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MAGAZINE

ISSUE 9

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MEDICO LEGAL MAGAZINE

Welcome to Issue 9

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

In this autumn issue of 2018, Laura McIntyre, from Hempsons Solicitors, presents an overview of the events leading to Dr Bawa-Garba's conviction for gross negligence manslaughter, and her resulting successful appeal not to be removed from the GMC's Medical Register.

Her colleague from Hempsons, Chloe Davies, reports on the landmark fundamental dishonesty case of Sandip Singh Atwal, who was sentenced to three months in jail for his deliberate attempt to defraud the NHS and deceive the Court.

Enable Law Legal Director Laurence Vick comments on who should foot the bill when outsourcing by the NHS goes wrong.

Dr Rajesh Munglani, Pain Consultant, speaker and organiser of the upcoming Cambridge Medico-Legal Conference, discusses consent issues in the area of pain management.

We are also pleased to include an article by Dr Chris Bass, Consultant Liaison Psychiatrist, on Complex Regional Pain Syndrome in the medico-legal setting.

Finally, we are pleased to announce that we have released SpecialistInfo's 2019 medico-legal course dates and have set a date for our 2019 Medico-Legal Conference, which will take 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 (see opposite page for details).

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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MEDICO LEGAL MAGAZINE

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):

- *18th September 2018* – London
- *21st November 2018* – Birmingham

£330 (plus VAT)

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

Clinical Negligence Medico-Legal Course (specific training for experts undertaking higher value medical negligence cases):

- *19th September 2018* – London
- *22nd November 2018* – Birmingham

£355 (plus VAT)

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

Advanced Medico-Legal Course (now including court-room skills and an update to the law and procedures for experienced experts):

- *20th September 2018* – London
- *6th December 2018* – London

£355 (plus VAT)

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

Mediation Training Course (5 days):

- *13th-14th & 26th-28th September* - Aberdeen
- *24th September* - London
- *15th-19th October* - London
- *10th-14th December* - London

£1,500

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

specialist info

2019 dates are now confirmed!
For further information please visit:
www.specialistinfo.com/a_ml_cal_next_year.php

IMMEDIATE CUSTODIAL SENTENCE FOR THOSE WHO SUBMIT FRAUDULENT CLAIMS AGAINST THE NHS

Chloe Davies, Associate from Hempsons Solicitors, healthcare law experts, charity lawyers and specialist NHS lawyers with offices in Newcastle, Harrogate, Manchester and London

Calderdale and Huddersfield NHS Foundation Trust - v - Sandip Singh Atwal

On 01 June 2018, in this landmark case, Sandip Singh Atwal was sentenced to three months in jail for his deliberate attempt to defraud the NHS and deceive the Court. He has also been ordered to re-pay £75,000 in legal costs.

The decision comes after Hempsons Solicitors, instructed by NHS Resolution on behalf of Calderdale and Huddersfield NHS Foundation Trust succeeded in establishing that Mr Sandip Atwal was in contempt of Court on 14 grounds for grossly exaggerating the effect of minor injuries and fraudulently claiming compensation against the NHS.

Factual Background

Mr Atwal, a former taxi driver and DJ, sought damages in excess of £800,000 for clinical negligence, following fractures of two fingers and a laceration of the lower lip sustained during a fight in 2008.

The Trust, through its solicitors, admitted liability at the earliest possible stage and even put forward an offer of £30,000 for the genuine injuries that Mr Atwal sustained. This has since been described by the Court as *"generous."* Nevertheless, Mr Atwal continued to allege that he was grossly incapacitated, had been left a social recluse and was unable to return to work. Based on expert care evidence, he claimed that he required 3.75 hours of care and assistance per day and that in the future, he would require agency care.

A period of covert surveillance and review of social media entries, revealed that Mr Atwal exhibited no disability and continued to work. Crucially, he was seen on video, to be working as a courier, lifting heavy boxes repeatedly and with ease and working as a DJ, even headlining a large festival in Birmingham in 2011.

Once the fraud was brought to his attention, Mr Atwal swiftly accepted the Trust's offer of £30,000. Due to the passage of time, this was swallowed up in legal costs and Mr Atwal received no compensation whatsoever and was left owing the Trust £5,000.

Due to the gravity of the fraud, a decision was made to pursue proceedings for Contempt of Court; allegations which, if proven, meant that Mr Atwal faced a custodial sentence and/or a fine.

Throughout the contempt proceedings (November 2016 onwards), Mr Atwal failed to engage and never sought to explain any of the discrepancies between the surveillance evidence, his pleaded case and claimed loss.

Contempt of Court

The claim against Mr Atwal proceeded on two grounds. First, that Mr Atwal deliberately set out to deceive the Court about the extent of his continuing disability and thus that he deliberately interfered with due administration of justice by falsely representing his symptoms to doctors and experts[1]. Secondly, that Mr Atwal verified Statements of Truth knowing those statements to be false.[2]

To succeed, the Trust was required to provide its allegations to the criminal standard; that is beyond all reasonable doubt.

Following a detailed and complex Hearing on 12.04.18, His Honour Mr Justice Spencer handed down Judgment, confirming that 14 separate grounds of contempt had been proven to the criminal standard. These included statements made within the Schedule of Loss and Mr Atwal's Witness Statement as well as statements made to the medico legal experts. Mr Justice Spencer was satisfied that all of these 14 statements were false, interfered with the administration of justice, that Mr Atwal had no honest belief in the truth of the Statements and that he knew of its likelihood to interfere with the administration of justice.

The Trust successfully relied on inference drawn from Mr Atwal's non- participation and crucially the rapidity at which the very large damages claim was abandoned following receipt of the surveillance material, as evidence that Mr Atwal himself recognised that he had deliberately misled and interfered with administration of justice.

