MEDICO LEGAL

MAGAZINE

ISSUE 15

Presented by:

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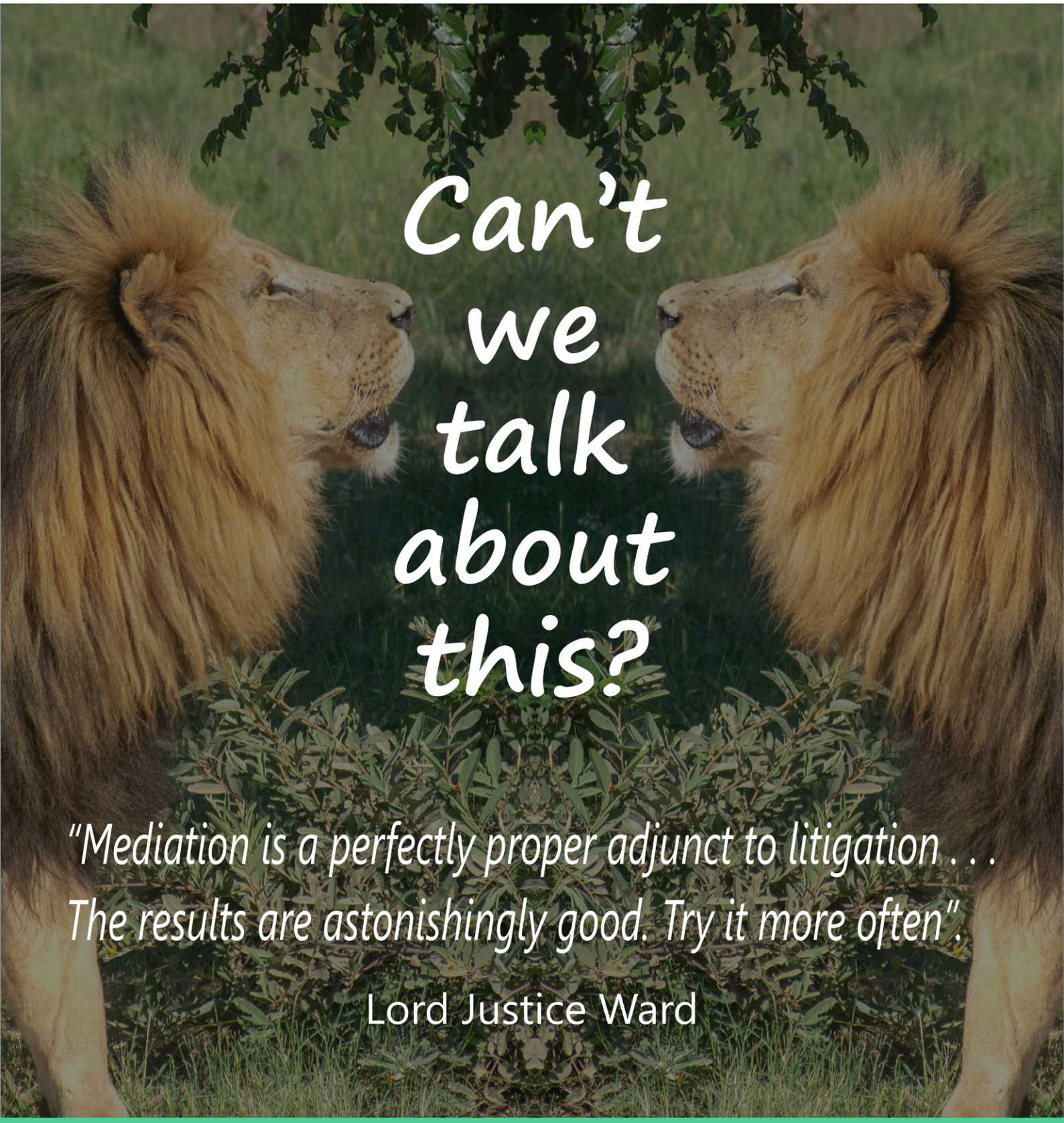

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Welcome to the Medico-Legal Magazine

Welcome to Issue 15 of the Medico-Legal Magazine, produced by SpecialistInfo and publishing partner Iconic Media Solutions Ltd.

This final issue of 2020 includes articles from several of the speakers from our recent Medico-Legal Conference:

Warren Collins, personal injury lawyer of Penningtons Manches LLP, reminds experts how they should all understand the importance of their duties to the Court, and the potential consequences if they fail in them.

Mark Waterstone, consultant obstetrician, covers the hot topic of consent in obstetrics.

Jonathan Dingle, barrister and mediator at Normanton Chambers, updates us on the use of alternative dispute resolution in healthcare disputes.

Also in this issue, regular contributor and healthcare law expert, Laurence Vick, discusses lessons learned from the Bristol heart scandal and the 2001 Kennedy inquiry.

Once again, the magazine will be circulated to up to 40,000 people in the industry, including doctors, insurance companies, law firms and medico-legal agencies. It is published on the Medico-Legal Section of the Specialistinfo.com website, and printed copies can be ordered from Iconic.

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

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

Lisa Cheyne

Specialistinfo
Medico-Legal Magazine

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 2020 are listed below with links to our booking page.

The Medico-Legal Essentials Course on the key skills and knowledge for safely preparing medico-legal reports in personal injury cases:

- *18th November 2020* – Live Online Course powered by Zoom
- *20th January 2021* – Live Online Course powered by Zoom

£225 (plus VAT)

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

The Clinical Negligence Course (5 CPD points) is invaluable for doctors who write reports in (alleged) CN cases against medical staff. Knowledge of this area can also help in avoiding allegations of clinical negligence:

- *19th November 2020* – Live Online Course powered by Zoom
- *21st January 2021* – Live Online Course powered by Zoom

£245 (plus VAT)

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

The Advanced Medico-Legal Course (6 hours CPD) will be of benefit to all experts who wish to refresh and enhance their Medico-Legal knowledge:

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- *10th March 2021* – Live Online Course powered by Zoom

£150 (plus VAT)

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

The Courtroom Skills Course (6 hours CPD) is essential if you are preparing Clinical Negligence or long-term injury reports, or likely to be called to any court or hearing as an expert witness.

- *17th December 2020* – Live Online Course powered by Zoom
- *11th March 2021* – Live Online Course powered by Zoom

£150 (plus VAT)

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

***NEW COURSE* The Consent in Medico-Legal Cases Course** (5 hours CPD) is vital to understand the real importance of this very topical issue:

- *7th January 2021* – Live Online Course powered by Zoom
- *7th April 2021* – Live Online Course powered by Zoom

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

***NEW COURSE* 2 day Medical Mediation Training Course** a perfect introduction to the power of this conflict resolution tool. Understand and develop key mediation-style management methods that can be deployed within the workplace before problems between colleagues, clinical or management teams and Trusts escalate into more serious complaints or even legal disputes.

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(should you wish to go on to qualify as a Civil Mediation Council (CMC) Accredited Mediator, you will need to attend a further three days of live workshops, at a later date (see below), having already covered the theoretical elements required.)

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- *11th - 15th January 2021* – London (subject to ongoing covid restrictions)

From £1200 (plus VAT)

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

SpecialistInfo is committed to expanding our growing range of Online Medico-Legal and Mediation Training Courses, to keep expert witnesses compliant with CPR.

Please be aware: Rules for expert evidence have significantly changed on 1st October 2020 and it is recommended that all experts book a remote updating session to ensure they are compliant.

Details of our upcoming Medico-Legal and Mediation courses are below and all confirmed dates are available on our course **website**.

To book your place(s) and for more information about all our 2020/21 courses, please click **here**, email **lisa@specialistinfo.com** or call me on **01423 727721**.

Kind regards

Lisa Cheyne
Medico-Legal Manager

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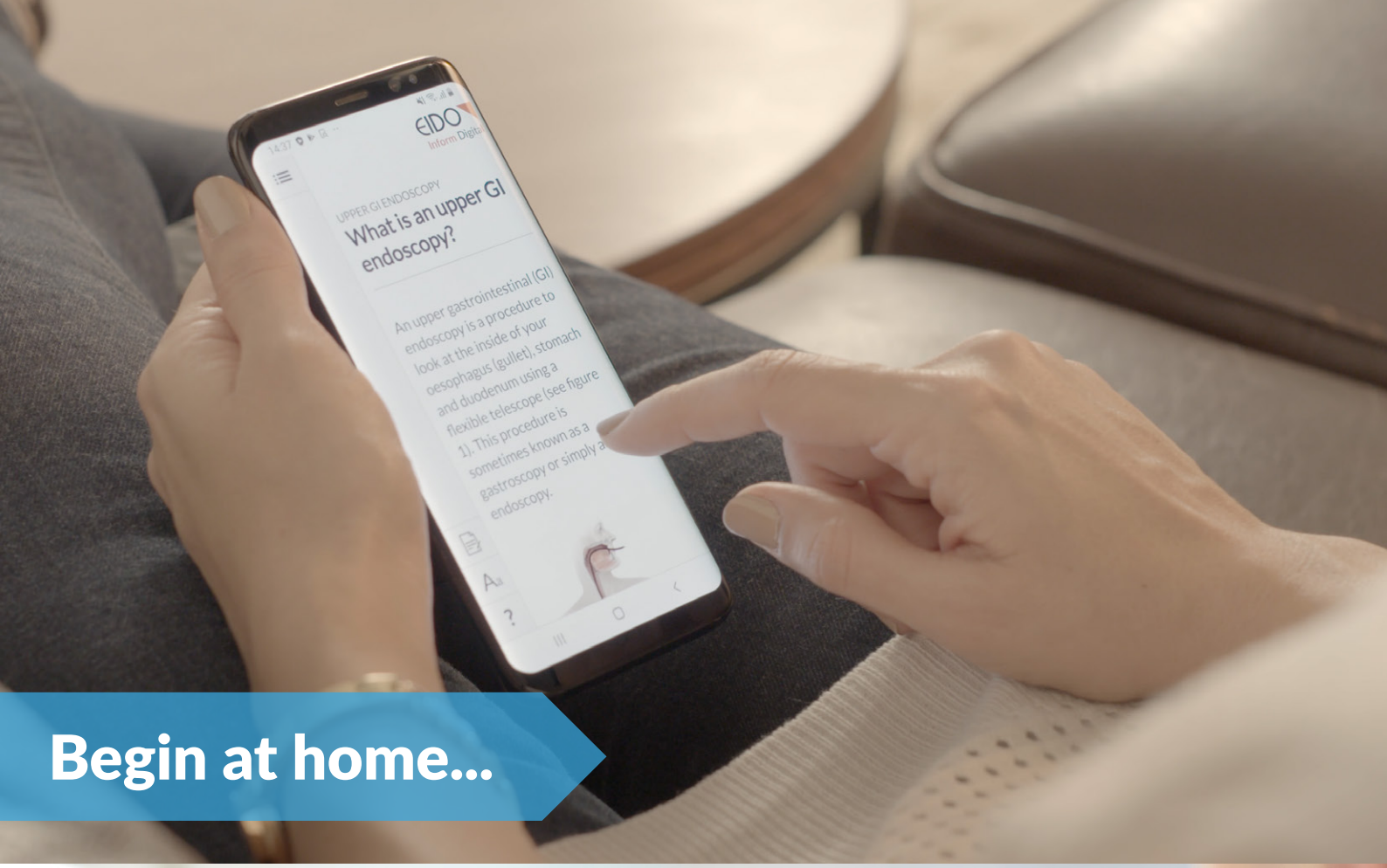

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WE CAN WORK IT OUT – OR DAY TRIPPER?

DISPUTE RESOLUTION IN NHS MEDICO LEGAL CASES

by Jonathan Dingle FRSA[1]

In December 2016, NHS Resolution (known at the time as the NHS Litigation Authority) took what it describes[2] as the "ground-breaking step of becoming one of the first indemnifers in the UK to establish a mediation panel with the focus of resolving clinical negligence and personal injury compensation claims". Historians of dispute resolution may differ on the chronology, there having been a number of important schemes dating from 20 years before, but in terms of a change in mindset for the NHS it was certainly "revolutionary" given the previously stoic defence of the indefensible and the slow adoption of the duty of candour by those instructed on behalf of Trusts.

This change in attitude was followed in 2017, by the name change from NHS Litigation Authority to NHS Resolution and the launching of a five-year strategy; as an organisation, under the cogent and inspiring leadership of Helen Vernon[3], NHSR determined itself to become more focused than ever before on prevention, learning, and early intervention. There was also what this writer considers to have been a genuine focus on improving the patient's experience by addressing concerns in ways other than by litigation.

Mediation and alternative dispute resolution (ADR) became fundamentally aligned with NHSR's strategy to deliver fair and cost effective resolution, by getting to the right answer quickly, safely, and reducing the number of claims going into formal litigation by keeping patients and healthcare professionals out of court. It was broadly recognised as successful. As the country went into lockdown, NHSR published a report reviewing the effectiveness of that commitment.

The purpose of this article is to review that report, and what has happened in the four unprecedented months since that time – and then to gauge the future of NHS Dispute Resolution, at least for patients and staff.

Spoiler alert – it is definitely a case of "we can work it out".

The context

Mediation is an independent, voluntary and confidential process in which a trained neutral, the mediator, helps the parties to resolve their dispute. Mediation is usually conducted by discussions 'off the record' both in meetings with all parties which the mediator will chair and in private and confidential meetings between individual parties and the mediator alone. The mediator does not act like a judge or arbitrator and makes no decision on who is right or wrong, but acts as a facilitator to help the parties reach settlement.

In 2008, the author recorded, in a review for the medico legal textbook *Powers & Harris*[4], that as an organisation, NHSR had undertaken a significant number of mediations throughout its 25-year history, often in high profile cases and group actions. More, however, could certainly be done: mediation had gained traction elsewhere in the sector. A trial of the idea was recommended and the then NHSR CEO, Steve Walker, seemed keen.

In July 2014, coinciding with the appointment of Helen Vernon, NHSR launched a pilot to test the effectiveness of mediation and how it could be better deployed as part of the case handler's "toolkit" for claims resolution. Under the pilot,

mediation was offered in a small cohort of cases involving a fatality or elderly care. The pilot ran for 12 months and came to an end on 1 August 2015.

Offers of mediation (which involved only one provider) were made in 91 cases and 49 cases were accepted into the pilot. One case settled before mediation and one case was withdrawn, and there were 47 completed mediations. Of the 47 completed mediations, 81% settled, of these 61% of the settlements were achieved on the day of the mediation and a further 20% a short time thereafter.

The pilot was rightly deemed a success – the more so given the scepticism of some in the professions. Claimant solicitors sometimes feared for their costs and some Defendant panel firms so distrusted claimant solicitors that it seemed that they did not wish to enter discussions before the door of the court. But supported by influential figures at the time, and repeated decisions of the Court of Appeal that encouraged mediation, more sanguine heads prevailed.

Thus, NHSR consulted with the expert providers and launched its Claims Mediation service on 5th December 2016. The service was designed to support patients, families and NHS staff in working together towards the resolution of incidents, legal claims and costs disputes and to avoid the need, expense, and potential emotional stress of going to court. The contracts were awarded to the Centre for Effective Dispute Resolution (CEDR) and Trust Mediation Limited[5] to mediate disputes arising from personal injury and clinical negligence incidents and claims.

Under the service for the mediation of substantive issues of liability and quantum, the mediator's fees, travel/accommodation expenses and any supplier costs are paid equally by the parties except in the following cases when the costs will be borne solely by NHS Resolution:

- Where liability is admitted in full.
- Partial admissions have been made and/ or it is the intention to settle the case.
- The claimant is unrepresented.

Trust representatives and patients, and their respective lawyers (if any) normally attend mediations, sometimes supported by barristers. The clinicians involved very rarely attend – although a clinical or medical director may do so if appropriate.

It followed that there were substantial benefits for patients and their representatives, and Trusts and their hard-working medical professionals. Unlike court proceedings, the confidential mediations do not provide a public distraction or risk to reputations. Discussions are without prejudice and swift, completing within a day and often (at least in a hundred or so cases the author has mediated) in around four hours.

Costs Alternative Dispute Resolution (CADR)[6] was appointed to mediate disputes arising from the recoverability of legal costs. This scheme is outside the scope of the article but has been less popular with practitioners. There is a vibrant legal costs industry that has, for many reasons, some of them self-interest, been slow to adopt mediation despite the best efforts of its Association[7] and many leading figures.

Case volumes

Since the inception of NHSR's Claims Mediation service, from December 2016 to 31 March 2019, 606 completed mediations took place. In 2017/18, NHS Resolution set a target to mediate at least 50 cases and this was exceeded threefold by the completion of 189 mediations. The identified trend year on year has been a significant increase in the overall number of mediations.

There was a 110% increase in the use of mediation, up from 189 cases in 2017/18 to 397 cases in 2018/19. NHS Resolution mediated more cases than ever before in its entire history. Mostly the cases were alleged medical negligence – although there were a small number of personal injury matters and still fewer costs cases:

Mediations 2018/19	
Clinical	380
Non-clinical	10
Costs	7
Grand Total	**397**

In 2019/2020 it is believed that the number of cases referred to mediation was nearer 800[8] and represented approaching 10% of the claims notified to NHSR. This trend appears to be continuing despite COVID-19. The vast majority of these were alleged clinical negligence matters.

Mediation outcomes

The following chart sets out the mediation outcomes for all of the 397 cases mediated in 2018/19 and is a useful analysis. The highlighted narrative explains the outcomes of cases settled on the day of the mediation or within 28 days of the mediation date.

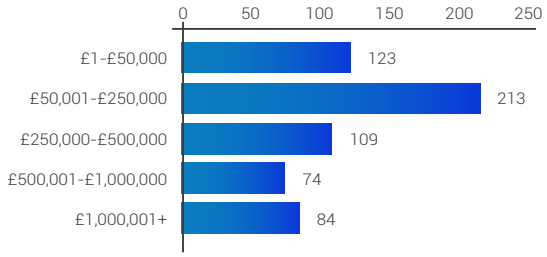
Importantly – and a tribute to the success of the process – only six cases (around 2%) taken to mediation subsequently proceeded to trials. In those six cases, the claimants were successful on three occasions, with the trusts also successful in defending three claims at trial.

No of Mediations 2018/19	Mediation type	
Outcome	Costs	Substantive issues liability /damages
Settled-claim discontinued at mediation		1
Settled-claim discontinued post mediation after 28 days		3
Not settled at mediation and proceeded to trial. Judgment for claimant at trial		3
Not settled at mediation and proceeded to trial - successful defence at trial		3
Settled at mediation - damages agreed		264
Settled within 28 days - damages agreed		21
Settled at mediation - liability issues only		3
Liability issues only settled within 28 days of mediation		2
Settled post mediation after 28 days - damages agreed		18
Settled at mediation-costs mediation	3	
Not settled - costs mediation	4	
Not settled		72
Grand Total	**7**	**390**

This ability to settle cases, and to do so effectively, provided a high level of satisfaction with the process to both lay participants and the professionals. Certainty of outcome, the ending of litigation, and the chance to receive a personal face to face apology were highly regarded. So too were the (rarer but important) options to have detailed explanations or a discussion with a Trust manager.

It genuinely transpires that for a great many people, it is not all about the money – for many, the process is a package where money will only be a factor in moving on with their lives. In more serious cases, money is, however, important to facilitate that recovery.

Mediation is offered for all types of claims across the value spectrum. The graph below provided by NHSR captures the value of the claim (excluding costs) at the date of the mediation, reflecting that in 2018/19, the majority of claims mediated fell within the damages tranche £50,001 - £250,000.



That said – there were still a substantial – almost a quarter – of claims mediated where the damages agreed were close to or above £1,000,000.

Workplace mediation and resolving staff differences

Mediation is not only about clinical negligence and personal injury. Increasingly it has been adopted in-house and is available to provide options to resolve – ideally at an early stage – those disputes that grow in departments, in teams, or between individuals. Workplace mediation, by clinicians trained as mediators, is new to the NHS in the last five years but offers real benefits.

One scheme, in a leading teaching Trust on the South Coast, has been pioneered by clinical leads

and has proved a success in improving morale and relationships between staff. The ability for a neutral to listen and help build solutions, often over a series of mediation meetings that are confidential, has proved to be an excellent asset.

Those pioneers are involved in training other Trusts and mediators. It is a strong sign of the times.

The impact of COVID-19

The times though are difficult – but the pandemic has not brought an end to mediations. On the contrary, the two providers have shifted to remote mediations using Zoom-pro, Teams, Skype, and (in the author's case at least) FaceTime and the good old fashioned telephone. The national figures are not yet available but anecdotally, and in the author's experience, the volume of mediations has remained broadly constant albeit that the outcomes have been fewer settlements on the day.

Looking at this, it appears that people need more time when not in the same physical space as their legal advisers, or their clients, or their Trusts, to obtain instructions and to reflect. Whilst the process works well up to a point, it is right that nothing replaces personal contact, conversation, and body language as a means of timing what is best to say to effect good discussions.

Mediation has, however, adapted and mediators are now being taught remote mediation skills. They are learning to take more time, to build rapport online, and to handle the tech with greater fluency. The process is there to be adapted and can be made to work well – though most people are looking to return to face-to-face mediation as soon as it is safe.

The future[9]

In terms of clinical negligence – it is not just NHS Trusts using the scheme. GPs have moved on the NHSR scheme now, and are being embraced. Two medical indemnity providers have also adopted mediation. It is undoubtedly the future. The NHSR itself concludes:

5. Conclusion: Driving cultural change

37. NHS Resolution is driving cultural change within the market - mediation is no longer seen as novel. The impact of the claims mediation service in improving the experience of patients and their families bringing claims against the NHS has been supported by patient groups and claimant lawyers.

Mediation has moved mainstream and is no longer novel. It is a day trip to resolution where we can work it out. The Beatles had it both ways – and so do patients, the NHS, and its staff. Let it be.

References

[1] The author is a leading barrister and mediator at Normanton Chambers, who has also been an integral part of SpecialistInfo's medico-legal faculty since it began. He helped found the NHS Resolution mediation scheme and has been at the heart of mediation in this country since 1996. He is chair of Trustees of the national mediation charity The Society of Mediators and an international mediation trainer. He writes in a personal capacity.

[2] https://resolution.nhs.uk/wp-content/uploads/2020/02/NHS-Resolution-Mediation-in-healthcare-claims-an-evaluation.pdf

[3] https://resolution.nhs.uk/leadership/helen-vernon/

[4] https://www.wildy.com/isbn/9781847660756/powers-harris-clinical-negligence-4th-ed-hardback-cd-rom-bloomsbury-professional

[5] https://www.trustmediation.org.uk/nhs-resolution/

[6] http://www.costs-adr.com/nhs-resolution-mediation-service

[7] https://www.associationofcostslawyers.co.uk/Services

[8] NHSR will confirm the figure in its annual report expected late July 2020 after this article was written

[9] Specialist Info offers monthly courses for medical professionals to train as mediators with a view to working in the NHS, or elsewhere, whether to provide clinical negligence mediation, workplace mediation or to facilitate difficult conversations in a range of situations. If you are interested in training as an Accredited Mediator through SpecialistInfo – please see https://www.specialistinfo.com/a_ml_mediation.php

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LESSONS LEARNED FROM THE BRISTOL HEART SCANDAL AND THE 2001 KENNEDY INQUIRY – PART 1

By Laurence Vick, Consultant Solicitor and Honorary Member of the AVMA Panel
Email: laurencevick@hotmail.com

Part 1 of a 2-part article

'All changed, changed utterly' said Richard Smith in the BMJ in 1998 in the aftermath of the 90s Bristol heart children scandal, borrowing from the line in W.B Yeats' Easter 1916. Writing after the GMC had found the surgeons Wisheart and Dhasmana and former chief executive Roylance guilty of serious professional misconduct but before the Public Inquiry, Smith predicted that the culture of British medicine would be transformed by the *"once in a lifetime"* drama of Bristol.

But did it? The families caught up in the scandal who fought so hard for the Public Inquiry certainly hoped so. Sadly, the litany of high-profile medical scandals that have followed one another relentlessly in the decades since Bristol - from Mid Staffs and Morecambe Bay, disgraced breast surgeon Ian Paterson and his involvement in NHS and private surgery , through to Shrewsbury and Telford (emerging as the biggest maternity scandal in the history of the NHS) and most recently East Kent with reports of more than 130 cases of babies suffering brain damage due to oxygen deprivation at birth over a 4 year period - show that this did not prove to be the case.

Professor Sir Ian Kennedy's 2001 Inquiry report with its 198 recommendations definitely did bring about major improvements in audit, governance, publication of surgical outcomes, and accountability within the medical profession. Self-evidently though, looking at all of these terrible scandals, Bristol did not succeed in bringing about the desired sea-change in the wider culture of the NHS. Nor did it produce what was going to be a root-and-branch reorganization of pediatric child surgery in this country which could have formed the basis of a blueprint for future reconstruction so that expertise and services can be concentrated in centers whose data demonstrated that they produce the best outcomes. So comprehensive and all-embracing were the Kennedy recommendations that it was hoped this, the largest and most expensive Public Inquiry in the history of the NHS, following in the wake of the longest ever GMC disciplinary hearing, would be definitive and would avoid the need for further Inquiries.

Disturbingly but presciently, Kennedy admitted on publication of his report that in spite of the abundance of NHS bodies and frameworks that had been created since the scandal broke he could not be confident that it would be possible to prevent another Bristol.

These are some of my personal reflections after representing the families as joint solicitor at the Public Inquiry and handling the claims of parents of children who died or survived but suffered brain damage and other serious injury in operations performed at the unit in Bristol by the two surgeons in the 90s. This has given me an insight into the world of heart surgery and paediatric cardiac surgery in particular with its own unique features and implications for the availability of data, and the development of the law of consent and the duty candour.

This quote from one of the nurses who accompanied many of the parents as they took

their children to the operating theatre sums up the Bristol situation at that time. This nurse who later gave evidence to the Public Inquiry told the BBC in an interview before the GMC decision how she had wanted to voice her concerns about the surgeons operating at the unit but:

"There was a sense amongst the nurses generally that 'we've let the baby down' - there were times when I wanted to pick up the baby and just run out of the operating theatre, bundle it into the car with the parents and take them anywhere else."

What an indictment. A key member of staff who felt unable to raise her concerns who was placed in an intolerable position. Many within and outside the Trust in Bristol were aware of the danger to which already very poorly children were exposed but failed or were unable to act.

The background

The story was played out in the GMC hearings, Public Inquiry and the national media, casting huge scrutiny on the hospital in Bristol and those who had put the lives of children born with congenital heart defects at additional risk. Equally a picture emerged of the difficulties faced by those who sought to expose the failings at Bristol. From 1991 Dr Steve Bolsin attempted to raise concerns with his superiors at the Trust, including fellow clinicians and managers, over the alarming surgical mortality rates he had noticed after his arrival from the Royal Brompton in 1988. Dr. Bolsin - later described as the 'gnawing conscience' of the NHS - did his best to escalate those concerns through all levels of authority up to the top of the NHS, Department of Health and the Royal Colleges. All refused to heed his warnings and children continued to die at an alarming rate or survive but sustain neurological injuries leaving them with often severe disabilities.

Joshua Loveday

The death of Joshua Loveday who underwent an arterial switch operation at Bristol in January 1995 at the age of 16 months became the pivotal event in the Bristol story and the catalyst for the GMC hearings and Public Inquiry into surgery carried out at the unit over the previous 10 years.

Mandy Evans, Joshua's mother, last saw her son alive on 12 January 1995, just after 7am. The surgeon assigned to carry out this complex operation was Janardan Dhasmana, the second of the two surgeons carrying out adult as well as the paediatric surgery at Bristol. Unbeknown to Mandy and Joshua's father Bert Loveday Dhasmana's survival rate for these operations was well below the national average – so far below that, on the evening before Joshua's operation, a secret eleventh-hour crisis meeting was held at the hospital. Despite concerns raised by Dr Bolsin it was decided that the operation must go ahead.

By the following afternoon Joshua was dead, after eight hours on the operating table. When later describing this meeting, at which he pleaded with his colleagues not to allow the operation to be carried out, Bolsin said he was overruled: he had been in a minority of one and his colleagues insisted that it must proceed. Professor of General Surgery Gianni Angelini had contacted the Department of Health and asked it to intervene and stop the surgery. Officials contacted the Trust's chief executive Dr Roylance who said this was a clinical matter in which he had no right to intervene. The Department of Health said it had no legal power to halt the operation.

Supra-regional status and the "learning curve"

The two surgeons Wisheart and Dhasmana were keen to keep Bristol at the forefront as a leading paediatric cardiac surgery unit, for which it received additional funding at that time as a supra-regional centre. Seemingly blinded to the unfolding dynamics, Joshua's surgeon Dhasmana appeared unaware that there was a problem. In his evidence to the Public Inquiry, he said he was shocked to learn of the severity of the situation, and why people had been so concerned about his 'learning curve.' This proved to be a controversial issue for the Inquiry: is it acceptable for surgeons to have a learning curve and if so, should patients be

warned that the surgeon is still gaining experience? In fact, Dhasmana had never performed the 'switch' procedure himself but had assisted another surgeon on one occasion, five years previously. Dhasmana conceded that, when starting a new procedure, he did anticipate some infant fatalities as he improved his skills. In his words:

'Nobody exactly knew what a learning curve was except for saying that, whenever you start any new operation, you are bound to have unfortunately high mortality . . . I do not think any surgeon wants to be seen as in a way practising with his patients, but that is the definition of "learning curve"

Joshua's parents knew nothing of Bolsin's eleventh-hour attempts to stop the operation going ahead, or of Bristol's record for child heart surgery, or Dhasmana's inexperience in the arterial switch.

