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MAGAZINE

ISSUE 7

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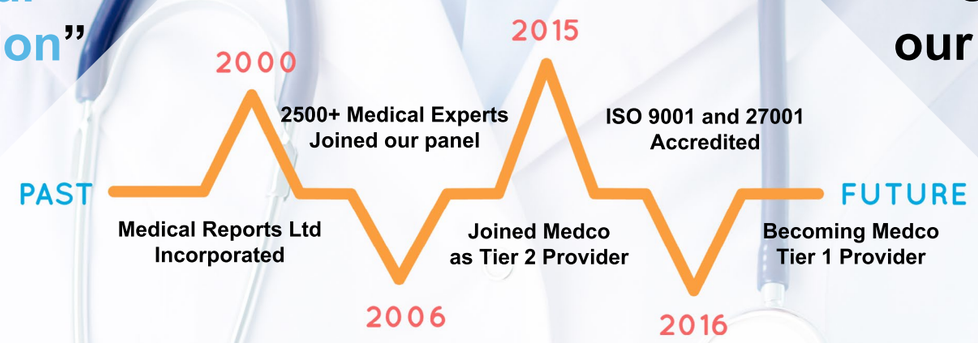


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# Welcome to Issue 7

Happy New Year and welcome to the seventh quarterly issue of the Medico-Legal Magazine, produced by SpecialistInfo and publishing partner Iconic Media Solutions Ltd.

In this first issue of 2018, we have advice for experts on fixed costs medical reports, MedCo and personal injury small claims from Kerry Underwood, Solicitor, who is an acknowledged expert on funding and the legal system.

We present an overview of (and possible upcoming changes to) child mental health and the law for clinicians by Dr Sarah Huline-Dickens, Consultant Child and Adolescent Psychiatrist.

We are also pleased to include an article by Dr Sikhar Sircar, Consultant Gynaecologist, on the risk of obstetric anal sphincter injuries during childbirth in the UK and strategies to reduce the incidence.

Dr James Palmer, Consultant Anaesthetist, discusses causes of accidental awareness during general anaesthesia and how patients can be affected in the longer term.

Brett Dixon, president of the Association of Personal Injury Lawyers (APIL), tells us about the work of APIL and how expert witnesses can get involved.

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 training 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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## Contents:



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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 2018 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):

- *24th January 2018* – London
- *8th May 2018* – Leeds
- *18th September 2018* – London
- *21st November 2018* – Birmingham

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

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**Mediation Training Course** (5 days):

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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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# THE USE OF FRACTIONAL LASER TECHNOLOGY TO REDUCE SCARRING

By Ben Elsom, Medical Reports Ltd


Scars are a very common complication of traumatic injuries affecting millions of people worldwide every year. Scars can be disfiguring, aesthetically unacceptable, and cause pruritis, tenderness, pain, sleep disturbance, anxiety, and depression in patients. In approximately 70% of medico legal instructions to plastic surgeons the expert is required to comment upon issues of scarring and provide a prognosis and recommend various treatment options.

Valuing claims for scarring is a complex issue given the nature of an individual claimant's perception of the scarring and the effects that it has on their daily life. The optimal effect is to reduce the scar to a minimum which will naturally reduce the effect it has on an ongoing basis and assist with settlement of the claim. There is no general consensus as to what is the optimal treatment for reducing scarring, however, the last few decades has shown that the use of lasers as a treatment option has delivered clinical and cosmetic benefits for patients for many types of scars.

## Timing of Treatment

The optimal time for treatment is during the premature phase of scar formation at approximately 6 to 8 weeks after injury. Newer non ablative, pulsed, or fractionated lasers place minimal mechanical stress on the tissues, making an argument for even earlier treatments. Earlier intervention can in theory alter the inflammatory phase of wound healing and change fibroblast migration, leading to a reduction in the appearance of scars. { Oliaei S, Nelson JS, Fitzpatrick R, Wong BJ. Use of Lasers in Acute Management of Surgical and Traumatic Incisions on the Face. Facial plastic surgery clinics of North America. 2011;19(3):543-550. doi:10.1016/j.fsc.2011.06.007.}

The proper classification of scars is essential in determining proper laser treatment choice and protocol. Scar type, texture, morphology, and colour will determine the choice of laser parameter and help predict the number of treatment sessions required. For the purpose of this article we discuss the use of Fractional laser treatment for the treatment of hypertrophic and keloid scars most commonly found in personal injury and clinical negligence cases.

## Fractional Laser Treatment

Fractional Laser Treatment is the latest technology being utilised to treat scars. Minute sections of the skin are targeted with laser light, which penetrate into the dermis to stimulate significant collagen renewal. The laser targets specific chromophores in the skin; namely, hemoglobin and oxyhemoglobin, melanin and water. The surrounding non affected areas of skin aid the body's natural recovery process.

Different scars may need a different length of course, or in combination with intralesional agents such as corticosteroids and antimetabolites, including 5-fluorouracil (5-FU) but almost all types of scar can be treated. Combating redness, uneven surface and tightness. Other benefits include a brighter more even skin tone and a smoother skin texture with improved skin elasticity.

Medical Reports Ltd is now able to offer solicitors access to a nationwide network of specialist clinics to provide laser treatment in cases involving scarring.
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# CHILD MENTAL HEALTH AND THE LAW: THE FUTURE MAY BE FUSION AND NO BRIGHT LINES

By Dr Sarah Huline-Dickens BSc, MA, MSc. BMBCh, FRCPsych, FAcadMed
Consultant Child and Adolescent Psychiatrist at Livewell South West, Plymouth

Dr Huline-Dickens is Associate Dean for Heath Education England Southwest, and Training Programme Director for higher training in Child and Adolescent Psychiatry in Devon.