Sentencing

On 27.04.18, Mr Atwal made a surprise appearance at Court, for the handing down of Judgment. On this occasion, he was represented by Counsel who successfully applied for sentencing to be adjourned in order that a plea in mitigation could be entered. Over the forthcoming weeks, Mr Atwal sought, through his new advisors, to explain the contempt and sought to mitigate the effect of his fraud by submitting a witness statement to Court. However, and although Mr Atwal did not seek to dispute the findings of the Court, he neither admitted full responsibility nor unequivocally apologized for his actions.

Therefore, having taken account of a range of aggravating and mitigating factors; not least the fact that this was a claim against the National Health Service, which, if successful would have resulted in a loss of precious public funds, Mr Justice Spencer remarked:

"…My firm and clear conclusion is that a sentence of immediate custody is necessary to mark these serious contempts, and to deter others. I am satisfied that appropriate punishment can only be achieved by an immediate custodial sentence…"

Implications

For many years, the Senior Courts have made it clear that those who submit false claims must expect to go to prison. This welcome decision simply highlights the extremely serious consequences of submitting dishonest and exaggerated claims. The closing remarks of Mr Justice Spencer reiterate how important it is that everyone appreciates that false claims undermine the administration of justice in a number of serious ways; damaging our system of adversarial justice and taking up a great deal of court time and precious resources.

The NHS is not an easy target and should not be looked upon as such. However, it is of equal importance to recognise that those who pursue genuine claims will be properly compensated.

Footnotes

[1]Airbus Operations Ltd v Roberts [2012] EWHC 3631 (Admin), and Homes for Haringey v Fari [2013] EWHC 3477 (QB)

[2]CPR 32.14(1); and, AXA Insurance UK plc v Rossiter [2013] EWHC 3805 (QB).

NHS OUTSOURCING: WHO FOOTS THE BILL WHEN IT ALL GOES WRONG?

Laurence Vick, Legal Director at Enable Law

In this article, Enable Law solicitor/Legal Director, Laurence Vick, comments on the arrangements by which private providers have the option of joining and paying into the NHS Clinical Negligence Scheme for Trusts (CNST) or obtaining indemnity on the insurance market to meet claims arising from work they carry out for the NHS.

Who picks up the bill for failed NHS treatment carried out by private providers?

NHS outsourcing arrangements raise important questions. Is the NHS able to recover the full cost of compensating outsourced patients who suffer injury as a result of a private provider's negligent care? Outsourcing contracts may include provision for an indemnity, but with the lack of transparency prevailing when the private sector is involved – even when working with public bodies – it is difficult to establish whether this is enforced by the NHS, enabling the NHS to recover its outlay from private providers or their insurers
Are those providers who opt to join the NHS CNST scheme meeting the full cost of securing indemnity or are they being allowed to contribute at a lower level then their NHS counterparts for equivalent cover?

In addition to the outsourcing issue, there is the wider question of why should we as taxpayers be expected to absorb the cost to the NHS of providing care for patients who have been harmed in the private sector?

The overriding principle, surely, is that a private provider carrying out outsourced care will deliver safe treatment, which is at least as good as that offered by the NHS, and that the NHS is able to recover losses incurred through the provider's negligent care, whether through indemnities or directly from the provider or its insurers? As patients, we have the expectation that we will be able to claim fair and reasonable compensation from an identifiable, insured defendant if we suffer avoidable injuries and losses resulting from negligent care.

Putting aside the political implications and fears held by many that the NHS is being deliberately under-funded to make way for privatisation, as we sleepwalk into a US style health system, outsourcing to the private sector is a phenomenon that is having an increasing influence on the NHS. Failures of NHS outsourcing and concerns over treatment standards in the private health sector, highlighted by the Paterson case, are receiving greater attention. However, the 'indemnity gap' which may well be opening up as private companies move into health provision has gone largely undiscussed.

As the private sector is beyond the reach of an FOI request, an investigation of these arrangements is difficult but I believe it is in the public interest to know how NHS indemnity works and whether private providers are contributing less than they should to the CNST scheme and if any preferential treatment they receive amounts to a public subsidy.

Does the insurance market have the appetite for indemnifying private providers carrying out NHS work?

Opting out of the CNST scheme and providing a self-funded indemnity of NHS-equivalent insurance doesn't appear to be a realistic option for private operators. The insurance market has shown little appetite to insure the kind of risks faced by a full-service NHS hospital with the potential for claims to emerge many years after treatment has taken place. Insurers must flinch at these unquantifiable liabilities.

Carillion and Collapsed Outsourcers

In our work on outsourcing failures, we have never yet had a client who has received outsourced care without a means of redress – the NHS has not been able to divest itself of legal and clinical responsibility. However, as the reorganisation and fragmentation of health serviced gathers pace, patients may find that have become the exclusive responsibility of the private provider. Liabilities have become blurred, for example, for patients pursuing claims for compensation against GP out-of-hours services.

There will be no problem for the injured NHS patient if the outsourced provider has joined the CNST scheme. Where the company has chosen not to join, but has made separate insurance arrangements or provided an indemnity from its own resources, the NHS should be able to recover the cost of claims arising from negligent care.

With the recent collapse of Carillion, another unsettling concern is that large contracts are being offered to private companies which may not be able to stay the course and may go under if liabilities become too big to bear. With profit an imperative in private healthcare, a rising tide of claims may cause an overseas parent company to withdraw support from its UK subsidiary. The financial position of many of these companies could not be described as rock solid; there is no requirement, for example, to lodge a bond as security should a provider collapse. If a private provider has not joined the CNST and does not have sufficient assets or adequate alternative insurance, the NHS finds itself in a dilemma. Medical negligence claims can have a long tail and Trusts will inevitably face negligence claims from outsourced treatment where the private provider has gone to the wall.