GMC disciplinary hearings

The GMC disciplinary proceedings in 1998, against surgeons Wisheart and Dhasmana and the Trust's former Chief Executive Dr John Roylance, focused on the unit's mortality rates for the arterial switch and atrioventricular (AV Canal) operations. It wasn't ideal to convene a GMC disciplinary hearing and decide who would be charged and what those charges would be before a wider public inquiry. The GMC hearings lasted 63 days and resulted in findings of serious professional misconduct against all three. Wisheart was struck off. Dhasmana was suspended from carrying out paediatric cardiac surgery for three years but cleared to continue adult cardiac surgery (conclusions arrived at without any analysis of his adult surgical outcomes, hence the *"would you let him operate on you?"* question put by Jeremy Paxman to the Health Minister Frank Dobson on that evening's BBC Newsnight – to which Dobson replied without hesitation *"No"*). Both surgeons had lacked insight into their shortcomings and had failed to call a halt to their operations in the face of clear evidence that they were achieving unacceptably high mortality rates.

The statistical analysis carried out for the public inquiry found that measured on the basis of 30 day mortality Bristol was "an outlier, and not merely 'bottom of the league'" and that a *"divergence in performance of this size could not be explained by statistical variation, systematic bias in data collection, case mix or data quality"*

Roylance, as a qualified doctor, fell under the GMC's jurisdiction and was struck off for failing to heed warnings and allowing the surgical failures to continue. It was hoped this would stand as a warning in the future for NHS managers who ignore concerns brought to their attention by whistle-blowers.

The aftermath of the revelations

I met Joshua's parents during the GMC hearings. Haunted by his son's death, Bert Loveday became progressively more depressed and disoriented; he had never been in any kind of trouble before but was persuaded to take part, keeping watch, in an armed robbery. He was sentenced to three years in prison and, unable to cope, was found hanging in his cell at Winson Green Prison, Birmingham, a month into his sentence. He was one of three, possibly four, Bristol parents from the 90s tragically caught in the eye of this developing storm to commit suicide.

Feeling quite wrongly and unfairly that they had let their children down, parents punished themselves for not asking probing questions and allowing incompetent surgeons to operate on their children. Unique in my experience was having clients say they hoped our experts would be unable to find negligence: in effect, wanting to lose their cases.

This was an inevitable consequence, repeated in subsequent large-scale scandals, of staff who knew of the failings at the unit on the one hand turning a blind eye and allowing the situation to get out of control or, on the other, like the nurse mentioned earlier, fearing reprisals if they were to raise concerns.

Steve Bolsin's position became untenable after the Joshua Loveday operation and he had to emigrate with his family in 1995, to take up a position in Geelong, Australia. where he was soon elevated to Professor. Feted in Australia for his role in the

Bristol scandal and his subsequent work in the development of governance and clinical audit Professor Bolsin was belatedly awarded the Royal College of Anaesthetists' Medal in Cardiff in 2013 in recognition for all he had done for patient safety. Interviewed in 1998 Bolsin said that to avoid a repeat of this kind of disaster we must 'never lose sight of the patient'

Media reports: the "Killing Fields" and the "Departure Lounge"

The lack of action over Bristol in the face of all the media reports had been extraordinary. Dr Phil Hammond, *'MD'* in Private Eye, first exposed the problems at the unit under the *'Killing Fields'* and *'Departure Lounge'* headlines in 1992, nine years before the publication of the Kennedy report. There were then no significant reports in the media until three years later, with Matthew Hill's BBC Close-Up West regional news programme in April 1995 and the Daily Telegraph's *'hospital took 6 years to act over baby deaths'* report of 1 May 1995. These were followed by the seminal Channel 4 Dispatches documentary of 28 March 1996, and the Times 1 April 1996 article: 'Why did they allow so many to die?'

It was hard to believe that heart surgery had been allowed to continue at the unit in spite of the lurid headlines in the media and the concerns expressed at senior consultant level - and that it took so long for anything to be done. Apart from suspicions or sixth senses confirmed in hindsight, no parent at the time of the operations had any inkling of the problems at the unit. Wisheart retired in 1995 with the highest grade A Merit Consultant Award, payments from the Department of Health worth a reported additional £40,000 a year. As well as his being senior of the two surgeons, performing adult as well as paediatric cardiac surgery, he held the position of Medical Director of the Trust. His replacement as surgeon heading the unit Ash Pawade who arrived from Melbourne in 1996 was achieving close to zero mortality when he gave evidence to the GMC in 1998. Dhasmana was dismissed by the Trust in 1998 after parents were unwilling to let him operate on their children and he had *"lost the trust and confidence of his colleagues."* He later lost his claim for unfair dismissal and breach of contract in which he had argued that he had been treated unfairly and made a scapegoat for the wider failings of the unit.

What occurred amounted to a betrayal of trust – not only by the surgeons but also by all those at Bristol and elsewhere who knew of the appalling death rates achieved by the unit. Parents of sick children in need of life-saving surgery had to cope with the cards they had been dealt. Bristol offered hope but, in so many cases, delivered despair.

This article first appeared in the AvMA Lawyers Service Newsletter March 2020. Part 2 of this article will be published in Issue 16 of the Medico-Legal Magazine and in the Lawyers' Service Newsletter.

SKIPPING THE LIGHT FANDANGO?

By Warren Collins, Solicitor Advocate and Personal Injury Partner at Penningtons Manches LLP

Ahead of his presentation at the Medico-Legal conference, Warren Collins, Solicitor Advocate and Personal Injury Partner at Penningtons Manches LLP, looks at the sharp edge of expert evidence.

It shouldn't be that difficult. Once the thorny issues of primary and comparative fault have been unravelled, personal injury claims are simply putting an accident victim back into the position he would have been had the accident not occurred. But that involves skilful lawyers with competing and opposite "crystal balls" to predict:

- What life in the future would have been like for the Claimant had the accident not occurred; and
- What life in the future is going to be like now that the accident has happened.

Comparing these two unknown tracks is fraught with difficulties and challenges. The Claimant has the burden of proving these "predictions" and the crystal ball used is made up of three (no, make that four) components:

(i) Documentary evidence;
(ii) Lay witness evidence;
(iii) Expert opinion evidence;
(iv) The lawyers' experience and expertise.

All of these components have their part to play in litigation but in the arena of large loss personal injury claims, it is the expert evidence that is the key determinant of how much compensation the Claimant will receive. While in a clinical setting, the medic's decisions and actions may often determine *whether* the patient lives, in a medico-legal setting such decisions may inform *how* the Claimant lives. It is for this reason that the role of the expert witness is catastrophic injury claims is paramount.

I explain to all of my clients that medico-legal experts (whoever you are instructed by) are kind people. You all entered a profession to heal the sick and help vulnerable people. But.... (there is always a "but" when you ask a lawyer), medico-legal work is not medicine in the sense of "treating" the sick. It is a battleground where the worlds of clinical and legal practice clash. Clinical certainty is abandoned into the murky and artificial world of *the balance of probabilities* – and who really knows the difference between a 45% prospect and a 55% prospect of recovery when there are so many generic as well as patient-specific imponderables? Then, the lawyers demand statistics and extrapolations from academic papers in the hope that you will be able to convert a broad medical view into their world of *"pounds, shillings and pence"*.

And finally doctor, I know you are not supposed to "play God" but can you tell me precisely how long my client is going to live for? or put it another way, on what date is the Claimant going to die?