She is the editor for Clinical Topics in Child and Adolescent Psychiatry (2014) and author of A Clinician's Brief Guide to Children's Mental Health Law (2016) both published by the Royal College of Psychiatrists.

## Introduction

The year 2018 may see the introduction of new Deprivation of Liberty Safeguards for young people.

For many clinicians, it is a difficult business keeping abreast with changes to the law affecting young people's mental health. Several significant changes in legislation affecting children's mental health have taken place over the last two decades and this seems likely to continue.

The Human Rights Act 1998 and the case law deriving from it, the Mental Capacity Act 2005, and the Mental Health Act, amended in 2007, count among these. In addition, the Policing and Crime Act 2017 has changed how section 136 of the MHA is used. In England, the introduction of Care, Education and Treatment Reviews (CETRs) for young people in March 2017 require that a multi-agency process be followed for young people with learning disabilities, including autism, before an admission to an in-patient facility takes place. The pending changes brought about by the Law Commission report and recommendations is likely to result in a new Act sometime soon and will introduce another layer of bureaucracy to the admission and treatment of young people to in-patient units.

It's useful to remember that the Mental Health Act (MHA) applies to England and Wales but Wales has its own Code of Practice for the MHA 2008, updated in October 2016, with a short section on children and young people. The Mental Capacity Act (MCA) applies to England and Wales and the MCA Code of Practice applies to both countries. Scotland has its own legislation which will not be discussed here.

## Though much (may be) taken, much abides

The Human Rights Act 1989 highlights the rights of children as individuals, and a number of important cases that have been heard in the courts have had a direct effect on psychiatric practice. The future of the Human Rights Act 1989 had been brought into question before the referendum to leave the European Union in 2016 but its life seems even more uncertain as a result of it.

The Children Act 1989 and the amendments made in 2004, however, emphasise parental responsibility, the private and public law elements and why a child or young person might need to be assessed using this legal framework. This seems likely to stay and is widely seen as a robust piece of legislation.

## The continuing problem of no beds

For doctors, these developments have occurred in the wider context of the Care Quality Commission (CQC) assuming responsibility for monitoring the MHA in England and Wales in 2009. Systems are still lacking for collecting data on the number of young people detained under the Mental Health Act. For the CAMHS clinician in many parts of the country, however, the main concern is the lack of available beds for young people who need emergency admissions. Lengthy delays before

a suitable psychiatric in-patient bed can be found in an adolescent unit are still occurring and often these beds are far from home. If the problems concerned physical illness rather than mental illness there would be a greater likelihood of this situation being seen to be the national disgrace that it really is.

## Case law and the deprivation of liberty

Case law has continued to evolve in the wake of the so-called Cheshire West case. As is now well known this judgment was given on the combined cases of *Cheshire West and P and Q (P v Cheshire West & Chester Council and another* and *P and Q v Surrey County Council [2014] AC 896* at the end of 2014. Some aspects of the case are relevant to adolescents, as the subjects P and Q, otherwise known as MIG and MEG, were aged 16 and 15 at the start of the proceedings, but 18 by the time of the final hearing in 2010. The judgment, delivered by Lady Hale, clarified that the definition of deprivation of liberty meant that a person is "under continuous supervision and control and…not free to leave". Moreover, at paragraph 46, "what it means to be deprived of liberty must be the same for everyone, whether or not they have physical or mental disabilities".

In the case of P and Q the conclusion was that they had both been deprived of their liberty and that the deprivation was the responsibility of the state.

Before Cheshire West a deprivation of liberty was considered to involve three components deriving from European law: an objective element, i.e. actual confinement for a non-negligible period of time; a subjective element, i.e. that valid consent to the confinement had not been given; and that the State was responsible for the deprivation of liberty. At paragraph 54 of the judgment Lady Hale says that similar constraints would not necessarily amount to a deprivation of liberty "if imposed by parents in the exercise of their ordinary parental responsibilities". Subsequently case law had established that although someone with parental responsibility could authorise restrictions on the liberty of his or her child this could not amount to a deprivation of liberty (see *RK (by her litigation friend and the official Solicitor) v BCC, YK and AK. 2011. EWCA Civ 1305).*

However, in a very recent, lengthy and comprehensively referenced judgment, Sir James Munby has ruled that a parent with parental responsibility can provide consent to a confinement that would otherwise be a deprivation of liberty for a young person who lacked Gillick competence, as this fell within the scope of parental responsibility.

In this case, *D (A Child) [2017] EWCA Civ 1695* where D was a 16 year old with ADHD, Asperger's syndrome, Tourette syndrome and a mild learning disability, many points especially relevant to clinicians are made but just three will be mentioned here. First, that Gillick capacity can be attained either below the age of 16 or above. In Sir James' words at paragraph 137: "there is nothing to suggest that there is some "bright line" distinction between the 15 and the 16- year old".

Second he points out that parental responsibilities are evolving and reflect the general standards expected in society. And third he observes that the MCA makes no statutory provision for the role of those exercising parental responsibility.

## Consent and confidentiality

Clinicians seeking to gain consent are now going to be influenced by the Montgomery case which broadly echoes existing professional guidelines (such as those of the GMC). This landmark case in the Supreme Court in 2015 *(Montgomery (Apellant) v Lanarkshire Health Board (Respondent) (Scotland) [2015] UKSC 11* has widely been interpreted as ending the principle of the Bolam test which had been established in 1957.