Spire, BMI and other private providers carry out a significant amount of work for the NHS. Spire's NHS referrals account for around a third of its £926m annual revenues. After the news of the pay-outs to Paterson's private surgery victims, Spire's shares fell by 28% and the company warned that a decline in NHS activity would hit profits.

With over half the private hospitals in the UK owned by overseas companies, it is difficult to establish their financial stability. The concern is that the NHS and patients can be left in the lurch if a private operator carrying out NHS work goes bust or its parent company withdraws support.

After Circle's unhappy experience with Hinchingbrooke – the first hospital to be run by a private company – when they pulled out less than a third of the way through their 10-year contract after a disastrous CQC report and mounting losses, there must have been doubt over the private sector's appetite for taking over and accepting the operating risk and indemnity cost of running a full-service hospital. The cancellation of that contract resulted in significant expense to the NHS. Circle had previously been feted as a shining example of the benefits that a private operator can bring to the NHS.

Conclusion

Patient safety must come first. It is crucial that the still comparatively unregulated private sector should be transparent and accountable for the treatment carried out in their hospitals.

The NHS should not be out of pocket or treated as a 'safety net' by the private sector and left to pick up the pieces when private treatment fails or if private providers carrying out NHS work collapse.
Whether private providers joining the CNST must meet the full cost of securing indemnity or are allowed to contribute at a lower level than their NHS counterparts for equivalent cover – including the creation of reserves and providing run-off cover – is unclear.

NHS hospitals may well be uninsurable outside the CNST. The difficulty for private providers of obtaining NHS-equivalent indemnity on the insurance market or meeting the full cost of joining the CNST may prove to be a bulwark against wholesale privatisation of the NHS.

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MEDICO LEGAL MAGAZINE

CRPS IN THE MEDICOLEGAL SETTING: EXPERTS NEED TO CONSIDER A RANGE OF OPINION

Dr Christopher Bass, Consultant Liaison Psychiatrist, The Manor Hospital, Beech Road, Headington, Oxford Email: christopher.bass@oxfordhealth.nhs.uk

Dr Bass is the author or co-author of several influential texts in psychosomatic medicine, including 'Somatisation: Physical symptoms and Psychological illness', 'Treatment of Functional Somatic Symptoms', 'Contemporary Approaches to the Science of Hysteria: Clinical and Theoretical Perspectives', and 'Malingering and Illness Deception'.

Complex regional pain syndrome [CRPS] is a chronic pain syndrome of unknown cause. It usually affects the lower or upper limbs after an injury, accident or surgery, which is why it often appears in a schedule of damages in a medico-legal claim. It is accompanied by a set of variable symptoms, which include allodynia [normal sensation is experienced as painful], vasomotor [vascular], sudomotor [sweating], and motor [abnormal movements] changes. It has traditionally been divided into Type 1 [the result of a soft tissue injury and previously termed reflex sympathetic dystrophy] and Type 2 [the result of nerve damage-so-called neuropathic pain, and previously called causalgia]. These criteria have been more systematically defined in the Budapest Criteria [see Box 1]

CRPS is uncommon and can occur at any age with the average age at diagnosis being 42. It is three times more common in females than males and is increasingly being seen in medico-legal settings. There is also some evidence that it is being over diagnosed [1]. The Royal College of Physicians published a document in 2012 describing the clinical features, treatment and prognosis of the disorder. [2]

In the last few years however there have been major criticisms of the disorder. I will divide these criticisms into three categories. First, the **diagnostic criteria** are very non-specific, because there is no gold standard laboratory or imaging test to establish it. As a consequence the diagnosis lacks what doctors refer to as "validity and reliability," and this leads in turn to very poor levels of inter-observer agreement among doctors. A good example of this was seen at a tertiary care pain clinic in Toronto, Canada, where three quarters of patients referred with a diagnosis of CRPS [I or II] by a primary care doctor or specialist did not fulfil the Budapest clinical diagnostic criteria [3]. This problem was also demonstrated recently in a study of patients with CRPS who presented in a medico-legal setting: in two fifths of cases there was lack of agreement between the examining clinicians about the diagnosis [4].

These shortcomings of the diagnostic criteria were recently summarised in a systematic review from the USA [1]:

- The use of diagnosis CRPS I has become a catch-all phase with serious questions on whether it exist at all; this has led to an extraordinary number of poorly defined diagnostic criteria.
- The overdiagnosis of CRPS has led to overzealous use of pain medications, including narcotics.
- The diagnostic criteria for CRPS I, and therefore the diagnosis itself, is unreliable
- The underlying pathophysiology of the signs and symptoms of CPRS I are not biologically plausible
- There are no consistent laboratory or imaging testing available

- The signs and symptoms of CRPS I fluctuate over time without a medical explanation, and most studies are derived from statistical analysis with little consideration to required sample size, i.e. power calculations

Second, there is evidence that the signs and symptoms of CRPS can be reproduced by **immobilization.** After a limb fracture and/or surgery with subsequent cast immobilization, a substantial proportion of patients will exhibit at least one of the signs and symptoms of CRPS Type 1, including movement-induced pain, sensitization to a variety of mechanical and thermal stimuli, oedema [swelling], vasomotor instability and joint stiffness. It has even been suggested by a Dutch expert that the clinical manifestations of CRPS can be reproduced by a combination of fear and immobilization. [5] Ek has recommended that the term CRPS should be renamed post–immobilsation syndrome or PIS, and has argued that this would in turn encourage the patient to engage in normal behaviour i.e. mobilization. Significantly, there is evidence that this treatment, recently described as "pain exposure" can be helpful in these patients. [6]