But this is fine. Medico-legal reporting is fun and intellectually stimulating (and for some it supplements the income of the genuinely overworked and underpaid). Unfortunately, it does not stop there. There are the challenging questions from your instructing solicitors, the fitting in of conferences with counsel around a busy clinical practice, the joint discussions and statements with equally busy clinical practitioners and the spectre of trial. Things can go wrong at every step.. and if they do go wrong, you may "get it in the neck" and I will be covering these tricks and traps at the Medico-Legal Conference in October. But it is at trial that things can get very difficult for the unprepared or unsuitable expert.

There are those lawyers that proudly proclaim that they are so good, they never go to trial. The whole legal process (based on a *cards on the table* approach) is designed to encourage settlement of claims. Each

and every step of litigation should present itself as a chance to settle the case. These settlement triggers start at the Pre-Action Protocol letter stage, through to early full and frank disclosure of documents, the early exchange of lay witness statements, exchange of witness statements, joint discussions of experts and the system of Qualified One Way Costs Shifting. Occasionally, the whole matter ends up in front of a High Court (or County Court) judge to adjudicate. And this can be a challenge for experts.

Firstly, trials are the cause of a calendar nightmare. It is not uncommon for trials involving many experts to last a week, two or even three weeks. And while you may only be giving evidence for just half a day, your instructing solicitor (or probably their barrister), wants you to hear the evidence of other experts (or lay witnesses) and so you may be required for a few days (and occasionally, the whole trial). That would be simple enough, except trial timetables are not predictable. A trial may be expected to start on a Monday, for example, but the concept of "floating court lists" means that it could well start on the Wednesday and that puts everything out. It is likely that your instructing solicitor will have served a witness summons on you so you have no choice but to turn up for court until you are "released" or risk prison (or at least your career as an expert). What the heck does that kind of arrangement do to your clinical commitments? Are patients going to suffer at the whim of the legal system?

But you go to the huge effort of making arrangements to accommodate a trial, only to turn up to court and be told "thank you very much, but we are delighted to tell you that the case has just settled on the steps of the court"!!

Secondly, there are the horrors of giving evidence if the case does go ahead. While you may be doing your best to express a genuinely held independent medical opinion, the adversarial system is designed to discredit you and your views. The "legals" will create traps and smokescreens to capitalise on irrelevant and insignificant inconsistencies resulting in the "are you lying now or were you lying then?" type questions.

Thirdly, you have to be absolutely certain that you are a genuine expert in the precise area of contention. The GMC Guidance *"Good Medical Practice"* is a good starting point to assess for yourself whether you are a true expert in your field. Readers of this publication may be familiar with the problems faced by Mr Jamil, a spinal surgeon giving evidence in a clinical negligence case of *Thimmaya –v- Lancashire Foundation Trust* in March 2019. Poor Mr Jamil (who accepted, with hindsight, that he was not fit to give expert evidence at trial) was unable to articulate the test for breach of duty in clinical negligence cases, such that the Claimant had to abandon the case. But not only that, the expert was ordered to pay the Defendant's legal costs. The trial judge, HHJ Claire Evans commented in her judgment *"Whilst it would not be right to use him as an example to send a message to experts, it is right that experts should all understand the importance of their duties to the Court, and the potential consequences if they fail in them."*

Having read this short commentary, my question is this: Are you ready to turn cartwheels across the floor or will you skip the light fandango?

Warren Collins is a Solicitor-Advocate at the London office of Penningtons Manches LLP. He handles a broad range of catastrophic personal injury and wrongful death cases but with a special interest in cases involving brain and spinal cord injuries and a niche in Anglo-American cross-border claims. He is the current Chief Assessor of the Law Society's Personal Injury Accreditation Scheme, a Fellow of APIL, Member of (and Assessor for) APIL's brain injury specialist and spinal cord injury specialist accreditation panels and is listed as a leading expert in his field in *Legal 500* and *Chambers UK Directories*. In the United States, Warren is a member of the Board of Governors of the *American Association for Justice*, - where he is also co-chair of AAJ's Spinal Cord Injury Litigation Group and Vice-Chair of AAJ's International Practice Section. He is the only UK solicitor member of *The National Trial Lawyers' Top 100, The Melvin Belli Society (pre-eminent personal injury lawyers of America) and the National Crime Victims Bar Association*. He may be contacted on 07771 725542.

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CONSENT IN OBSTETRICS – THE MUSINGS OF AN OBSTETRICIAN FIVE YEARS POST-MONTGOMERY

By Mark Waterstone
Email: waterstone@tw-medleg.uk

From the time of Hippocrates until late into the 20th century it was generally accepted practice that the doctor knew best and it was not beneficial for the patient to know all the possible risks they were facing when agreeing to a procedure. It has been argued that we are cruel listing all potential risks when all the patient really wants is to be made better, no matter how that is done to them (within reason).

For this essay I will limit my attention to consent being obtained for procedures being performed on the labour ward (due to time and word pressures). I will address the principles upon which I understand the Montgomery ruling has been based and these can be translated into any conceivable situation.

In order to provide valid fully-informed consent the patient must have the mental capacity to make the decision, be provided with the relevant information and be free from coercion.

As any clinician should know, the Montgomery ruling applies to any procedure where there is a reasonable alternative and in these situations the duty of the clinician is to determine what risks the patient would want to know. This can be a very difficult process to get right, as the consent process is often conducted in tense moments when the outcome for the baby (+/- mother) may be in the balance and any delay could result in significant harm to either or both. A review of settled claims since Montgomery has demonstrated a 10% increase in claims where consent was the main or significant issue. The doctor has a few minutes to get the process right whereas the patient has the luxury of months or years to consider whether they would have taken the same path if alternative information had been provided.

Examples on the labour ward that an obstetrician faces on a daily basis include the following:

Category 1 caesarean in the first stage of labour –

There is an immediate threat to the maternal or fetal wellbeing requiring urgent delivery; timescale 10-30 minutes depending on urgency.

It is clear that in this situation if a caesarean section is not performed the baby would be harmed and could die. There is no (reasonable) alternative but to perform a caesarean section and therefore the degree of information could be limited to "I need to deliver your baby by caesarean section immediately otherwise it could suffer permanent harm. Is that ok?". The patient nods and the procedure is performed without delay. No further information or exchange of words is required (although I have been involved in a case where the mother did say no and the baby died – her choice, or possibly, and more likely in her case, her family's choice). No formal consent form should be signed as this adds delay which I would argue is unreasonable. Gone should be the days of seeing patients being wheeled down the corridor with a (usually) very junior doctor shoving the consent form in the patient's face insisting they sign it.

Trial of instrumental delivery in theatre:

This is performed at full dilatation and usually when there has been delay in the second stage. The obstetrician has made an assessment in the room and is not confident that a vaginal delivery will be completed. There is, therefore, an inherent failure in the process following which a potentially very difficult, and damaging for both mother and baby, caesarean section would follow. In this situation there is time to discuss the options, of which there are two: namely, go for the trial and the possible even more complicated caesarean or not even attempt the trial and go straight for delivery by second stage caesarean section. Both options have significant complications and there is little evidence to provide relative risks to the mother other than to say that the caesarean section following a failed instrumental delivery may have increased risk of complications, especially to baby. The problem is that by this stage most women will be extremely tired, stressed, in considerable pain and very concerned for their baby. It is debatable whether a court would deem that she was of sound mind not unduly influenced by other factors (concern for her baby, putting its interest before hers). A suitable option when there is no analgesia would be to discuss the options briefly and suggest that she is moved to theatre for a spinal (which will remove the pain) and then discuss the situation more fully.

Just the other week, after I had a 'meeting of experts' in a consent case, I had the opportunity to obtain a woman's consent for a trial of instrumental delivery. I had barely started with the various risks when she said, "I trust you doctor, do what you have to" and clearly did not want any further information. What is important in these cases is not the piece of paper with her signature but the contemporaneous notes (i.e. those notes written before any knowledge of complications) detailing the extent (or lack) of the conversation in which her consent was obtained for whatever was going to happen.