Confidentiality and its limits (which it turns out are many) in the doctor-patient relationship is also an evolving topic. Clinicians need to be aware of the professional guidelines (the GMC has just updated these in 2017) and also the seemingly broadening definitions of the public interest.

Cases of adolescent refusal of treatment also continue to vex both clinicians and the court in the face of mounting recognition of adolescent autonomy. Similarly, the emphasis has been shifting away for some time now from parental rights to parental responsibility.



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## The Mental Health Act

The Mental Health Act was last amended in 2007 with a new Code of Practice issued in 2015 (Department of Health 2015). The amendments to the MHA then included changes to terminology, roles and aspects of treatment. For example, the definition of mental disorder has changed and there is now a requirement in some sections for appropriate medical treatment to be available. There is the introduction of Approved and Responsible Clinicians and Approved Mental Health Practitioners (AMHPs). There are also some specific changes to aspects of treatment that affect young people under 18 years such as age-appropriate environments and the administration of ECT. There is no lower age limit in using the MHA and a case has been published illustrating its use in an eight-year-old child (Thomas et al 2015).

It should be mentioned here that, although not directly concerning the MHA, the confusing term *zone of parental control* only ever appeared in the MHA Code of practice for England (not for Wales) in 2008 and then has passed out of use in the current version (Department of Health 2015). It has now been replaced by the more restrained term *scope of parental responsibility.* Nevertheless, it has continued to be used in court as if it were a well-defined entity.

It is also noteworthy that there have been changes to the use of section 136 of the MHA following the introduction of the Policing and Crime Act 2017. The time of detention reduces from 72 to 24 hours; no longer can police stations be used as places of safety for young people under the age of 18; and the police are to consult with mental health professionals before using the section.

## The Mental Capacity Act

Whilst the MCA can only be used for those who lack capacity over the age of 16, the deprivation of liberty safeguards (DOLS), as currently configured cannot be used for anyone under 18. Clinicians need to know about the principles of this Act, how to undertake capacity assessments and also the interaction between this Act and the MHA.

The Law Commission envisages a fusion of the MHA and the MCA in the future (Law Commission 2017), but for young people under the age of 18 this will be complicated by the interaction with provisions such as the Children Act and Gillick competence.

## The future for those in between

For those young people between 16 and 18 whose mental disorder does not warrant using the MHA, a no-man's land has developed for those who lack capacity. Secure accommodation under section 25 of the Children's Act will not be appropriate for many; and court authorisations are costly and rarely sought in practice. Until recently it has been understood that parental consent cannot be relied upon to authorise a deprivation of liberty (although see above in the case of *D*) and there has been uneasy concern about safeguarding the article 5 rights of such young people.

The Law Commission review in March 2017 makes the case for reform well, and the Commission has clearly been concerned about the use of parental consent to authorise what would otherwise be a deprivation of liberty for 16 and 17 year olds. It suggests the swift abandonment of the DOLS and the replacement with Liberty Protection Safeguards which will apply to young people over the age of 16. These recommendations are accompanied by a draft Bill, the Mental Capacity (Amendment) Bill.

As outlined in the proposals, decision makers will need to assess the deprivation of liberty as being justified; there will be an internal review; and a new role created of an Approved Mental Capacity Professional to give independence to the arrangements.

There are however significant questions in these proposals for clinicians. Whist these safeguards are intended for those of unsound mind they are not for the authorization of assessment and treatment of mental disorder. Neither are they just for those who lack Gillick competence: an application to either the Family Court or the Family Division of the High Court is required for such cases.

It is therefore still not clear how these new proposals will interact with the Children Act and Gillick and take

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account of parental responsibility, which applies until a child reaches the age of 18. In the draft Bill we are told that "substituted consent", i.e. by someone with parental responsibility has not been expressly prohibited and that the Liberty Protection Safeguards provide that parents have rights to be consulted.

Finally the draft Bill firmly dismisses the idea that extending the new scheme would increase the burdens placed on health and social care services. The reasoning here appears faulty and to be based on the fact that court authorizations have not been occurring although they should have been.

Whether or not these safeguards and the new Bill will lead to an enhanced process for young people and their families will depend on a workable system being deployed, which is properly resourced and which takes into account the demand on the professionals expected to enact it. With the number of in-patient beds for young people with mental disorders at critically low numbers and young people, their families and clinicians in risky and distressing situations when admission is being contemplated, it is hard to see how changes in legislation alone are going to lead to improvements. There's the real injustice.


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# ACCIDENTAL AWARENESS DURING GENERAL ANAESTHESIA (AAGA)


By Dr James Palmer FRCA, Consultant Anaesthetist, Salford Royal NHS Foundation Trust

James Palmer is Consultant Anaesthetist at Salford Royal NHS Foundation Trust and was a steering group member and author of the NAP5 study. He has interests in AAGA, clinical governance, difficult airway management and anaesthesia for ENT and Neurosurgery.


Two fears almost universally expressed by patients before surgery are first that they might die during the operation, and secondly that they may wake during the procedure unable to alert anyone to their plight. The latter is fear of 'accidental awareness during general anaesthesia' (AAGA), a very rare event arising from a variety of causes and in a number of ways.

