MEDICO LEGAL

MAGAZINE

ISSUE 20

Presented by:

specialist info

EIDO HEALTHCARE

Trusted Digital Consent

Trusted Digital Consent: EIDO thinks outside the ☑ box. Do you?

Everyone knows that valid informed consent is:

- ☑ Built on the conversations and engagement between patients and clinicians
- ☑ Supported by clear, proven content which is provided to patients
- ☑ Underpinned by a hospital-wide culture and understanding around consent

The proven informed consent medicolegal experts for over 20 years

ONLY EIDO ticks all these boxes and more which is why we've been selected to deploy into both NHS Trusts and Private hospitals, supporting digital transformation and shared decision-making.

www.eidohealthcare.com
info@eidohealthcare.com
+44 (0) 115 878 1000

In association with:

Royal College of Surgeons of England · The Royal College of Surgeons of Edinburgh · ASGBI · James IV Association of Surgeons · The Preoperative Association · BAPS · British Association of Day Surgery · Trusted Information Creator, Patient Information Forum · Crystal Mark 12345, Clarity approved by Plain English Campaign · Health & care information you can trust

consentapatient

The new standard in informed consent

An AI-powered, multimedia informed consent platform.

consentapatient does basic digital consent better than any other provider.

In addition, we offer far more features to ensure the consent 'process', rather than just the 'form', is enhanced.

- Digitises key components of GMC, Montgomery & Paterson Inquiry recommendations
- Patient-friendly interface with largest consent animation library in the world
- Covers private, NHS, emergency & elective work
- Suitable for all specialties and sub-specialties with full customisability
- One hundred languages translated
- Information Governance cleared in most NHS Trusts already.

For more information, demo or free pilot visit:
bloomsburyhealth.org/consentapatient

Scan this with your phone camera to watch our videos and read more

Welcome to the Medico-Legal Magazine

Welcome to Issue 20 of the Medico-Legal Magazine, produced by SpecialistInfo and publishing partner Iconic Media Solutions Ltd.

This summer issue of 2022 coincides with the Medico-Legal Conference on 28th June and includes articles from more of the confirmed speakers and exhibitors from the Conference:

Clare Stapleton, Medicolegal Consultant, Medical Protection, discusses how best to assist the Coroner when involved in an Inquest as a medical professional; and

Flora McCabe, Head of Advocacy and Risk Management Healthcare, Lockton LLP, shares her insight on the conduct expected from an expert witness in a recent case report; and

Brian Westbury, Academic Lead, Royal College of Physicians and Dentolegal Consultant, shares his expertise in dental practice and responsibility for dental claims.

Also in this issue, Georgina Parkin, Personal Injury Lawyer and Managing Director at TruthLegal, Harrogate, summarises her top tips for medical expert witnesses;

Finally, Derek P Auchie, Professor and Chair in Dispute Process Law, University of Aberdeen; Solicitor and Tribunal Chair, shares his experience of using and teaching alternative dispute resolution effectively.

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 now has a dedicated website www.medicolegalmagazine.co.uk and a page on the Medico-Legal Section of the Specialistinfo.com website, where all the back issues can be viewed. Printed copies can be ordered from Iconic.

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

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

Lisa Cheyne

Specialistinfo
Medico-Legal Magazine

Contents:

Presented by: specialist info

Published by: ICONIC MEDIA SOLUTIONS

SpecialistInfo
t: +44 (0)1423 727 721
e: magazine@specialistinfo.com
www.specialistinfo.com

Iconic Media Solutions
t: +44 (0) 20 3693 1940
e: info@iconicmediasolutions.co.uk
www.iconicmediasolutions.co.uk

Front cover: image - Freepik.com / author: snowing

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 2022 are listed below with links to our booking page.

Medico-Legal Essentials Course
(a general personal injury overview, with Georgina Parkin from TruthLegal):

- *14th September 2022* – London

More dates TBC

From £325 (plus VAT)

to book the Essentials course, please visit: www.specialistinfo.com/ml-essentials-course

Clinical Negligence Medico-Legal Course
(for higher value medical negligence cases, with Barrister Jonathan Godfrey from Parklane Plowden Chambers):

- *15th September 2022* – London

More dates TBC

From £325 (plus VAT)

to book the Clinical Negligence course, please visit: www.specialistinfo.com/ml-clinical-negligence-course

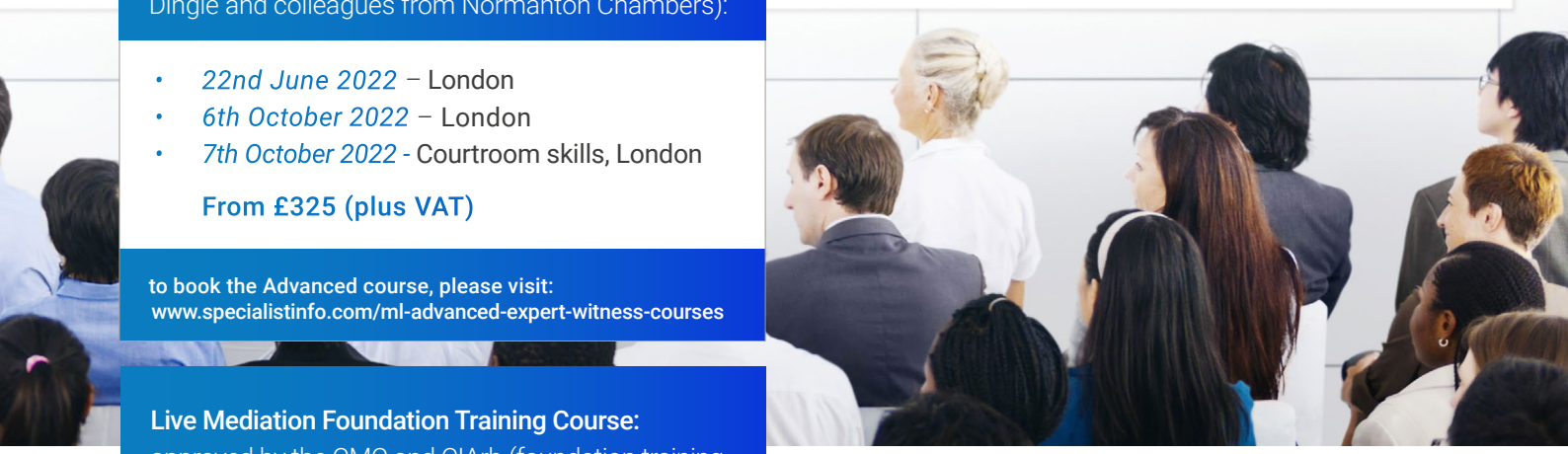
NEW WEBINARS
(pre-recorded with Barrister Jonathan Godfrey from Parklane Plowden Chambers):

Expert Evidence Cases Update
or
Informed Consent Post Montgomery – The Practicalities

- *Download and watch at your leisure*
  (1.5 hr, 2 CPD points)

£95 (plus VAT)

For details and to book the Clinical Negligence webinar, please visit: www.specialistinfo.com/course-calendar



Advanced Medico-Legal Course (a general update for experienced experts with Jonathan Dingle and colleagues from Normanton Chambers):

- *22nd June 2022* – London
- *6th October 2022* – London
- *7th October 2022* - Courtroom skills, London

From £325 (plus VAT)

to book the Advanced course, please visit: www.specialistinfo.com/ml-advanced-expert-witness-courses

Live Mediation Foundation Training Course: approved by the CMC and CIArb (foundation training, leading to full accreditation, is 5 days with Jonathan Dingle and faculty from Society of Mediators):

- *4th–8th July 2022* – London
- *18th–22nd July 2022* – Leeds
- *5th–9th September 2022* – Taunton
- *12th-16th September 2022* – London
- *3rd-7th October 2022* - Bristol or Online

More dates TBC

5 day Foundation from £1,200 (plus VAT)

to book or for further information about the Mediation course please visit: www.specialistinfo.com/mediation-course

NEW SCOTTISH COURSE

Being an Expert Witness in Scotland: Practical Essentials with Professor Derek P Auchie, Chair in Dispute Process Law, University of Aberdeen

- *21st September 2022* – Online

More dates TBC

From £295 (plus VAT)

to book or for further information about the NEW SCOTTISH COURSE please visit: www.specialistinfo.com/course-calendar

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

Please be aware: Rules for expert evidence have changed since 2020 and it is recommended that all experts book an 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 2022 courses, please click **here**, email **lisa@specialistinfo.com** or call me on **01423 787984**.

Kind regards

Lisa Cheyne
Medico-Legal Manager

specialist info

DENTAL PRACTICE AND RESPONSIBILITY FOR CLAIMS

By Brian Westbury FFFLM, FCGDent, FFGDP, LLM, BA, MGDS, LDS, BDS,
Dental Protection Limited (DPL), London and Leeds

Brian is an experienced dental practitioner and has spent over 20 years as Senior Dentolegal Adviser at DPL. He is currently the Academic Dean at the Faculty of Forensic and Legal Medicine of the RCP
academicdean@fflm.ac.uk

Dentolegal work and cases are not in essence any different to medicolegal work in general. Secondary care dentolegal work is exactly the same as its medical counterpart.

But the majority of dental work (about 95%) is carried out in General Dental Practice. It is carried out mainly by dentists, but also by an increasing number of other dental registrants, such as therapists, hygienists, and clinical dental technicians. All of these are required to have adequate indemnity/insurance.

Dental practices can be owned by any registrant (not just dentists), by partnerships of registrants, and by Dental Corporations (certain conditions apply to these arrangements). This is important because of the recent rise in vicarious liability claims against practice owners. All of the major indemnifiers now offer cover for this (and Non-Delegable Duty of Care) although not always retrospectively.

One of the reasons why dentistry is vulnerable to such claims is the relationship between dentists in practices. Associates (non-practice owners) are usually self-employed and, before 2006, worked on NHS patients under their own contractual arrangements. In the "new" NHS GDS contract of 2006, the contract with NHS England was with a Provider. In essence this was the practice owner (registrant or corporate). The Provider then contracted with associates for them to be Performers and carry out work on NHS patients on the Provider's behalf. The Performers are not in contract with the NHS. The NHS patients are patients of the Provider. The Provider may never have seen them.

One recent case was against a Provider who had not even been in the practice (he had retired) for many years.

It may be that the Providers are easier to track down than the actual treating dentists who may not even be in the country anymore.

There may be a different outcome where Private patients are concerned. These are "introduced" by the practice to associates, who then assume full responsibility for their treatment. Estimates and quotes are set by the associate, although there may be a practice advisory price list. Although it would seem that these are not the non-delegable responsibility of the Practice Owner, there are issues that cloud this. Patient fees are usually paid to the practice and receipts are from the practice. All the paperwork usually has the practice details. In most practices, the practice pays the associate his/her percentage of the fees. To counter that, most contracts between owner and associate stipulate that the associate must leave all the patients at the practice if they depart, and the practice will assume responsibility for them (thus indicating that the Associate had responsibility up to that point).

Summary

Although there have been vicarious liability cases in medical practice, these have generally been in specialist clinics and not in general practice. Depending on how the current cases turn out (e.g. Dental Law Partnership and Rattan shortly at the Supreme court) these dental cases may become more widespread dentally and medically. Dental Practitioners, both Owners and Associates, must look carefully at the contracts between them and at what is covered in their indemnity and for what periods. It might be prudent to look at monthly paysheets to see which way the transactions go for Private patients (from the practice or to the practice).

Finally, the insurers and indemnifiers of all involved should have a joint understanding of dealing with such cases seamlessly and swiftly.

REFLECTIONS ON DISPUTE RESOLUTION: MEDIATION AND EDUCATION

By Professor Derek P Auchie, Chair in Dispute Process Law, University of Aberdeen; Solicitor and Tribunal Chair

Derek has a judicial career spanning 17 years. He sits regularly on two judicial Tribunals. He has chaired over 600 hearings in which expert evidence has featured. Derek holds a Chair in Dispute Process Law at the University of Aberdeen.

We are pleased to announce that Derek will be leading SpecialistInfo's new training course for Scottish expert witnesses: BEING AN EXPERT WITNESS IN SCOTLAND: PRACTICAL ESSENTIALS – A ONE-DAY ONLINE COURSE (5 CPD hours) from September 2022

Why Mediation?

In my experience of conducting numerous mediations, it seems that disputes of any type can be driven by three main issues: perception, personality and communication.

Let's consider each in turn.

We all *perceive* the world differently. Even a concrete item such as an e-mail can, although in black and white, be perceived differently by the author and the recipient. When it comes to fluid in-person interactions, the problem of perception is amplified.

Where each party understands the perception of the other person in the dispute, this often explains their behaviour. This can help to remove ill-feeling caused by that behaviour, paving the way to discussing a solution.

We have different *personalities*. Some of us are calm and collected. Others are emotional and reactive. Some of us are broad-brush visionaries; others thrive on detail. Some of us like to work independently; others need support. Recognising the personality traits of those around us helps us to see how they approach an issue, and this can allow parties to understand why a particular problem has arisen and how it might be fixed.

Communication has been mentioned already. Many disputes arise, at least in part, out of misunderstandings from things written or said.

Taking offence when none is intended is not unusual. Making wrong assumptions about motive from an ambiguous or badly expressed communication is common.

The mediation process allows perception, personality and communication issues to be identified, explored and recognised. That is half the battle. The other half is: what should be done about them? The practicality of mediation means that precise and bespoke solutions can be built, agreed and recorded in writing. This means that not only is the relationship repaired, similar issues are unlikely to arise in future.

Where perception, personality and communication issues exist, the law will not resolve them. This is not a criticism of the law: it is not designed to resolve these things. Indeed, a legal outcome can worsen relations, since it relies on a 'win-lose' decision, not on building bridges.

That's the answer to the question: Why Mediation? It works.

How To Teach Dispute Resolution

The title of this section could be 'how to teach law', but that is perhaps too controversial, for now at least...

Teaching dispute resolution to hundreds (if not thousands) of postgraduate and undergraduate students has led me to two guiding principles on how that is best done.

My first principle is that process subjects should be taught by taking students through that process, stage by stage.

Arbitration is no exception, and I have recently finished coordinating another year of the University of Aberdeen's Professional Arbitration Skills course, taught over 10 days across 3 weeks. Students are put through their paces by a number of expert external tutors, each of whom teaches a different part of the process: the arbitration agreement, jurisdiction, written pleadings, preliminary hearing, document discovery, expert witnesses, oral advocacy, the hearing, the award, award challenge and award enforcement.

This gives students a global view of the process, so that they can understand how it all fits together, from start to finish. It works.

Back to my initial point: all law could be taught in this way - I call it a 'transactional approach' and I recently wrote an article in the journal for Scottish lawyers[1] on the subject.

My second principle is that process is best learned by doing as well as understanding. That's why when teaching mediation, I find that students learn from role-paying and observing role-play. They can really see the value in the techniques when they try them out and see others doing so. It brings the theory alive.

In arbitration tuition, examples of leaning by doing include: drafting an arbitration agreement, making an oral submission, writing arbitral pleadings and preparing an award. Having used all of these in class activities and assessments, it is obvious that it brings home the nuances of these critical practical tasks.

A creative, practical approach to how we learn is needed when it comes to the law, especially process law.

These guiding principles allow teaching on dispute resolution to come alive and be memorable.

That's how to teach the subject (in my view, anyway!).

Derek has his own dispute resolution consultancy, Auchie Dispute Resolution:
www.resolve-dispute.co.uk

Reference:

[1] https://www.lawscot.org.uk/members/journal/issues/vol-66-issue-02/legal-education-discontent-with-content/

EIGHT TOP TIPS FOR MEDICO-LEGAL EXPERTS

By Georgina Parkin, Solicitor and Managing Director of Truth Legal Solicitors, Harrogate and Leeds

Georgina Parkin is the Managing Director and a co-owner of Truth Legal solicitors, based in Harrogate and Leeds. Georgina has over 12 years' experience in personal injury litigation, and leads the SpecialistInfo Personal injury CPD courses for expert witnesses.

Whether you are just starting out as an expert witness, or you are a veteran report-writer with hundreds of cases under your belt, it is always good to have the fundamentals of medico-legal work firmly in mind. The tips that follow touch upon a number of these key concepts and will hopefully give you some food for thought.

1.Always remember that your duty is to the court

Your role as an expert witness is to assist the court in arriving at a just decision. Whilst 'the court' here can be something of an abstract idea – particularly as personal injury cases often settle before any actual court gets involved – this key duty remains. You must remain impartial, and you must provide your opinion honestly and in good faith.

In most cases, you will be instructed by one of the parties in a case. However, you should never see yourself as being 'on their side'. There can be serious consequences if, as an expert, you attempt to act as an advocate for one side or the other. And worse still if you should allow your medical opinion to be influenced or altered by your instructing solicitors.
A good rule of thumb, when preparing your report, is to ask yourself whether you would be willing to express the same opinion if you had been instructed by the other side.

For the full implications of your duty to the court, read Part 35 of the Civil Procedure Rules and its accompanying Practice Direction. These can be found at:

(https://www.justice.gov.uk/courts/procedure-rules/civil/rules/part35).

2. Consider all of the evidence that you have

This might sound obvious but overlooking significant evidence can be a major pitfall for the unwary expert – especially when faced with voluminous records and limited time.

Taking the appropriate time to thoroughly consider all evidence will improve the accuracy of your report and the strength of your opinion.

3. Be open-minded when presented with new information

Whilst confidence in your professional opinion is important, failing to consider new evidence with an open mind can lead to problems. For example, if the matter proceeds to court and you are unable to support your position, the credibility of your evidence may be undermined. A court may also conclude that an expert with an unreasonably entrenched opinion is not fulfilling their duties as an expert witness.

It is far better to re-evaluate your opinion when receiving fresh information. If your opinion remains unchanged, you should explain your reasoning.

4. Appreciate the legal context of your report

As a medical expert, you will be called upon frequently to give opinions on the claimant's injuries and the extent to which they are attributable to the incident in question. Appreciating the legal context means, in part, recognising just how important your opinion can be to a lawyer's assessment of the case at hand. It can determine the claim's value and often whether the claim is even viable.

The best medico-legal reports will be written with the legal context in mind and provide opinions (where possible) in recognition of it. If a claimant has mentioned some loss – such as lost wages due

to time off work – or another effect upon on their life following the incident, can you give an opinion on whether this is attributable to the incident? If so, is the full extent of it attributable, or only a certain period? If not, what would you attribute it to instead? Also, whilst you are not expected to be an expert in law, an understanding of relevant legal tests and standards can help you to frame and express your medical opinions effectively. For example, claimants are required to prove the elements of their case to a standard known as 'the balance of probabilities' – i.e. that something is more likely than not – and you can adopt this wording. Similarly, you might use the wording of the *Bolam* test when giving an opinion on clinical negligence liability.

Considering and expressing your medical opinions within this context can increase the clarity and utility of your reports.

5. If you don't know, say so

Never be tempted to give opinions which you cannot support. If there are matters which fall outside of your area of expertise – or where you are unable to provide an opinion with the current information – it is important to acknowledge that fact. It forms part of your duty to the court.

Your instructing solicitors will also be grateful for the clarity, especially if you are able to recommend an expert who can provide an opinion on the matter or recommend further investigations to be carried out.

6. Double-check your report

Re-reading your report before you send it is crucial. Again, this may sound like an obvious step, but one which can be overlooked when you have other demands on your time. Look out for any statements which may be interpreted ambiguously and clarify them.

Basic errors, such as typos, using the wrong gender, referring to the right leg instead of the left, etc. may not cause too many problems ultimately, but they make a bad initial impression.

Double-checking might take time, but if you don't, your instructing solicitors will likely return to you anyway to seek corrections and clarity. And at that point, the case may not be as fresh in your mind.

7. Build a web presence to get more instructions

Often, when looking into medical experts, solicitors will search online to get a better idea of their suitability. If you have built your own web presence – through platforms such as LinkedIn or your own website or blog – you can showcase your expertise, create a good impression, and hopefully secure more instructions.

8. Attend regular refresher training

In the past nine years the way that many personal injury claims are dealt with has significantly changed and this has also led to changes in relation to which experts' solicitors can instruct and how they go about this. It is likely that further changes will be coming in relation to Clinical Negligence claims. It is also worth noting that the Civil Procedure Rules are regularly updated. For these reasons I would recommend that, even if you are an experienced medico-legal expert, you attend refresher training every two to three years to ensure that you are aware of any developments which relate to your report writing.

SpecialistInfo has been providing Medico-Legal CPD Courses for medical professionals since 2007. