns for men, women and children. This area of our work has become the driving force to expand our patient services with scar therapy management.

What expert witness services do you provide and what makes you different?

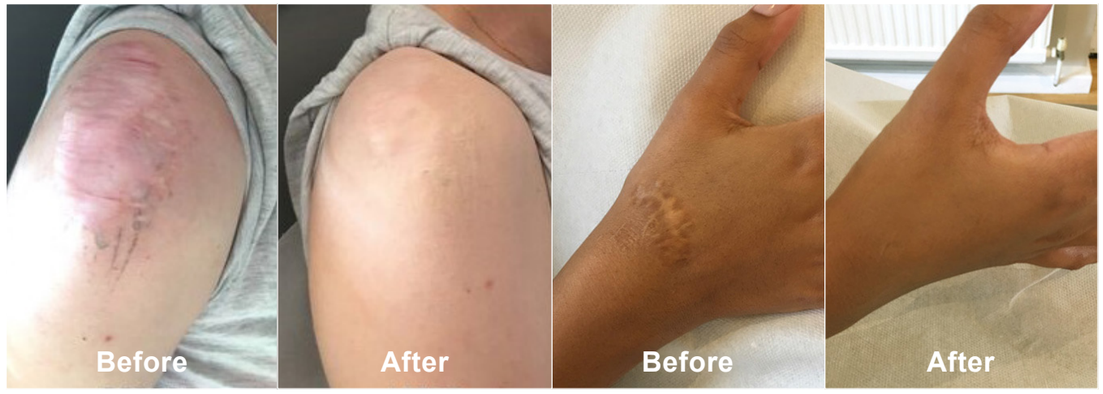
We provide a full range of expert witness services including reports for personal injury, clinical negligence and cost reports for rehabilitation. Essentially 25 years of professional para medical skin camouflage experience sets us apart. We form our opinion from 'repeated clinical practice' of multiple site injuries, burns including chemical, fire, hot liquids and electricity, pigmentation and traumatic scarring of all origins including dog attacks and self-harm. Our report writing has been professionally recognised since 2007 and is vetted every year.

Our expert witness reports are CPR compliant and provide quantum expertise. Expert witness training, CPD with Bond Solon and the Expert Witness Institute, GDPR compliance along with our long-standing expert witness memberships offer the best possible practice in providing professional medico-legal opinion in skin camouflage treatment.

UK Register of Expert Witnesses – Registered

EXPERT WITNESS INSTITUTE – Individual Member

APIL 1st tier expert



How is your Harley Street Clinic different from your other clinics?

Our Harley Street Clinic is different in that we see more International patients. We liaise with Embassies, arrange interpreters and chaperones where required. However, all our clinics have one important thing in common, to find the best skin camouflage solution possible.

REDEFINING THE REHABILITATION MODEL

Jules Leahy and Toria Chan, STEPS Rehabilitation, Sheffield

STEPS Rehabilitation is a state-of-the art, purpose-built rehabilitation facility in Sheffield. Since opening its doors in 2017 it has quickly established itself amongst the legal sector as the 'go to' rehabilitation facility for seriously injured clients looking for high quality rehabilitation care.

But what sets the centre apart? What impact does this have on a client's recovery? In this article, Founding Directors, Jules Leahy and Toria Chan explain how STEPS is striving to set new standards of best practice when it comes to rehabilitation by embracing an inter-disciplinary and holistic approach to achieve better results.

Whatever the circumstances of a person becoming severely injured, all are united by a common goal: to return, as near as possible, to pre-injury activity and independence levels. Experience has shown the team at STEPS that because each client's needs are unique, for rehabilitation to be as effective as possible, their rehabilitation programme must be unique too.

The medical and rehabilitation needs of a seriously injured client can be complex and wide ranging. STEPS see first-hand the benefits clients derive from having an inter-disciplinary team (IDT) approach to rehabilitation. Every aspect of the rehabilitation needs of an individual must be carefully assessed and managed by medical and therapy experts working across a range of specialisms.

STEPS provide a wide range of treatments and therapies to clients who have suffered brain and spinal injuries. It is also the only residential rehabilitation centre for amputees in the UK – working closely with Blatchford and often dealing with insurers directly – to provide a comprehensive amputee rehabilitation programme from casting of the prosthetic limb to fitting and subsequent rehabilitation.