Agents used to induce and maintain anaesthesia have individual effects on the brain (hypnosis, memory formation, blocking painful stimuli) and the spinal cord (impeding purposeful movement and blocking spinal reflexes) so that during very deep anaesthesia patients neither move nor have recall. However this depth has serious (potentially life-threatening) side effects (cardiac, respiratory and cognitive impairment) and a balance has to be struck. In consequence, consciousness is not uniformly absent and cognitive processing occurs in many patients but without recall or sequelae.

Recall after surgery has been reported and investigated for many years. It may be voluntary and spontaneous (very rare) or elicited by Brice questionnaire after surgery (about 1:600). The experience of AAGA is equally wide ranging; from detailed explicit recall, to implicit memory for 'key words' discoverable by psychological assessment. Outcomes vary from no harm at all to long-lasting psychological trauma, and doctor-patient communication, stoicism and patients' knowledge of anaesthesia have effects on outcome.

General anaesthesia for adults in the UK is mainly induced intravenously and maintained with volatile agents ('gases'). In young children induction is often by volatile agents alone. Sometimes (e.g. transfers) intravenous drugs are used both for induction and maintenance: total intravenous anaesthesia (TIVA). Once asleep, patients may be permitted to breathe spontaneously or are given a paralysing agent (muscle relaxant/neuromuscular blocker (NMB)) and their lungs ventilated mechanically. To maintain a clear airway patients have a device placed in their mouth (laryngeal mask) or their trachea (intubation). The former usually occurs without paralysis; the latter almost always requires it. Muscle relaxation permits surgery which would otherwise be impossible (cardiac, thoracic, abdominal, obstetric, and laryngeal) and is monitored by electrical stimulation of peripheral

nerves and palpation (or objective measurement) of the resultant twitch in a muscle; confusingly, not all muscle groups are equally sensitive.

Depth of anaesthesia is assessed by surrogate means: absence of movement, changes in heart rate and blood pressure, absence of lacrimation or sweating. However, these are unreliable so expired concentration of the volatile agent (etAG) is compared to a dose-response curve of minimum anaesthetic concentration (MAC); the concentration which prevents movement in 50% of subjects (often animal) and due more to effects on the spinal cord than on the brain. The concentration which prevents recall to Brice questionnaire *(v.s.)* is about 0.7MAC.

For TIVA another surrogate monitor is used: usually processed EEG. This has significant processing time, artefactual error and is less reliable than etAG at preventing recall. One final monitor exists: the isolated forearm technique (IFT). The forearm is isolated from the circulation by a tourniquet preventing NMB effect. The anaesthetised patient is then asked (usually via headphones) to move their hand. Further commands establish if the patient is comfortable, knows what is happening, or has pain or concern.

The IFT demonstrates connected consciousness, but presence of IFT response in studies was not followed by explicit recall or adverse outcome. Drawbacks of IFT are that it is possible only in some operations and the tourniquet may not be without complications.

AAGA is extremely unlikely if paralysis is avoided. A large national audit in 2014 (NAP5) reported a rate of 1:135,900 for this subset: with paralysis the incidence rises (1:8,200). There is also variation between specialties. In cardiothoracic surgery the rate is 1:8600 whereas in obstetrics it is 1:670. To complicate matters, not all reports of awareness are from patients receiving general anaesthesia at all. NAP5 estimated that 1:15,000 patients receiving sedation reported 'awareness' from miscommunication and suboptimal expectation management.

Half of all UK reports arise around the point of intubation or soon after (transfer into theatre/start of surgery) and half these (25% of the total) were emergencies. A third of reports came from the period of surgery itself and a fifth from emergence and extubation (tube removal).

Contributory factors for AAGA are: failure to maintain anaesthesia during prolonged or difficult intubation (particularly 'rapid sequence induction' used for emergency surgery); obesity (rapid offset of drugs and relative underdosing); and the 'gap' during transfer from anaesthetic room to theatre, exacerbated by failure to 'switch on' the volatile in theatre. During emergence, failure to monitor (and reverse) intraoperative paralysis led to patients being awakened who were unable to move, breathe or communicate. Others, not paralysed, disliked the experience of extubation which had not been explained to them before surgery. The final group (10% of NAP5 reports) were drug error: administration of a neuromuscular blocker to an awake patient.

Main findings from reports were that paralysis and pain (however caused) led to greatest distress and long term effects, including post-traumatic stress disorder (PTSD) and that some patients have increased risk: young adults, women, the obese, and those with a past history of AAGA (or difficult intubation). In contrast, there are no apparent links with race or health status. When assessing a report of AAGA it is important to recognise that memory is not a tape recording and that patient experience contains misunderstandings. Events may be misplaced in time or place, overheard speech and actions misinterpreted, well intended reassurance from staff produce erroneous assumptions. Even with good communication, good patient information systems and the best care, the experience of surgery and anaesthesia may itself lead to unavoidable distress. Finally, about 7% of patient reports of AAGA occur even when all the evidence points to impeccable care. These patients may represent a subgroup 'resistant' to anaesthesia where no fault can be ascribed.

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# EXPERTS AND FIXED COSTS EXTENSION

By Kerry Underwood, Senior Partner and Solicitor, Underwoods Solicitors

Kerry is an acknowledged expert on funding and the legal system generally. He is a former Judge, current author, lecturer, broadcaster and a former Councillor and Parliamentary Candidate. He deals extensively with Fixed Costs medical reports, MedCo and these matters are in his recent book – Personal Injury Small Claims, Portals and Fixed Costs, running to three volumes and 1,300 pages and available from his website www.underwoods-solicitors.co.uk/book-kerry-underwood.htm

Lord Justice Jackson's report – Review of Civil Litigation Costs: Supplemental Report: Fixed Recoverable Costs – was published on 31 July 2017.