Finally, there is the vexed question of **psychological contribution** to the pain complaints. It was reported in the RCP document that *"CRPS is not associated with a history of pain-preceding psychological problems, or with somatisation."* [2] However, evidence is accumulating to suggest that there is a subset of patients who are diagnosed with CRPS who have a vulnerability to develop so-called "functional" i.e. non-organic syndromes. These include a group of overlapping disorders such as fibromyalgia, irritable bowel syndrome, non-cardiac [muscular] chest pains, tension headaches, migraine etc. Because medical records [often dating from birth] are made available to doctors writing medicolegal reports, it is often possible to examine the longitudinal health record for evidence of previous pain syndromes. It has recently been shown for example that a previous diagnosis of fibromyalgia is a predictor of CRPS after a distal radius fracture, and that migraine is also over-represented in the histories of these patients. In a study carried out in a medico-legal setting, 40% of patients with CRPS involved in litigation were found to have experienced previous episodes of two or more functional syndromes such as IBS and migraine [4]. This suggests that a subgroup of patients designated CRPS have a pain vulnerability or pain sensitivity. There is also an increased likelihood that these patients have evidence of a current somatic symptom disorder or SSD, defined below:

A **somatic symptom disorder** does not exclude the possibility of a co-existing physical disorder. Indeed, DSM-5 states that – *The symptoms may or may not be associated with another medical condition. The diagnoses of a somatic symptom disorder and a concurrent medical illness are not mutually exclusive, and these frequently occur together. For example, an individual may become seriously disabled by symptoms of somatic symptom disorder after an uncomplicated heart attack, even if the heart attack itself did not result in any disability. If another medical condition or high risk for developing one is present, e.g. strong family history, the thoughts, feelings and behaviours associated with this condition are excessive.*

In these cases the patient has usually responded to an injury/accident with an exaggerated sense of fear and alarm [so-called "catastrophic thinking"] as well as fear-avoidance behaviour i.e. immobility of a limb or part of a limb which has contributed to the condition becoming chronic.

Evidence that the patient with CRPS has a SSD [or what used to be called a somatoform disorder] is greatly assisted therefore by the expert providing a chronology documenting a longitudinal health record. In some cases this will reveal past histories of multiple recurrent episodes of pain [some with "functional" syndromes co-occurring with recurrent low back, neck and other musculoskeletal pains], which may be punctuated by episodes of depression, anxiety and occupational stress. Alcohol and/or drug misuse may also be detected, and provide evidence of the patient's coping resources, which may be compromised by repeated episodes of pain.

For example, patients with emotionally unstable personalities are habitually alarmed by the pain experience and may respond to it by repeatedly and impulsively admitting themselves to A and E departments. An example of the importance of the longitudinal health record was made clear in a recent judgment in a CRPS case with SSD [7].

The influence of iatrogenic factors and the nocebo effect cannot be under estimated in these cases. These patients often end up being prescribed opiates and may be informed by a clinician that the pain "might spread to the other limb." In patients who are vulnerable to and have a heightened awareness of pain complaints with high levels of illness worry such comments may become self-fulfilling.

Treatment

There is a lack of consensus about treatment of CRPS. Deborah Bean, a psychologist from New Zealand, has carried out a number of studies showing that anxiety, pain-related fear and disability are associated with poor outcomes in patients with CRPS. [8] Her findings support the theory that CRPS represents an aberrant protective response to perceived threat of tissue injury, and support the view that the most appropriate therapeutic and cost effective intervention is physical activity. This should be instigated early and supervised by clinicians with experience of treating patients with a combination of physical and psychological problems.

Conclusions

CRPS is a heterogeneous condition with multiple causes. Evidence is accruing to suggest that psychosocial factors are more important in the maintenance of the disorder than was previously considered. There is a range of opinion about the causes, maintaining factors and optimum treatment approaches, and there is evidence that in some cases the disorders are somatoform in nature. Dogmatic approaches to the clinical dilemmas posed by these patients are ill advised, and experts should always consider a range of opinion. Diagnoses should be influenced not only by an awareness of pre-existing medical history [especially recurrent pain syndromes, which may reflect a vulnerability shaped by genetic and environmental factors] but also by an awareness of those psychological factors that are maintaining the current pain complaints and behaviour.

Box 1 | Current International Association for the Study of Pain: clinical diagnostic criteria for complex regional pain syndrome1
Continuing pain, which is disproportionate to any inciting event

- **Must report at least one symptom in three of the four following categories*:**
  - Sensory: Reports of hyperalgesia and/or allodynia
  - Vasomotor: Reports of temperature asymmetry and/or skin color changes and/or skin colour asymmetry
  - Sudomotor/oedema: Reports of oedema and/or sweating changes and/or sweating asymmetry
  - Motor/trophic: Reports of decreased range of motion and/or motor dysfunction (weakness, tremor, dystonia) and/or trophic changes (hair, nails, skin)
- Must display at least one sign at time of evaluation in two or more of the following categories*:
  - Sensory: Evidence of hyperalgesia (to pinprick) and/or allodynia (to light touch or deep somatic pressure, or joint movement)
  - Vasomotor: Evidence of temperature asymmetry and/or skin color changes and/or asymmetry
  - Sudomotor/oedema: Evidence of oedema and/or sweating changes and/or sweating asymmetry
  - Motor/trophic: Evidence of decreased range of motion and/or motor dysfunction (weakness, tremor, dystonia) and/or trophic changes (hair, nails, skin)
- There is no other diagnosis that better explains the signs and symptoms

*For research settings in which it is desirable to maximize specificity, a more stringent research diagnostic decision rule requires all four of the symptom categories and at least two of the sign categories to be positive for diagnostic criteria to be met.