They are one of only a very small number of specialist rehabilitation facilities who can treat clients with complex injuries under one roof, rather than clients being required to attend multiple centres to treat different aspects of their condition. This allows all the professionals who make up the IDT to collaborate more easily to deliver the very best rehabilitation programme possible, this in turn means that clients are better engaged in the whole process which helps achieve optimum results.

Take the case of a teenage boy injured in an accident who was told there was nothing further that could be done for him and was referred to STEPS to be *"cared for"* whilst his home was adapted. He arrived in a low awareness state with no purposeful movement, doubly incontinent and with a tracheostomy. After assessment and a comprehensive rehabilitation programme, one year on he can walk, talk, eat and is making positive progress with his bladder and bowel regime.

Lawyers who refer seriously injured clients to STEPS recognise not just the benefits that early and interdisciplinary rehabilitation has on their clients, but also the added benefits of taking a holistic approach to the care. *"It's our holistic approach that really sets us apart"* says Director, Toria Chan. *"Our ethos is to look after the person as a whole and not just think about clients in typical rehabilitation terms."*

This means appreciating the important role that families play, encouraging family members and friends to get involved in 'normal' activities such as cooking together, playing games and sharing mealtimes. *"We have a high-ratio of staff to clients which enables us to respond to client requests and run organised activities in the evening and over weekends"* says Managing Director, Jules Leahy. *"Things don't stop at the end of a normal working day."*

Ed, a doctor who was severely injured in a cycle accident and a residential client says: *"STEPS have a totally different philosophy. It's about improving my quality of life in as many ways as possible. Staff are well trained, have a positive 'can-do' attitude, and a willingness to try anything. STEPS have humanised me again."*

The girlfriend of one client explains, *"STEPS are passionate about including family members in the care of individuals and I love that about them. I can see just how well all the therapists, doctors and nurses collaborate and the positive impact this has on the treatment and recovery of clients."*

This modern approach to rehabilitation not only improves outcomes for clients but does so in a timelier and cost-effective manner than traditional methods. The traditional model can be disjointed, prolongs rehabilitation and invariably increases costs of rehab and litigation.

MEDICO LEGAL CONFERENCE 2019

AGENDA

Thursday 16th May 2019
Queen Elizabeth II Conference Centre, Westminster, London

Badge Collection & Refreshments from 8.45

Welcome and Introduction From the Master of Ceremonies
Jonathan Godfrey, Barrister, Parklane Plowden

Keynote Address
Sir Rupert Jackson, retired Justice of the Court Of Appeal of England and Wales

Learning From Litigation
Mr Amar Alwitry, Consultant Ophthalmology, Leicestershire Partnership NHS Trust, Safety and Learning Special Advisor, NHS Resolutions

A Better Way to Resolve Claims and Complaints
Peter Causton, Barrister, Solicitor, Mediator, Deputy District Judge

Refreshments & Networking

Fundamental Dishonesty
Kerry Underwood, Senior Partner, Underwoods Solicitors

Lack of Effort, Deliberate Underperformance or Simply Malingering: Determining Claimant's Behaviour in Neuropsychological Assessment
Professor Gus Baker, Consultant Clinical Neuropsychologist, The Walton Centre NHS Foundation Trust

Mesh in Gynaecology
Mr Simon Jackson, Consultant Gynaecology, Oxford University Hospitals NHS Foundation Trust

Diagnosis of Sepsis - The History and Pitfalls
Dr Chris Danbury, Consultant Intensive Care Medicine, Royal Berkshire NHS Foundation Trust

Lunch & Networking

Gross Negligence Manslaughter in Healthcare – Debunking the Myths
Shannett Thompson, Senior Associate , Kingsley Napley

How to Avoid Traps For the Unwary Medico-Legal Witness When Providing Expert Evidence
David Stothard, Managing Director MAPs Medical

How to Be a Better Medical Expert: 5 Top Tips
Paul Sankey, Partner, Enable Law

Refreshments & Networking

Ian Paterson Breast Surgeon - The Lessons to Be Learnt
Linda Millband, Head of Clinical Negligence, Thompsons Solicitors

The Scottish Perspective on Montgomery and Informed Decisions
Ann Logan, Partner, Balfour+Manson LLP

Post Montgomery: Where Are We Now?
Olive Lewin, Partner, Leigh Day

The Shape of Things to Come
Professor Dominic Regan, Medical Decisions Ltd

Closing Comments

Champagne Reception and Networking

Close 18.30

Programme may be subject to change

www.medicolegalconference.com

Medico-Legal Conference 2019 - Speakers

SIR RUPERT JACKSON, KEYNOTE SPEAKER

Sir Rupert Jackson joined chambers in 1973 and practised here until 1998, specialising in professional negligence, insurance and construction work. He became a QC in 1987. During his practice at the Bar, Sir Rupert appeared as counsel in both domestic and international arbitrations, principally in London and Hong Kong. He also sat as arbitrator. Sir Rupert and John Powell QC jointly wrote Jackson & Powell on Professional Negligence, which first appeared in 1982. That work is now in its eighth edition, entitled Jackson & Powell on Professional Liability, with contributions from many members of chambers. It is the leading textbook in the field. He was a judge from 1999 to 2018, but is now back in chambers as an arbitrator.

JONATHAN GODFREY, MASTER OF CEREMONIES

Jonathan specialises almost exclusively in clinical negligence work as his repeated recommendations in the Legal 500 attest. His expertise covers the whole breadth of clinical negligence work including orthopaedic injury, cancer misdiagnosis, cerebral palsy birth injury, surgical mishap and wrongful treatment and consent. Jonathan also undertakes cases concerning negligence and/or assault in football, rugby and other sporting activities. He has been specifically recommended by the Legal 500 as being an "expert in sports related injuries". Jonathan has considerable and invaluable experience in conducting conferences with medical experts of all disciplines and often on a multi expert basis. Jonathan regularly undertakes JSM's and in doing so has achieved very favourable and high value settlements.

MR AMAR ALWITRY

Consultant Ophthalmologist with Masters in Medical Law. Published more than 35 pieces in world literature and author of three text books.

PROFESSOR GUS A BAKER

Over 25-years experience in Clinical Neuropsychology spent equally between Clinical Research and Clinical Practice at the University of Liverpool and The Walton Centre of Neurology and Neurosurgery. Fellow of the British Psychological Society and recipient of BPS Lifetime award, Lord Hastings Award and the Barbara Wilson Award for outstanding contributions to Clinical Neuropsychology. Author over 240 books chapters and papers on relevant subjects. Presented papers and workshops in 53 countries. Over 20 years of providing expert neuropsychological reports for the Court Recognised expert witness with APIL [Association of Personal Injury Lawyers], Expert Witness Institute and BPS. Chair of the Professional Standards Unit for the BPS Division of Neuropsychology. Author of the BPS Guidelines for effort testing in Clinical Practice.

Medico-Legal Conference 2019 - Speakers

PETER CAUSTON

Peter is a solicitor advocate who is also a Civil Mediation Council Registered Mediator and runs a CMC Registered Mediation Provider and Mediation Training Provider, ProMediate (UK) Limited. ProMediate offers Mediation in civil disputes and is accredited by the CMC to train mediators through its courses. Peter is a very experienced mediator appointed to the Court of Appeal Pilot Panel. His ADR business, ProMediate, is certified by the Chartered Trading Standards Institute under the ADR Regulations to deal with Consumer disputes about goods and services. He is also a deputy District Judge on the Northern Circuit. He sits on the Law Society Council. Peter set up and is treasurer of the United Kingdom Association of Fee Paid Judges. He runs the Manchester Mediation Pilot. He has worked at various national law firms including Browne Jacobson, Hill Dickinson and BLM.

CHRIS DANBURY

I have almost 30 years experience in managing critically ill patients, with over 15 years of them as a consultant in intensive care. After gaining an M.Phil in Medical Law, I was offered a personal appointment as Visiting Fellow in Health Law by the Senate of the University of Reading and have lectured on the LLB for over 12 years. I am an experienced expert witness and give oral evidence regularly, particularly in the Court of Protection. I am also an experienced mediator, specialising in healthcare mediation – clinical negligence and serious medical treatment.

SIMON JACKSON

Consultant Gynaecologist working in Oxford. NHS and private surgical practice. Specialises in Urogynaecology (prolapse and incontinence) and laparoscopic gynaecology.