It proposes that all cases of all kinds valued at up to £25,000 be subject to Fixed Recoverable Costs (FRC) and thus those personal injury matters currently outside the scheme will now be brought in.

The government has already announced that holiday sickness claims will be brought into the scheme early in 2018 and that it is now working with stakeholders in the clinical negligence sector with a view to making all clinical negligence claims of £25,000 or less subject to FRC sooner rather than later.

Noise-Induced Hearing Loss claims, currently generally outside the scheme, are to be brought in as soon as possible and the figures and procedure have now been agreed.

Thus, it is likely that all personal injury work up to £25,000 will be subject to FRC from October 2018.

Lord Justice Jackson's report also proposes a new Intermediate Track which will capture all personal injury claims valued at between £25,000 and £100,000, except clinical negligence claims which will be subject to a separate regime.

All cases in the Intermediate Track will be subject to FRC and there will be a streamlined procedure to ensure that those fixed costs adequately compensate lawyers for the work done.

The good news for experts is that at present the existing system of fixed costs for medical reports, largely in the existing Fixed Costs Scheme, will not be extended and nor will the MedCo system of supposedly randomly allocating experts.

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In the Fast Track, the rule remains that oral expert evidence is limited to one expert per party in any field and not more than two expert fields, but as Lord Justice Jackson says: "that definition is unrealistic. It is usually impracticable to have multiple expert witnesses giving oral evidence in the context of a one-day trial."

The Intermediate Track trials will last up to three days, so many cases currently allocated to the Multi-Track due to the amount of expert evidence, will now go into the Intermediate Track.

In the Intermediate Track, oral expert evidence will be limited to one, or if reasonably required and proportionate, two expert witnesses for each party.

Each expert report shall be no more than 20 pages, plus any necessary photographs, plans and academic or technical articles attached to the report.

In appropriate cases opposing experts shall give their evidence concurrently, in accordance with Practice Direction 35, Section 11, a process sometimes called "hot-tubbing".

## Costs

There is no costs budgeting in any FRC cases, whether that is the Fast Track or Intermediate Track, but the court can use its costs capping powers to restrict the fees of experts.

Given that all other aspects of the costs are fixed, including counsel's fees, the court is likely to exercise these powers to avoid costs assessments in relation to just the issue of expert's fees.

## The future

Experts should regard this as a temporary reprieve.

In relation to the Intermediate Track and experts the report says this:

"5.12 Disbursements. The above table does not include disbursements. The principal disbursements will be court fees, expert fees and (where ADR takes the form of mediation) the mediator's fee. In some cases, translators and/or interpreters are needed. I recommend that once the new fixed costs regime is in place, work should commence on developing fixed costs for experts. This is essentially what happened in the fast track. Once the fast track fixed costs for personal injury cases had been in place for a year, a scheme of fixed costs for medical reports was introduced: see chapter 15, paragraph 5.22 of my previous report and CPR rule 45.19. It would also be sensible to develop fixed costs for mediators, translators and interpreters."

## Indemnity costs due to experts' conduct

In *The Governors and Company of the Bank of Ireland (1) and Bank of Ireland (UK) PLC (2) v Watts Group PLC [2017] EWHC 2472 (TCC)*

the Technology and Construction Court ordered that the costs incurred as a result of the conduct of the Claimant's expert be assessed on the indemnity basis.

The court said that it was particularly critical of the Claimant's expert quantity surveyor who gave evidence on behalf of the bank and had "grave concerns about his evidence."

The court took the opportunity to review the case law in relation to conduct so bad that it warrants indemnity costs orders.

The court concluded that there is authority for the proposition that where a court concludes that the conduct of an expert should be marked in the Costs Order, it may be appropriate to order that the specific costs generated by that expert should be assessed on an indemnity basis – see

*Balmoral v Borealis [2006] EWHC 2531 (Comm) and*

*Williams v Jervis [2009] EWHC 1837 (QB).*

"Accordingly, I consider that the costs of the Defendant's QS expert, Mr Whitehead, should be assessed on an indemnity basis, as should the costs of and occasioned by Mr Vosser's oral evidence at the trial."

## Comment

There is a view that experts have got away with it as far as the extension of fixed costs is concerned, as, alone, their costs remain unfixed and uncapped.

However, there is increasing evidence that the courts are looking at experts' fees and conduct much more closely than in the past.



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## Book Review: Personal Injury Small Claims, Portals and Fixed Costs by Kerry Underwood

By Georgina Parkin, personal injury solicitor and director of Truth Legal Solicitors, based in Harrogate, North Yorkshire

Kerry Underwood's informative text comprising three volumes, serves as a breadth of practical advice for all claimant and defendant personal injury practitioners who deal with lower value personal injury claims and claims on the borderline between fast track and multi-track. Topics covered include the personal injury portals, issues surrounding medical evidence including soft tissue injuries and MedCo, portal costs, fixed recoverable costs and extending the remit of fixed recoverable costs.