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A SUMMARY OF THE DR BAWA-GARBA CASE; SHOULD A DOCTOR'S GROSS NEGLIGENCE MANSLAUGHTER CONVICTION LEAD TO AUTOMATIC ERASURE FROM THE GMC REGISTER?

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On 13th August 2018, the Court of Appeal ruled that Dr Bawa-Garba's conviction for gross negligence manslaughter, in relation to the death of Jack Adcock, should not have resulted in her being struck off the GMC's Medical Register. Laura McIntyre summarises the events leading to this judgement.

Timeline

- **February 2011** - Jack Adcock dies from sepsis at Leicester Royal Infirmary
- **December 2014 -** Dr Bawa-Garda, Ms Amaro and Ms Taylor are charged with gross negligence manslaughter
- **November 2015** - Dr Bawa-Garba and Ms Amaro are convicted of gross negligence manslaughter and given two year suspended prison sentences
- **August 2016 -** Ms Amaro is struck off the Nursing and Midwifery Council (NMC) Register
- December 2016 - Dr Bawa-Garba is denied permission to appeal against her manslaughter conviction
- **June 2017 -** Dr Bawa-Garba is suspended for 12 months by the Medical Practitioners Tribunal Service (MPT)
- **January 2018** - The High Court substitutes the sanction of erasure from the medical register
- **March 2018 -** Dr Bawa-Garba is granted leave to appeal her erasure and the GMC's argument that a manslaughter conviction should result in automatic erasure from the Register is rejected
- **July 2018 -** Dr Bawa-Garba's appeal is heard in the Court of Appeal.
- **August 2018 –** Judgment is handed down; Dr Bawa-Garba's appeal was successful and her erasure is set aside and the Order for 12 months suspension restored.

Background

On 18th February 2011, six-year-old Jack Adcock, who had Down's syndrome and a heart condition, was admitted to Leicester Royal Infirmary with sickness and diarrhoea. Dr Bawa-Garba, a Trainee Paediatrician, was responsible for the care of Jack and has been found to have been responsible for a series of errors, which led to Jack's death later the same day. These errors were also contributed to by agency nurse, Isabel Amaro, who was responsible for Jack's hands-on care.

Importantly, the Trust's internal investigation concluded that no single root cause could be identified, and multiple actions were recommended in order to minimise risk to future patients. Concerns have been raised that the wider system in which Dr Bawa-Garba and Ms Amaro were working also contributed to Jack's death and that they have been 'scape-goated' for systemic failures.

The systemic failures included the lack of cover provided for the other Registrar to attend a training day and the on-call Consultant not being on-site until the afternoon. Additionally, there were difficulties with the IT system used to review test results. Dr Bawa-Garba also worked her 13-hour shift without a break and had just returned from maternity leave to a Hospital which was new to her, having received no induction.

Criminal Convictions and Professional Sanctions

In November 2015, Dr Bawa-Garba and Ms Amaro were found guilty of gross negligence manslaughter and were both handed two-year suspended prison sentences.

In August 2016, it was found that Ms Amaro's Fitness to Practise was impaired and she was stuck off the Register by the NMC. In June 2017, Dr Bawa-Garba's Fitness to Practise was also found to be impaired by the MPT and she was suspended from practice for 12 months. The MPT considered Dr Bawa-Garba's actions to be neither 'deliberate or reckless' and decided that she did not 'pose a continuing risk to patients'; erasure would therefore be disproportionate.

GMC's Appeal

The GMC was of the view that the MPT had re-examined the criminal case and arrived at their own, less severe, conclusion regarding Dr Bawa-Garba's personal culpability. They therefore appealed the decision of the MPT to avoid setting 'a wider precedent in allowing tribunals to unpick the findings and outcomes of the criminal court process'.

In January 2018, the High Court held that Dr Bawa Garba's sanction should be substituted for erasure from the GMC Register, saying that "The Tribunal did not give the weight required to the verdict of the jury, and it was simply wrong to conclude that, in all the circumstances, public confidence in the profession and its professional standards could be maintained by any sanction short of erasure."

In March 2018, Dr Bawa-Garba was granted leave to appeal this decision and the High Court rejected the GMC's argument that a manslaughter conviction should result in automatic erasure from the Register.

Dr Bawa-Garba's Appeal

Dr Bawa-Garba appealed the decision of the High Court and was successful. Accordingly, the sanction of erasure has been set aside and the original order of 12 months suspension from practice, subject to review by the MPT, has been restored, with a review hearing to be held as soon as possible.

In handing down their unanimous judgment, the Court of Appeal held that the Divisional Court was wrong to interfere with the decision of the Tribunal and commented that an appeal court should only interfere with the "evaluative decision" of a Tribunal if:

1. *there was an error of principle in carrying out the evaluation, or*
2. *for any other reason, the evaluation was wrong, in the sense that it was a decision which fell outside the bounds of what the adjudicative body could properly and reasonably decide.*

The Court of Appeal held that neither of the above grounds applied in this case and highlighted that the criminal court and the MPT are different bodies with different functions. They also said that the Tribunal were just as entitled to take the systemic failings of the Hospital and others into account when deciding sanction, as the criminal court had been when passing sentence.

The GMC has confirmed that they will not appeal to the Supreme Court.