OLIVE LEWIN

Olive Lewin is an experienced clinical negligence solicitor who has specialised in the field for some 25 years, having previously trained as a nurse. She has significant and extensive experience of settling complex and high-value claims. The two leading legal directories have ranked Olive as a recommended lawyer in the area of medical negligence for many years. Chambers and Partners 2016 said; 'Olive is something of a force of nature, she is bright, combative and absolutely adored by clients'. Legal 500 2017 said, Olive Lewin is singled out for her 'exceptional ability' and 'particular experience in the highest-value cerebral palsy claims'

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Medico-Legal Conference 2019 - Speakers

ANN LOGAN

Ann is an Accredited Specialist in Medical Negligence Law for the Law Society of Scotland and an Accredited Clinical Negligence Specialist and Assessor for the Association of Personal Injury Lawyers. Ann specialises in pursuing clinical negligence claims in the Court of Session in Scotland. She has extensive experience of dealing with birth trauma cases, including cerebral palsy and stillbirth claims and deals with a wide range of cases against hospitals, GPs, optical and dental professionals. Ann lectures to medical and legal professionals, particularly on consent, as Balfour+Manson LLP brought the case of Montgomery v Lanarkshire Health Board.

LINDA MILLBAND

I have been specialising in clinical negligence cases since 1990;. I have settled numerous cerebral palsy cases and from 2015 to 2017 I was the lead solicitor in the generic Paterson case against Spire , Paterson and Heart of England Foundation Trust. The case raised issues of non-delegable duty of care. The case settled for £37 million on behalf of almost 700 women. It has had far reaching consequences for actions against private hospitals and on the management of such institutions.

DOMINIC REGAN

Dominic is an acknowledged authority on civil litigation and liability. He assisted Sir Rupert Jackson between 2010 and 2018 on costs controls and has advised the Government on law reform .

PAUL SANKEY

Paul is a specialist clinical negligence solicitor based in Bristol and partner at Enable Law. He represents patients seriously harmed by negligent treatment from GPs, NHS trusts and private doctors. He has a specialist interest in claims involving brain injuries to adults, the delayed diagnosis of cancer and amputation. He has published widely in the legal press and lectures to lawyers and doctors on medico-legal issues particularly on consent to medical treatment and the duties of experts. He has spoken regularly on local and national radio and TV. He also provides training to medical experts.

Medico-Legal Conference 2019 - Speakers

DAVID STOTHARD

David has 30 years of experience in this sector. He was a specialist personal injury and industrial disease solicitor, partner and director in the largest national claimant only law firm. He handled cases of utmost severity, fatal accidents and disease and represented injury victims in claims right across the spectrum of complexity and value. He was Chief Assessor to the Law Society's specialist Personal Injury Accreditation Scheme. Since 2015 he has run a medical reporting organisation which has delivered over 300,000 reports. His focus is on working with medico legal expert witnesses to deliver high quality reports at reasonable cost.

SHANNETT THOMPSON

Shannett has a mixed regulatory practice. She commenced her career in the NHS. Her practice involves acting on behalf of regulatory bodies in relation to fitness to practise concerns. She also advises individuals in relation to their regulatory responsibilities, representing individuals before Fitness to Practise committees and assisting individuals in respect of registration/licensing applications. Shannett also advises individuals in relation to niche regulatory issues involving their businesses. Shannett's client base is broad. She has built up a wealth of knowledge in dealing with matters that touch on various aspects of the law including crime. Shannett is also an experienced advocate.

KERRY UNDERWOOD

Kerry Underwood is Senior Partner of Underwoods Solicitors and is the acknowledged expert on funding, costs, legal systems, client care, marketing and advertising of legal practices. Kerry is author of many books including Qualified One-Way Cost Shifting, Section 57 and Set-off, No Win No Fees No Worries, Fixed Costs, Personal Injury Small Claims, Portals and Fixed Costs. Kerry is Vice-Chairman of Hemel Hempstead Town Football Club and Underwoods Solicitors sponsor the football club as well as Hemel Storm Basketball Team and Hemel Stags Rugby League Club. He is a former councillor and Parliamentary Candidate. Kerry travels extensively and home is his beloved adopted town of Hemel Hempstead, but he also spends time in his firm's office in Wellington near Cape Town in the Western Cape of South Africa. Interests include football, cricket, gardening and reading and he prefers the poetry of T.S. Eliot to the Civil Procedure Rules, and comments that T.S. Eliot's poetry is rather easier to understand! Kerry's Blog is https://kerryunderwood.wordpress.com/ Kerry's Twitter is @kerryunderwood

MEDICO -LEGAL NEWS:

By Lisa Cheyne, Medico-Legal Manager, SpecialistInfo

A round-up of news in the industry for the first quarter of 2019.

Court of Appeal ruled lying GP expert witness should have been jailed

NEWS

A GP who lied and signed a false witness report should have been jailed immediately rather than handed a suspended sentence, but he will still avoid prison, the Court of Appeal has ruled.