The subject matters are much an extension of Kerry's excellent blog (kerryunderwood.wordpress.com/) and it is recommended that his blog is read in conjunction with the books. Prior to reading these books I was, and still am, an avid reader of Kerry's blog which I have found on many occasion to be a straightforward and useful resource when dealing with loopholes in the Civil Procedure Rules and Pre-Action Protocols. A standard response in our offices to an unusual query raised in relation to costs is; *"Have you checked whether Kerry Underwood has written anything about it?"*

This text is of further interest to Directors/Partners/Team Managers, in that Kerry also offers practical business advice on how to keep fixed costs work profitable. In recent times we have seen a number of personal injury firms reduce their staff numbers and/or close their doors.

These books are not only a useful starting point for personal injury case-specific queries but also for considering whether there are any improvements which can be made to the way law firms operate and manage personal injury claims. An essential text for all personal injury practitioners.


# CHILDBIRTH AND OASIS - **WHAT IS NEW?**

By Dr Sikhar Sircar, Consultant Gynaecologist and Medico-legal Expert, NHS Lanarkshire

Dr Sircar has over 15 year's clinical experience in Obstetrics and Gynaecology and is involved in risk management, clinical governance and training. He works with the Royal College of Obstetrics and Gynaecology (RCOG) as college tutor and regional spokesperson.

Childbirth is exceptionally safe in United Kingdom, thanks to the progress made over decades in safety and quality of care. Despite this, perineal trauma in the form of anal sphincter injury is increasing in incidence. The reported rate of OASIS (Obstetric anal sphincter injuries) in singleton, term, cephalic, vaginal first births in England has tripled from1.8% to 5.9% from 2000 to 2012. The overall incidence in the UK is 2.9%, with an incidence of 6.1% for first birth compared with 1.7% for women having subsequent birth.

The NHSLA 10-year report on maternity claims identified perineal trauma as being the fourth highest indication for claims, with £31 million in legal pay outs. It accounts for nearly 9% of all maternity claims and is superseded by claims related to the management of labour (14.05%), Caesarean section (13.24%) and cerebral palsy (10.65%).

(Ref: http://www.nhsla.com/safety/Documents/TenYearsofMaternityClaims2012.pdf)

The National Patient Safety Agency (NPSA) stratification considers OASIS as moderate to severe harm and its definition is outlined below.

**Moderate:** Any patient safety incident that resulted in a moderate increase in treatment and which caused significant but not permanent harm, to one or more persons receiving NHS-funded care.

**Severe:** Any patient safety incident that appears to have resulted in permanent harm to one or more persons receiving NHS-funded care.

(Ref: http://www.npsa.nhs.uk/corporate/news/npsa-releases-organisation-patient-safety-incident-reporting-data-england/)

Recently, a High Court Judge awarded £1.6 million in damages for *'claim for damages arising from a serious obstetric injury suffered by the Claimant, Mrs Sarah Davison, during the delivery of her first child, whilst under the care of the Defendant, a Consultant Obstetrician'. (Davison v Leitch EWHC 3092, Court of Appeal- Queen's Bench Division*).

There are two national 'guidance' over standard of care regarding perineal injury and its management. They are from the Royal College of Obstetrician and Gynaecologists as a Green top guideline, number 29, 'The Management of third and fourth degree perineal tears', dated June 2015.

(Ref: https://www.rcog.org.uk/globalassets/documents/guidelines/gtg-29.pdf).
This guidance was revised after the above-mentioned judgement and now incorporates detailed evidence based guidance for prevention and management of such injuries.

The other relevant guidance is under 'intrapartum pathway' developed by NICE and published first in December 2014. It has outlined 'interventions to reduce peirneal trauma.

(Ref: https://pathways.nice.org.uk/pathways/intrapartum-care#path=view%3A/pathways/intrapartum-care/care-in-second-stage-of-labour.xml&content=view-node%3Anodes-interventions-to-reduce-perineal-trauma.)

Though the above two guidances largely concur, there remains some difference in the guidance above regarding the 'angle of episiotomy' and potential 'hands poised' approach for vaginal birth. This could lead to differences in expert opinion based on interpretation of such guidance.

Guidance does not have a legal status in English Law. However they are evidence-based documents prepared by learned Societies and Organisation with credible background. Many Maternity units will have their own 'protocol' based on such documents. It would be prudent to examine case records meticulously with contemporaneous national guidance to determine any liability issues.

There is no validated risk scoring system to predict OASIS and occurrence of such is not necessarily considered 'negligent'. However failure to detect such injuries and perform primary adequate repair of OASIS has formed the bulk of successful litigation and claims.

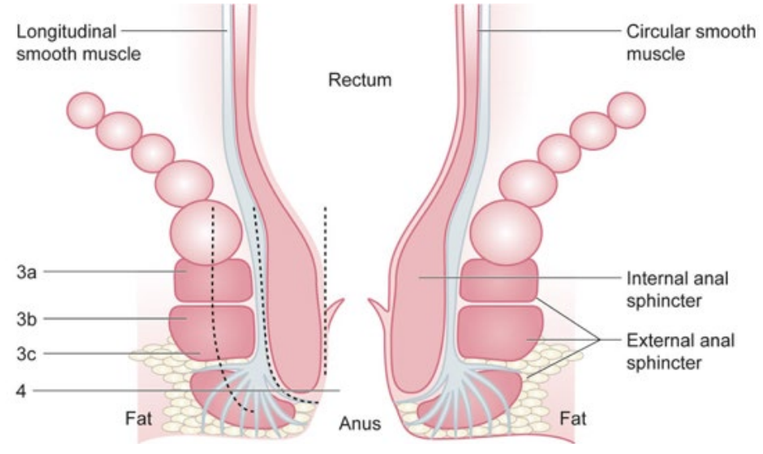
In light of recent Montgomery ruling (*Montgomery v Lanarkshire Health Board,* (Ref: https://www.supremecourt.uk/decided-cases/docs/UKSC_2013_0136_Judgment.pdf), the medico-legal aspects of 'consent' has attracted great attention. The duty of care is not only to avoid or avoid exposing any personal injury or its risk, it is also an entitlement for the patient to decide whether or not to incur the risk. The Court effectively concluded that the 'Bolam test' is no longer appropriate in consent cases.