Many complications can arise following a trial of instrumental delivery including, but not limited to, third- and fourth-degree perineal tears, fractured fetal bones, intracerebral bleeding, hypoxia, ureteric damage, massive haemorrhage etc… If there is a poor outcome and the patient makes a claim, it could be attractive for lawyers to look at the consent process in the cold light of day and to state that it was deficient. Most women will confirm they signed a consent form (difficult to deny) but could state that they have no recollection of any information provided to them in order for them to give informed consent for the procedure that resulted in the harm they now suffer (difficult to prove otherwise). Without good contemporaneous documentation detailing as best possible the discussion, there is room for a court to find in favour of the claimant, perhaps erroneously.

Capacity:

I have been involved in two very different cases of capacity, one where it fluctuated due to paranoid

schizophrenia and another in a patient with learning difficulties. I have also been instructed to provide an opinion in a case where a woman refused intervention during labour because she lacked capacity at the time (degree of learning difficulty not recognised antenatally) and it took 40 minutes for her to allow instrumental delivery by which time her child suffered irreversible brain damage. Where capacity fluctuates it is necessary to discuss at length with the woman what her preferences are and then seek a Court Order to ensure that should she lose capacity in labour a good outcome can follow. In this case we prepared an 11-page birth plan to cover all eventualities. When capacity is lacking then the doctor has to make the decisions as would be expected with the patient's best interest in mind. An elective caesarean section (possibly under GA with severe learning difficulty) may well be the best option.

So, has Montgomery changed my practice? Yes and no. I have always and will continue to provide as much information that my patients require, tailored to what I perceive to be the amount of information they wish to have. What has changed perhaps, is the documentation of our discussions. I may also start my discussions with the words "how much do you want to know?".

However consent is obtained it should be remembered that it is a process, not a single point in time and not only should you describe the risks of any path taken, e.g. 3:1,000 risk of uterine rupture with TOLAC (trial of labour after caesarean), but also the consequences of that complication, i.e. 6-10:10,000 risk of brain damage or death of the baby (same as for a first-time mother).

There is a move towards obtaining consent for any eventuality in the antenatal period. This is already in place in the US where patients are given information about potential interventions; but I feel this could result in information overload and most women would probably not relate the intervention to them as they would be expecting a normal vaginal delivery (which currently remains the default option – a discussion for another article…).

No matter how the consent process is conducted it is clear that women need and deserve all the information pertinent to them in order to make the right choice for them, even if it could be deemed the wrong choice medically. Doctors do not, however, have to remain completely impartial and can guide a patient to what they perceive is the correct choice, e.g. if they believe that the trial of instrumental is highly likely to succeed then the information about the risks can be weighted accordingly, but very carefully. As long as the women are happy to accept the consequences of whatever decision they have taken then consent will have been appropriately obtained.

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Webster v Burton Hospitals NHS Foundation Trust [2017] EWCA Civ 62. One of the first cases I ever prepared a report on, in 2005, which failed on Bolam but later succeeded on Montgomery (I believe one of the first to do so)

Declaration of conflicting interest.

I prepare medico-legal reports for both Claimant and Defendant solicitors on consent and other obstetric and gynaecology issues

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"I am very happy to recommend Flora McCabe.

She has been enthusiastic and helpful with our wishes to optimise record keeping and the consent process especially. She has been a re-assuring source of advice, always available, able, positive and constructive.

She has been keen to work on projects together and empathic in relation to the many difficulties that surgical practices now face. I am pleased to have her as an advocate and ally."

Julian Rowe Jones
Consultant Facial Plastic Surgeon FRCS (ORL)

MEDICO -LEGAL NEWS:

By Lisa Cheyne,
Medico-Legal Manager,
SpecialistInfo

A round-up of news in the industry for the second/third quarter of 2020.

NEWS

Covid-19 negligence protocol

NHS Resolution, patient safety charity Action against Medical Accidents and the Society of Clinical Injury Lawyers agreed a Covid-19 Clinical Negligence Protocol to encourage claimant and defendant lawyers to behave positively during the pandemic.

The protocol is wide-ranging, covering:

- moratoriums upon limitation until 3 months after the protocol ends;
- making use of email to serve and receive documents the default position;
- encouraging much more innovation for example on-line examinations of clients for medical expert reports;
- encouraging more co-operation in the progress of claims, and in particular interim payments of damages and costs to avoid unnecessary court hearings;
- settlement meetings and mediations to take place remotely wherever possible;
- consideration of whether costs budgeting needs to take place initially or can be requested to be adjourned in order to save court and other resources.

On hearings and adjournments, the protocol states that NHS staff should not be required to do anything which affects frontline clinical care. 'Equally, however, the Covid-19 situation should not be used as an excuse for avoidable delay in matters.'

The agreement will continue indefinitely until one of the parties gives notice to end it, and the provisions will be reviewed every eight weeks.

Read more:
https://resolution.nhs.uk/wp-content/uploads/2020/08/COVID-19-Clinical-Negligence-.Protocol-2020.pdf

Mandatory changes to Statement of Truth wording for Expert Witnesses from 1st October 2020

The new wording which must now be used for the SoT on expert witness reports is below:

"I confirm that I have made clear which facts and matters referred to in this report are within my own knowledge and which are not. Those that are within my own knowledge I confirm to be true. The opinions I have expressed represent my true and complete professional opinions on the matters to which they refer. I understand that proceedings for contempt of court may be brought against anyone who makes, or causes to be made, a false statement in a document verified by a statement of truth without an honest belief in its truth."

Updated GMC guidance on decision making and consent applies from 9 November 2020

The GMC have updated their consent guidance (last updated in 2008) and have summarised their reasons for updating now below:

"Obtaining patients' consent needn't be a formal, time-consuming process. We've updated our guidance so it's easier to apply in everyday practice. New features include:

- a focus on taking a proportionate approach, acknowledging not every paragraph of the guidance will be relevant to every decision
- seven key principles which summarise the guidance
- a new section to help doctors find out what matters to patients so they can share relevant information to help them decide between viable options
- suggestions for how other members of the healthcare team can support decision making.

Shared decision making and consent are fundamental to good medical practice. Getting this right can empower patients, which helps to improve health outcomes, patient experience and reduce complaints."

Read more:
https://www.gmc-uk.org/ethical-guidance/ethical-guidance-for-doctors/decision-making-and-consent

Covid compensation claims from cancer patients

Clinical negligence lawyers are expecting a surge of claims involving delayed cancer diagnoses and treatment during the pandemic.

The journal Lancet Oncology recently predicted that delays in treatment since March could lead to 3,500 avoidable cancer deaths in England in the next five years.

Compensation payments are likely to be case-specific and will depend on whether the courts are prepared to allow such claims. Defendants may successfully argue it was a resources issue during the pandemic and that other services had to suffer.

Read more:
https://www.thelancet.com/journals/lanonc/article/PIIS1470-2045(20)30388-0/fulltext#seccestitle150

Griffiths v TUI UK Ltd 2020 - not all holiday sickness claims are fraudulent

A pivotal civil court ruling could affect hundreds of holiday sickness claims cases in the pipeline, meaning that defendants will no longer be able to easily find faults in expert evidence, as long as it is CPR Part 35 compliant, and should be compelled put forward their own expert evidence.

Mr Justice Martin Spencer overturned a county court judgment and awarded damages of £29,000 to claimant Peter Griffiths for gastric illness suffered after eating contaminated food at a Turkish hotel.