Concerns with the GMC's Decision to Appeal

The GMC's appeal of the MPT's decision has led to widespread unrest within the medical profession, largely because it is recognised that the systemic failures which contributed to Jack's death are becoming the norm. Some of the concerns raised are:

- A fear that written reflections may be used against doctors in future cases (though this

was not the case here). As a result, there is concern that doctors will be less frank in reflecting upon mistakes and that this will, in turn, threaten the learning culture within the profession, thus impacting on patient safety.

- The GMC's own Regulator, the Professional Standards Authority, considered the GMC's appeal to be without merit, given the established case law.
- The perception that the GMC is lenient in cases where personal conduct is more worrying, for example doctors placed on the Sex Offender's Register, or found guilty of fraud. It is argued that the GMC should concentrate on dealing with doctors who are deliberately and repeatedly dishonest, rather than those who are conscientious and make a single clinical error.
- The GMC's Sanctions Guidance clearly outlines that the purpose of Fitness to Practise proceedings is not to punish the doctor a second time. Therefore, if the doctor presents no danger to the public, their career should not be sacrificed in order to satisfy a demand for blame and punishment.

Future

Independent reviews have been commissioned by both the GMC (Marx Review) and the Government (the Williams Review) in relation to manslaughter charges for doctors. The Williams Review, published on 11th June 2018, included a recommendation to strip the GMC of its right to appeal MPT decisions. Then Health and Social Care Secretary, Jeremy Hunt, said that he planned to implement this change, amongst others, which included a review of all deaths which are not considered by Coroners.

The legislative process to repeal the GMC's right of appeal will be lengthy and, in the meantime, the GMC has confirmed that they intend to continue exercising this right.

CONSENT IN PAIN MEDICINE

Dr Rajesh Munglani, Consultant in Pain Medicine, St Thomas Hospital, London

The Hippocratic oath, whilst holding the physician to account over his actions, implicitly assumes the agreement of the patient and/or the relatives to whatever course of action the physician decides.

Dalla-Vorgia, 2001[1] notes that from ancient times, physicians have, at least on occasion, been driven to seek consent of their patients either because of respect for their patient's autonomy or from fear of the consequences of a failure.

The test of legal consent used in the UK courts was based on the case of Bolam (1957)[2]. Bolam was in fact a case about clinical negligence, and deciding whether a particular course of medical action would be considered professionally responsible by a body of the doctor's colleagues. Therefore, the decision in Bolam (applied and accepted in many subsequent cases including the important case of Bolitho in 1996[3,4]) was essentially about how to judge a doctor in performing *the duty of a doctor in areas of diagnosis and treatment*. However, the Bolam/ Bolitho tests were also being applied to (and certainly not distinguished from) another equally important area of a doctor's duty, that of *the disclosure of information to patients* in the process of obtaining consent to treatment.

To understand why this was and how the recent Supreme court ruling of Montgomery (2015) has profoundly changed this, one needs to understand the different roles of a doctor;

[a] diagnosis and treatment
[b] disclosure of information to obtain consent.

Many Courts outside the UK common law jurisdictions had already recognised that obtaining consent through the provision of sufficient information was a vital part of a doctor's duty, for not to do so could well constitute a case of battery or assault.

The provision of that information permits patients to make choices about what risks they are prepared to run, and these (ultimately medical) *choices of the patient* depend on factors that may transcend professional medical training and knowledge. Many studies suggest that non-medical factors and patient specific factors are important.

This leads to the point of what is known as therapeutic privilege of filtering information. It was argued in Montgomery (2015) that the medical profession should not be permitted to filter information or substitute their own best medical judgements for the informed decision of the patient.

The duty to provide the patient with information should not be defined by the amount of information the doctor thinks the patient should know, but by the information the patient needs to enable them to make an autonomous choice. (Sutherland, 2015)

In 1999, Nadine Montgomery gave birth by vaginal delivery. The birth was complicated by shoulder dystocia and during the 12-minute delay, Sam, her

baby was deprived of oxygen and subsequently diagnosed with cerebral palsy with ongoing lifelong consequences. .[5,6,7]

Mrs Montgomery was diabetic and small in stature and the risk of shoulder dystocia was thought to be 9-10%. Despite her expressing concern to her consultant about whether she would be able to deliver her baby vaginally, the doctor failed to warn Mrs Montgomery of the risk of serious injury from shoulder dystocia or offer her the alternative possibility of an elective caesarean section.

Mrs Montgomery brought a claim, alleging that had she been advised of the 9-10% risk of shoulder dystocia associated with vaginal delivery (notwithstanding the risk of a grave outcome was small, less than 0.1% risk of cerebral palsy), then she would have opted for delivery by caesarean section and that this would have prevented her child's injury.

All the medical experts, and indeed the (defendant) treating obstetrician at the time, when asked what they would likely have wanted had they been in Mrs Montgomery's position, agreed they would have wanted a caesarean section too but the Defendants in the case maintained their position that a reasonable body of obstetricians would not have informed Mrs Montgomery of the risk. That is, they stated it was the treating doctor's right to choose what to tell the patient and that a reasonable body of responsible peer doctors would not have advised of the risk.

The Supreme Court rejected the Defendant health board's argument and ruled that the Bolam test was no longer suitable as a test for deciding what information should be provided in order to obtain valid consent. The Supreme Court decided that the discussion of risks with patients, and the extent to which a doctor may be inclined to discuss risks with patients, should not be determined by what was established medical practice:

The Supreme Court ruled that Mrs Montgomery should have been informed of the risk of shoulder dystocia and given the option of a caesarean section. Mrs Montgomery was awarded £5.25 million in damages for the injury sustained by her child.

As stated by Lord Brodie (Brodie, 2018)[8], what Montgomery did was radically to rethink just what should be understood by the notion of consent to treatment and to endorse (as the GMC had been stating for many years) a model of a therapeutic relationship in which, when it comes to deciding treatment, the focus is turned upon the patient and the patient's rights and responsibilities.