At present, normal vaginal birth is not 'consented' but it could open a debate whether such needs to be the practice. Some Maternity units have started 'consent' process for operative vaginal deliveries, which (operative deliveries) are known to increase the risk of OASIS. The validity of such consent process while under analgesics and extreme physiological duress is still to be tested in the Court of Law. The Montgomery ruling recognises that such discussion is unlikely to take place in emergency situations, which are often the case during childbirth scenario.

Considering the above, the question to answer in case of an OASIS could be the adequacy of information for patients and consideration of avoidance of such risks for health care providers in selected cases.

There are now gathering evidence in strategies to reduce the incidence of such injuries. This includes use of specialised scissors, episiotomy techniques and role of improvement of sustained targeted training for the health care providers. One also needs to keep in mind the already published evidence and guidance in proper management of such injuries, once detected.

**Diagram to depict OASIS – 3rd and 4th degree Perineal tears**




Normal childbirth should be safe and an experience to cherish. While incidence of 'harm' is rare, the increase in incidence of OASIS together with is devastating consequence in some women is real. The medico-legal profession needs to take cognizance of the evidence-based guidance, which are available as established standards of care.

# ABOUT THE ASSOCIATION OF PERSONAL INJURY LAWYERS (APIL)

By Brett Dixon – APIL president, mail@apil.org.uk

A group of barristers and solicitors founded APIL in 1990 to give a voice to those injured through no fault of their own. Since then we have worked tirelessly to preserve the rights of injured people. Those doing the groundwork are personal injury practitioners, who make up APIL's 3,400 strong membership. APIL campaigns for improvements in the law, promotes safety so that needless injuries can be prevented, trains its members to develop expertise in the field, and provides a communication network for its members.

We campaign relentlessly for redress in the legal system. Through persistent lobbying and legal battles, for example, the discount rate, which calculates how much should be deducted from a lump sum of damages so a claimant does not receive more compensation than he should, was changed for the first time in 16 years. What is important here is that people are able to receive the right compensation to meet their needs when they have been catastrophically injured. The mechanism for making sure this happens has not worked for many years. Unfortunately, our fight is not yet over as the Government is, at the time of writing, reviewing the process of calculating the rate.

Cold calling for personal injury claims is another area in which we have pushed for change. The association has long called for a ban of all cold calls for personal injury claims as they are tasteless and intrusive. They generate the false perception that obtaining compensation for whiplash and other injuries is easy, even when there is no injury. It brings the whole sector into disrepute. An amendment to ban these calls has now been proposed by the Government to be added to the Financial Guidance and Claims Bill.

High standards are essential to ensure injured people receive the best possible service from their lawyer. All APIL members subscribe to a code of conduct and consumer charter, to reassure people about the service they can expect from our members. An accreditation scheme for APIL members was established in 1999. To be accredited, they must satisfy specific and extensive criteria providing evidence of their competency and experience in handling personal injury claims.

Access to first rate experts is crucial to the service our members provide. Almost a thousand online expert witness searches are carried out by our members every month from APIL's directory of experts. We have 596 experts in the directory, covering 300 categories including orthopaedics, health and safety, and psychiatry.

The association runs its own programme of training events, conferences and webinars nationwide for subjects ranging from advanced clinical negligence to military claims to help our members provide the best possible service for the injured people who need them. I am involved personally in delivering some of this training. Ensuring those who represent injured people have the most up to date and relevant skills possible complements all the other work APIL does to support the needs of injured people and their families.





# MEDICO -LEGAL NEWS:

By Lisa Cheyne, Medico-Legal Manager, SpecialistInfo

A round-up of news in the industry for the final quarter of 2017 and into 2018.

## Supreme Court Ruling Imminent on Litigants in Person (LiPs)

The Law Society Gazette has reported that the Supreme Court has been asked to decide for the first time whether litigants in person (LiPs) should be granted special dispensation in a landmark case that could rewrite Civil Procedure Rules.

Mark Barton took his appeal to the court last November, arguing he was ill-equipped to understand the Civil Procedure Rules as a LiP. A successful appeal could mean the rules are changed to help the growing number of claimants without legal representation.

He brought professional negligence proceedings against law firm Wright Hassall in relation to a negligence claim against his former solicitors. Unrepresented, Barton emailed his claim form to Wright Hassall's lawyers without confirmation that it would be accepted this way. The claim was subsequently ruled invalid.

A district judge ruled that Barton was not entitled to 'special rules or indulgences' and the Court of Appeal backed that decision.

In a one-day hearing at the Supreme Court in November, the appellant, now represented by Parklane Plowden Chambers on a direct access basis, argued that the rules are too complex for LiPs.

His lawyers told the court: 'Judges at all levels appear to have substantially underestimated the difficulty that a LiP would have in relation to the commencement and service of a claim.'