The court disapproved of the defendant's tactic of not putting forward their own expert evidence. The tour operator is considering whether to appeal.

After the Court of Appeal's 2017 judgment in Wood v Tui, it has been very difficult to prove food or drink was not of satisfactory quality, leading to a tendency to dismiss these claims in bulk. The recent Griffiths v TUI judgement may create a more even playing field and reduce the burden of proof on the claimant.

Read more:
http://www.bailii.org/ew/cases/EWHC/QB/2020/2268.html

World Patient Safety Day

On 17 September 2020, the World Health Organization (WHO), international partners and all countries celebrated World Patient Safety Day.

World Patient Safety Day was created by the 72nd World Health Assembly, in May 2019, with the adoption of resolution WHA72.6 on 'Global action on patient safety', and an endorsement for the Day to be marked annually on 17 September.

The main objectives of World Patient Safety Day are to enhance global understanding of patient safety, increase public engagement in the safety of health care and promote global actions to enhance patient safety and reduce patient harm. The origin of the Day is firmly grounded in the fundamental principle of medicine – *First, do no harm*.

Health systems can only function with health workers, and a knowledgeable, skilled and motivated health workforce is critical for the provision of safe care to patients.

Objectives of World Patient Safety Day 2020:

- Raise global awareness about the importance of health worker safety and its interlinkages with patient safety
- Engage multiple stakeholders and adopt multimodal strategies to improve the safety of health workers and patients
- Implement urgent and sustainable actions by all stakeholders which recognize and invest in the safety of health workers, as a priority for patient safety
- Provide due recognition of health workers' dedication and hard work, particularly amid the current fight against the COVID-19 pandemic.

Call for action

WHO urges all stakeholders to "Speak up for health worker safety!"

"The COVID-19 pandemic has highlighted the huge challenges health workers are currently facing globally. Working in stressful environments exacerbates safety risks for health workers, including being infected and contributing to outbreaks in the health care facility, having limited access or adherence to personal protective equipment and other infection prevention and control measures, and inducing errors which can potentially harm patients and health workers. In many countries, health workers are facing increased risks of infections, violence, accidents, stigma, illness and death."

Read more:
https://www.who.int/news-room/detail/17-09-2020-keep-health-workers-safe-to-keep-patients-safe-who

More support for those representing themselves in court

People representing themselves in court as litigants in person (LiPs) in civil matters will receive enhanced legal support following £3.1 million in additional funding from the Ministry of Justice announced in August.

In a joint initiative with the Access to Justice Foundation, funding will be provided to not for profit organisations across the country to provide free legal support - ensuring better advice and clear guidance for those without legal representation in court. As well as helping LiPs to understand legal processes and their rights within them, they will also be provided with practical support throughout the duration of proceedings.

This is part of the MOJ's Legal Support Action Plan, which is helping people resolve legal problems at the earliest opportunity.

MOJ has already awarded over £500,000 to national charities through this grant, delivering a helpline that provides practical and emotional support to clients throughout the court process, web-based legal advice and an online hub that offers a greater range

of solutions to legal problems, including advice for remote hearings.

Another £270,000 of the grant has been earmarked for emergency support to several organisations providing vital expert advice to litigants in person, ensuring they can continue to offer their services during the coronavirus pandemic.

Read more:
https://www.gov.uk/government/news/more-support-for-those-representing-themselves-in-court

Clinical Negligence Scheme for Coronavirus (CNSC)

A new scheme was launched in April 2020 by NHS Resolution to meet liabilities arising from the special healthcare arrangements being put in place in response to the coronavirus pandemic.

The scheme, known as the Clinical Negligence Scheme for Coronavirus (CNSC), has been designed to respond to the new contracts being put in place for healthcare arrangements to respond to coronavirus such as those with the Independent Sector and organisations supporting testing arrangements. Membership of this new indemnity scheme is not required and cover will be provided automatically under the relevant contracts.

The scheme has been established under the new powers delivered under the Coronavirus Act 2020 and will indemnify healthcare providers for any clinical negligence liabilities which arise where existing indemnity arrangements (such as the Clinical Negligence Scheme for Trusts) do not apply. Where NHS Trusts are hosting special healthcare arrangements, for example the NHS Nightingale hospitals, then clinical negligence liabilities will be covered by CNST.

This cover is in addition to the arrangements already in place to indemnify healthcare workers for the NHS work they already do, through state indemnity schemes operated by NHS Resolution on behalf of the Secretary of State for Health and Social Care which will continue.

Any general queries concerning the arrangements should be directed by email to CNSC@resolution.nhs.uk.

Claims numbers fall during the pandemic, but volumes expected to surge

The coronavirus pandemic has seriously reduced the number of civil justice claims.

Statistics published by the Ministry of Justice, covering the second quarter from April to June, show a significant decrease in civil justice activity linked to Covid-19.

From April to June, personal injury claims were down 42% to 16,000, and judgments in general fell by 78%. The vast majority (86%) of judgments that were made were default judgments.

The MoJ said that during the response to the pandemic, administrative and judicial resources were a 'significant challenge', with suspension of court operations leading to unprecedented falls in volumes. There was also a significant impact on timeliness of civil justice: the mean time taken for small claims to go to trial was 41.8 weeks – 5.2 weeks longer than in the second quarter of 2019. Multi and fast track claims took 61.9 weeks to reach trial, which was an increase of almost three weeks.

The MoJ said: 'As society and the economy begins to recover from the impact of Covid-19, it is expected that claims volumes will return to historic trend levels, and may even temporarily exceed the pre-covid-19 volumes as the backlog of claims is processed.

The annual Medico-Legal Conference in London goes virtual

The second annual Medico-Legal Conference took place remotely on 21st October 2020, due to ongoing Covid19 restrictions. Delegate feedback has confirmed that the event was a resounding success, despite the challenges of the remote format, and we hope to be welcoming delegates back to a more traditional event next time.

The keynote address was given by Helen Vernon, Chief Executive of NHS Resolution, who outlined the growing importance of alternative dispute resolution in healthcare cases. The rest of the first morning session followed this theme with excellent presentations from Andrea Barnes of Normanton Chambers/Trust Mediation and Professor Dominic Regan.

The second morning session covered the hot topic of Reflection and Remediation: A Weapon to be Used Against Doctors? From clinical negligence experts Stephen Hooper, of Hempsons and Shannett Thompson, of Kingsley Napley.

Consent for Operative Obstetrics was thoroughly discussed by three experts in this field: Mr Mark Waterstone, Consultant in Obstetrics & Gynaecology, Dr David Levy, Consultant Anaesthetist, and Dr Gary Hartnoll, Consultant Neonatologist. They highlighted the growing importance of consent in all areas of medical practice, and consent was also covered in the specialty of Ophthalmology in the afternoon session by Mr Amar Alwitry.

The first session of the afternoon was perhaps the most popular among the medical delegates, covering Top Tips for Medical Experts from Warren Collins, from Penningtons Manches Cooper and A Lawyer's Wish List for Their Medico-Legal Experts by Flora McCabe, Head of Healthcare Claims, Lockton LLP and Angus Piper, Barrister.

Ruth Kelliher, from Digby Brown updated us with a Scottish Case Update.

Another emotive hot topic was covered in Life and Death Treatment of Children – Who Decides? By Katie Gollop QC, Serjeant's Inn.

The final presentation considered another topic of increasing importance: AI and Robotics in Healthcare: the Legal and Regulatory Landscape by Peter Rudd-Clarke, Legal Director, and Emma Kislingbury of Reynolds Porter Chamberlain (RPC).

The day was a fascinating overview of current topics of importance to both medical and law experts in the medico-legal field.

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