Judges in *Liverpool Victoria Insurance Company Ltd v Zafar* found Dr Asef Zafar had been dealt with too leniently. The court heard Dr Zafar, who made £350,000 a year from writing 5,000 reports, produced two versions of a report for one claim, with significant differences in the seriousness of the injuries diagnosed. The misconduct was uncovered when the original report was mistakenly included in the trial bundle.

Appeal judges stressed the deliberate or reckless making of a false statement in a court document would usually be serious enough for a prison sentence – particularly in the case of an expert witness. This was not mitigated by the comparatively modest sum involved in the underlying claim.

The attempted cover-up, and making of further false statements, 'significantly increased' the doctor's culpability, judges ruled.

The judges said the sentence should have been significantly longer than six months and served immediately rather than suspended.

The doctor had been motivated by a concern for financial profit, acted with deliberate dishonesty and persisted with in the conduct which constituted his contempt.

The General Medical Council has confirmed Dr Zafar was made subject to interim conditions on his registration at an interim orders tribunal in November. He must not undertake any medico legal work, including writing reports or giving evidence in court. The GMC's investigation is ongoing.

Read more: https://www.bailii.org/ew/cases/EWCA/Civ/2019/392.html

The Medico-Legal Conference – 16th May 2019, at the Queen Elizabeth Hall, South Bank, London

Tickets are still available for SpecialistInfo's Medico-Legal Conference in London on 16th May 2019. Over 160 delegates are already confirmed for this exciting event. Topics to be discussed include: issues around consent post Montgomery, gross negligence manslaughter, malingering and sepsis.

Please visit the website for details of the programme and to book:

www.medicolegalconference.com/programme.html

Please contact:

craig.kelly@iconicmediasolutions.co.uk. for further information if you are interested in hosting a stand at the event.

Dr Hadiza Bawa-Garba can return to work after gross negligence manslaughter conviction

The Medical Practitioners Tribunal Service (MPTS) has now ruled Dr Bawa-Garba can return to work, but only under close supervision, after being struck off the register last year.

She was convicted of GNM after 6-year-old Jack Adcock, who had Down's syndrome and a heart condition, died from a cardiac arrest caused by sepsis 11 hours after being admitted to hospital in 2011.

In 2017 the MPTS suspended her from the medical register for a year, but the GMC appealed against the decision and in January 2018 she was struck off at the High Court.

Dr Bawa-Garba subsequently took her case to the Court of Appeal and in August won her bid to be reinstated this month.

Read more: https://www.mpts-uk.org/hearings-and-decisions/medical-practitioners-tribunals/dr-hadiza-bawa-garba-apr-19

GP indemnity insurance cover changes from April 2019: The Government's state-backed clinical negligence scheme for general practice (CNSGP)

The new NHS indemnity scheme for GPs (CNSGP) covers all future clinical negligence claims from this month for GPs and associated medical staff practising in England, but discussions are still ongoing about whether it will also apply to incidents that occur before the scheme's introduction.

It is also important to note staff may need to check they are covered in relation to areas that fall outside of the scheme, such as expert witness work. For example, membership of a medical defence organisation or other indemnity providers will be needed for activities and services not covered by CNSGP. This includes non-NHS or private work, inquests, regulatory and disciplinary proceedings, employment and contractual disputes, and non-clinical liabilities.

Health Education England (HEE) will also fund personal indemnity cover for all GP trainees from April 2019.

Eventually it is hoped the scheme will provide consistency directly through NHS Resolution for medical negligence lawyers dealing with all aspects of complex claims involving alleged GP and hospital errors.

Read more: https://www.england.nhs.uk/gp/gpfv/investment/indemnity/

Claimant jailed for five months by the High Court for contempt of court after attempting to defraud the NHS out of compensation

Browne Jacobson LLP, instructed by NHS Resolution on behalf of George Eliot Hospital NHS Trust in Nuneaton, established that Lesley Elder, from Poole, lied about the extent of her injuries and disabilities following vaginal mesh surgery in 2010.

She claimed the surgery left her in such severe and constant pain in her groin and leg that she couldn't work, travel, or walk unaided. She said she needed more than £1m worth of care and support.

She demanded the seven-figure sum from The George Eliot Hospital NHS Trust - which awarded her £120,000 after the surgery was found to be have been unnecessary.

She was particularly upset that she had not been able to go to her daughter's hen do, she claimed.

After surveillance by private investigators and searches of social media, the gross exaggeration of her disability was exposed.

She was photographed in an Ibiza nightclub, with her daughter and other women, the court was told. Miss Elder insisted the trip was not a hen party, but simply a holiday.

Judge Iain Hughes QC pointed out that the party was women-only, all of them wearing t-shirts emblazoned with the words 'Tania's hen party'.

This April she was found in contempt of court and jailed for five months by Judge Karen Walden-Smith, who said it was an 'attempt to effectively defraud the NHS' out of more than £2m.

Read more: https://resolution.nhs.uk/2019/04/08/poole-woman-jailed-for-nhs-fraud/

Royal College of Physicians adopts a neutral stance on the issue of assisted dying

Following a poll of its members, the Royal College of Physicians (RCP) has now adopted a neutral stance on the issue of assisted dying. The survey was completed by 6,885 respondents from more than 30 specialties.

Members were asked:

What should the RCP's position be on whether or not there should be a change in the law to permit assisted dying?

- 43% thought the college should oppose a change in the law
- 32% wanted the college to support a change
- 25% were neutral

Under UK law, it is still illegal to encourage or assist a suicide.

The online survey, carried out between 5 February and 1 March, also asked members whether they personally support a change in the law on assisted dying. Those supporting such a change increased to 40.5% from 32.3%, while those opposing it fell from 57.5% to 49.1%.

The college has shifted to a neutral stance because neither side achieved a majority of 60%.

Prof Andrew Goddard, President of the RCP said: "It is clear that there is a range of views on assisted dying in medicine, just as there is in society.

"We have been open from the start of this process that adopting a neutral position will mean that we can reflect the differing opinions among our membership.

"Neutral means the RCP neither supports nor opposes a change in the law and we won't be focusing on assisted dying in our work.

"Instead, we will continue championing high-quality palliative care services."

Read more: https://www.rcplondon.ac.uk/news/no-majority-view-assisted-dying-moves-rcp-position-neutral

NICE recommends vaginal mesh ban can be lifted with management changes

Controversial vaginal mesh implants can be offered again on the NHS in England once certain conditions are met.

Under the new guidelines, *Urinary incontinence and pelvic organ prolapse in women: management*, patients would receive a "decision aid", detailing all the latest evidence on available treatments, and mesh implants would be used only after non-surgical options, such as lifestyle changes and pelvic floor training, had failed.

Studies suggest as many as one in 10 patients can experience complications after vaginal mesh surgery, including chronic pain and difficulties walking.

Labour MP Owen Smith, who chairs a cross-party group of MPs on surgical mesh implants, called for the continued suspension of vaginal mesh until an independent review, led by Baroness Julia Cumberlege, publishes its findings later this year.

The Royal College of Obstetricians and Gynaecologists (RCOG) and the British Society of Urogynaecology (BSUG) said they welcomed NICE's recommendation "that the full range of non-surgical options should be offered to women before any surgical procedures" and "fully endorse" NICE's patient decision aids.

But they added it was "important to note" that a period of "high-vigilance" remained regarding the implants' use.

Read more: https://www.nice.org.uk/guidance/NG123

National Audit Office warns lengthening NHS waiting times could lead to a rise in clinical negligence claims

In a report, *NHS waiting times for elective and cancer treatment*, the NAO notes that the elective care waiting list grew from 2.7 million to 4.2 million between March 2013 and November 2018. The number waiting more than 18 weeks grew from 153,000 to 528,000, while, the number of people treated each month increased from 1.2 million to 1.3 million.

'Long waiting times may lead to an increased risk of more negligence claims against the NHS,' the report states. 'Almost 40% of such negligence claims against the NHS are related to failures or delays in diagnosis or treatment.'

The NAO has found that while increased demand and funding constraints affect the entire system, other factors that are linked to declining waiting time performance include NHS staff shortages for diagnostic services, a lack of available beds and pressure on trusts from emergency care.

It adds: 'However, it is not possible to identify whether delays were due to long waiting times or other factors such as missed diagnoses. Excluding maternity, ambulance and emergency cases, which are not usually related to elective care, in 2017-18 about 3,000 such claims were resolved by NHS Resolution. 'Damages were paid in 56% of these cases, at a total cost of some £600m.'

Read more: https://www.nao.org.uk/press-release/nhs-waiting-times-for-elective-and-cancer-treatment/

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