Read more at: https://www.lawgazette.co.uk/news/supreme-court-ruling-on-litigants-in-person-could-redraw-cpr/5063855.article

NEWS
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## Medico-Legal Expert Questions Practical Delivery of Small Claims Rise

A leading independent medical reporting organisation, MAPS Medical Reporting, has responded to an academic's call for an overhaul of the claims process before the government presses ahead with plans to increase the small claims limit from £1,000 to £5,000.

Reacting to comments made by Cardiff Law School academic Annette Morris at the Westminster Legal Policy Forum (and reported in the Law Society Gazette Thursday 26 October 2017) that ministers must 'adapt' the claims system and portal to handle litigants in person (LiP) before considering raising the small claims limit, David Stothard, an expert in the medical and legal aspects of personal injury claims and director of MAPS Medical Reporting, says that for LiPs not to struggle with the claims process would require a complete overhaul of the system.

The intervention follows confirmation from Justice Secretary David Lidington that the current government intends to proceed with a proposed Civil Liability Bill, which would see a 100% increase in the small claims limit for all non-road traffic-related personal injury cases and a fivefold increase in the limit for road accident cases.

"The idea of a system able to withstand thousands of lay people bringing forward claims up to the value of £5,000 – some of which would be medically complex - without help from qualified solicitors, takes quite a leap of imagination.  It is incredibly ambitious, bordering on fanciful. Is the government tied up as it is with Brexit really going to commit to the kind of huge IT project that will be required to deliver a workable and fair system?", Mr. Stothard asked.

"It's extremely questionable if there is the political will for the substantial investment required and without it the likely outcome is chaos and gross unfairness. An implementation date of April 2019 as is currently being mooted by commentators is starting to look somewhat unlikely."

MAPS Medical Reporting argues that without substantial changes to the claims portal, it would be near-impossible for litigants in person to effectively use the MedCo system.

David Stothard, managing director of MAPS Medical Reporting said: "Ms. Morris – repeating a government line - says that most minor injury claims are 'straightforward and routine', however the automated portal and MedCo systems are far from it.

"Selecting and appointing appropriate medical experts and procuring accurate medical reports are essential to lodging a claim and getting the best outcome for injured people. Unless the government really doesn't care about the quality of the medical evidence or for that matter justice, you have to ask, if qualified professionals from major law firms have raised concerns about the efficacy and ease of dealing with MedCo, how will injured lay people cope?"



## PI Sector Still Confident for 2018

A survey carried out by marketing collective First4Lawyers found that 69% of personal injury firms surveyed are expecting profits to rise and 76% envisage that turnover will increase.

First4Lawyers managing director Qamar Anwar said: 'Whatever the outcome of the government reforms, there will still be injured people looking for legal assistance. The question is where they will go and our analysis of the market shows that firms realise that they have to raise their game and their profile.

The government is preparing to raise the small claims limit and set fixed tariffs for soft tissue RTA claims. Both developments are likely to put greater pressure on firms operating in this field. The majority of respondents expect more closures, mergers and redundancies in the next 18 months, but most were confident in their own firm's ability to adapt.

Read more at: https://www.lawgazette.co.uk/news/pi-sector-confident-for-2018-but-another-firm-in-administration/5064144.article

## New "Early Redress" Scheme to be Introduced for High Value Negligence Claims

Health Secretary, Jeremy Hunt, confirmed at the end of November that a new compensation scheme for expensive maternity negligence claims should be in place from April 2019.

After detailing the unsustainable costs of £500m last year settling obstetric claims, Hunt stated:

"Really when people go to the law, we have failed. If we get this right - if we can be more open, honest and transparent with families earlier on - it will, I hope, mean many fewer legal cases, although I am sure that the lawyers will always find work elsewhere."

Following a consultation, the Department of Health will develop the rapid redress and resolution scheme with the aim of improving safety and patients' experience and reducing costs.

Read more at: https://www.gov.uk/government/consultations/rapid-resolution-and-redress-scheme-for-severe-birth-injury

# Expert Witnesses Surveyed

A 2017 survey of 800 experts for The Times by Bond Solon, has concluded that cuts to legal aid, rising numbers of litigants in person and the 'hired gun' are major concerns for expert witnesses.

Mark Solon, solicitor, says: "A high number of experts surveyed, 50 per cent, indicated they have felt stressed as a result of their work as an expert witness.

He elaborated: "Reforms introduced to the rules in 2013 means they have to comply with court timetables and tighter deadlines for reports. Changes in costs budgeting, proportionality and funding have also put a strain on experts within tight budgets.

"A litigant in person has the ultimate vested interest in winning and may not understand the rather unusual position of an expert witness — that although instructed by a party in a case and paid by them, the duty of the expert is to assist the court and not to win the case for one party.

"The fact that the litigant in person cannot afford a lawyer does not bode well for the expert being paid. Also, experts may have to hold the hand of the litigant in person who doesn't understand the legal process and this could take a great deal of time, possibly unpaid."

Additionally, the survey revealed that about 30 per cent of experts have been asked or felt pressurised to change their report by the lawyers who instruct them in a way that damages their impartiality. And 46 per cent feel that the 'hired gun' still exists, despite the provision in the rules made by Lord Woolf, the former lord chief justice, that an expert's duty is to the court, not those instructing them.

"Solicitors need to understand the role of experts and should not consider them as an adversarial tool," Solon says. "Judges need also to keep a careful eye out for bias. If lawyers put such pressure on experts, that is even more likely with litigants in person."

Worryingly, around 75 per cent of experts say that they have come across unqualified expert witnesses who have provided poor quality advice.

Read more at: https://www.bondsolon.com/expert-witness/survey-report-2017/



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