The GMC has provided a framework for consent which all medical practitioners are expected to be familiar with ('Consent: patients and doctors making decision together' GMC 2008). Briefly the principals include the following:

[a] listen to patients and respect their views about their health
[b] discuss with patients what their diagnosis, prognosis, treatment and care involve
[c] share with patients the information they want or need in order to make decisions
[d] maximise patients' opportunities, and their ability, to make decisions for themselves
[e] respect patients' decisions.

There is recognition of the complexity and uncertainty in medical information and practice and the difficulty in applying appropriate information to a specific individual.

So, doctors must now ask themselves three questions (Sokol 2015[9]):

1. Does this patient know about the material risks of the treatment I am proposing?
2. Does this patient know about reasonable alternatives to this treatment?
3. Have I taken reasonable care to ensure that this patient knows this?

It is not the purpose of this article to provide a definitive or approved medical course of action but the following practices need to be demonstrated to have been performed.

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1. A provision of information which will allow for the understanding of this particular patient. The complexity of information and issues that needs to be considered means that in practice the prior provision and consideration of written information (for example a patient information leaflet or similar and a copy of the clinic letter) followed by a subsequent discussion is most likely to achieve this. This consenting process will take time and usually require more than one occasion and should not be rushed. The fact it has taken place and the key points discussed must be recorded.

2. A discussion of those particular factors that are likely to matter to this particular patient. Risks or complications which may not concern another patient may be very important to this one.

3. That care has been taken to ensure that this patient understands what are the implications of any treatment which is being suggested, what alternative or variant treatments exist together with their implications and the implications of not going ahead with the proposed or any active treatment.

There are a number of areas where this will come into play in pain medicine and in particular may give rise to issues in regards to consent to treatment and the provision of information to the patient The basic principles are:

1. That the natural history of the pain condition needs to be considered, that is pains may get better, or worse, but usually they are persistent regardless of treatment.

2. That there is very little evidence that *any* treatment in pain medicine will reliably make a long-term difference to the condition of a patient.

3. That certain treatments *may* produce long-term change but may also be associated with (potentially catastrophic) risks.

4. That certain treatments may or may not be more efficacious than other treatments, but do carry greater risks. This is particularly relevant in the case of particulate steroids for neuraxial use. The choice about the composition of the injectate now lies with the patient who should be informed of the current medical range of opinion in the matter.

5. That patients need to be given adequate time to consider the proposed treatment and particularly where invasive treatments may be associated with serious complication and with no clear benefits in terms of long-term outcome are recommended. These issues need to be discussed fully and the patient needs to be given adequate time as needed to reflect and consider whether to accept them.
Currently patients are often given little or no time just before surgery, for which they have been carefully consented, to consider the use of invasive regional anaesthesia (e.g brachial plexus block, spinal other, regional block) and their effects on short and long term outcome and the possible serious (but fortunately rare) complications.

6. That consent of a patient for a procedure by a particular individual, say a consultant in pain medicine, does not automatically give any other person the right to perform the same procedure without further discussion and further consent.

It is therefore important that care is always taken to ensure that consent is appropriate, fully informed, and transparent.

Dr Munglani is the founder and co-organiser of the Cambridge Annual Medico-Legal Conference, held at Peterhouse, Cambridge, this year on 28 September 2018 - see www.medicolegalpain.com for details.

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NEWS
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MEDICO -LEGAL NEWS:

By Lisa Cheyne, Medico-Legal Manager, SpecialistInfo

A round-up of news in the industry for the second quarter of 2018.

Claimants lose mass action "metal-on-metal" hip replacement court case at the High Court: *Gee & Others v DePuy International Limited [2018] EWHC 1208 (QB)*

In May, Mrs Justice Andrews ruled that manufacturer DePuy was not liable to the 312 patients who claimed they had been injured by the implants.

The Pinnacle Ultamet replacement was withdrawn from sale in the UK in 2013 and 312 people said they had had to have remedial surgery after it had failed prematurely.

Lawyers for claimants, Leigh Day, alleged it had released metal particles, damaging the surrounding tissues and causing pain, difficulty walking, swelling and numbness or loss of sensation in the leg.

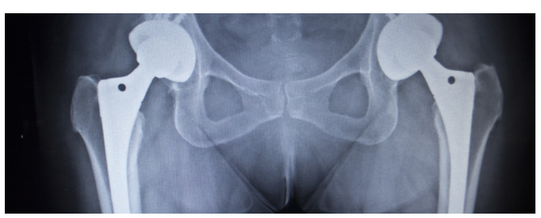
Mrs Justice Andrews said they had failed to prove the hip joint:

"did not meet the level of safety that the public generally were entitled to expect at the time when it entered the market in 2002"

Last year, the Medicines and Healthcare products Regulatory Agency said every patient with a metal-on-metal prosthetic hip should have regular check-ups to spot any complications.

About 56,000 UK patients have had a metal-on-metal hip device implanted.

Read more: http://fy68w4dd72j1r1z33vbuky14-wpengine.netdna-ssl.com/wp-content/uploads/2018/05/Pinnacle-MOM-final-approved.pdf



SpecialistInfo sets the date for its 2019 Medico-Legal Conference – 16th May 2019, at the Queen Elizabeth Hall, South Bank, London

We are excited to announce that plans are now well underway for our first ML Conference in London on 16th May 2019.

We are aiming to have 4 or 5 sessions during the conference with 2 to 4 speakers talking on different aspects of each session from a medical and legal standpoint.

The current planned sessions are:

- Fundamental Dishonesty,
- Rehabilitation (including traumatic brain injury),
- Medico-Legal Challenges,
- Medico-Legal Hot Topics (including Consent Issues, Sepsis and Gynaecological Mesh),
- Interesting Medico-Legal Cases

Please visit the website for more information and to book: www.medicolegalconference.com

Please contact nicola@specialistinfo.com for further information if you are interested in presenting a talk or sponsorship.

Dr Bawa-Garba reinstated to the medical register by the Court of Appeal

On the 13th August the judges of the Court of Appeal ruled that Dr Bawa-Garba's actions leading to her conviction of Manslaughter in the case of Jack Adcock had been neither deliberate or reckless and she should not have been struck off.

The GMC has accepted the judgement.

"*The lessons that I've learnt will live with me forever. I welcome the verdict because for me that's an opportunity to do something that I've dedicated my life to doing, which is medicine. But I wanted to pay tribute and remember Jack Adcock, a wonderful little boy who started this story,*" Dr Bawa-Garba said.

"*My hope is that lessons learnt from this case will translate into better working conditions for junior doctors, better recognition of sepsis, and factors in place that will improve patient safety.*"

See page 14 for a full account of the case.

NEWS
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Landmark Supreme Court judgment on withdrawing clinically assisted nutrition and hydration: *Y [2018] UKSC 46*

Hempsons Law Firm acted for the successful CCG and NHS Trust in a Supreme Court judgment in July on when an application to Court is needed to withdraw clinically assisted nutrition and hydration

Mr Y was an active man in his 50s when, in June 2017, he suffered a cardiac arrest which resulted in brain damage. After extensive assessment, his treating team concluded that he was suffering from a Prolonged Disorder of Consciousness (PDOC) and would likely require a significant level of care for the rest of his life. His family believed that he would not wish to be kept alive in such circumstances. They agreed with his treating team that it was not in Mr Y's best interests to continue to receive clinically assisted nutrition and hydration (CANH) and that this should be withdrawn, allowing him to pass away with dignity. An expert clinician, independent of the NHS bodies involved, agreed that this was in Y's best interests.

Supreme Court judgment

Lady Black giving the leading judgment concluded that neither the common law nor the ECHR impose a mandatory requirement to involve the Court to decide upon the best interests of every patient in a PDOC before CANH can be withdrawn. As long as the provisions of the Mental Capacity Act 2005 (MCA) are followed, the relevant professional guidance is adhered to and there is agreement between family and clinicians as to best interests, there need not be an application to the Court prior to withdrawal (see link to judgement below).

This is a significant judgment which provides much needed clarity as to the role of the Court in end of life care:

For clinicians working with patients in PDOC, there will be no need to involve the Court or the Official Solicitor prior to withdrawal of CANH of patients in a PDOC when all are agreed as to best interests.

In cases where there is no such agreement, i.e. when there is a dispute as to diagnosis or best interests, an application must still be made to the Court prior to withdrawal.

Read more: https://www.supremecourt.uk/cases/docs/uksc-2017-0202-judgment.pdf

Government delays state-backed GP indemnity update

The Government has been unable to update GPs on their long-awaited state-backed indemnity solution by the deadline it had set itself in May.

The Department of Health and Social Care announced the scheme last year, after acknowledging that high costs of medical negligence cover were impacting GPs' ability to work.

A DHSC spokesperson said: 'We are continuing to work closely with key stakeholders in the development of the scheme from April 2019. We will provide a further update in the near future.'

GPs have been contending with indemnity cost rises of up to 25% annually for the last few years, which are unsustainable.

Read more: http://www.pulsetoday.co.uk/news/gp-topics/legal/cost-of-nhs-clinical-negligence-payouts-continues-to-soar/20037086.article

NHS England action plan hopes to prevent over 600 stillbirths a year

Clinical improvements such as better monitoring of a baby's growth and movement in pregnancy, along with better monitoring in labour, means that maternity staff have helped save more than 160 babies' lives across 19 maternity units, where the Saving Babies Lives Care Bundle, had been implemented, according to an independent evaluation published on 30 July 2018.

The best practice guidance is now being introduced across the country.

The Saving Babies Lives Care Bundle is part of an overall plan by NHS England to make maternity care safer and more personal.

There are approximately 665,000 babies born in England each year, but of these 3,000 are stillbirths, with one in every 200 babies stillborn. Although this is the lowest number for 20 years, there is still a need for improvement.

Key successes identified in the report include:

- Increase in the detection of small babies – there was a 59% increase in detection attributed to better monitoring and scanning in pregnancy
- Better awareness of a baby's movement in pregnancy – with a high number of women attending hospital due to reduced movement.
- Carbon monoxide testing for smoking in pregnancy was almost universal – Smoking is strongly associated with stillbirth. A 1% increase in smoking rates increases the chances of stillbirth by 1.7%. Alongside carbon monoxide monitoring there has been a decline in the number of women smoking, at time of booking.

Whiplash PI reforms delayed until April 2020

The Ministry of Justice decision in July to postpone reform of the personal injury market has been met with unanimous approval across the industry.

The MoJ said the changes introduced through the Civil Liability Bill will 'fundamentally transform' how low-value whiplash claims are handled, and it needed to address concerns about access to justice.

The extra year is designed to give officials more time to create an online platform capable of allowing litigants to make their own claims without legal representation. As well as the new small claims limit removing recoverable costs, the bill includes plans for a tariff of fixed damages at a reduced rate, effectively making it unviable for lawyers and most expert witnesses to be involved in the claims process.

Read more: https://www.lawgazette.co.uk/news/moj-confirms-whiplash-reforms-delayed-to-april-2020/5066893.article

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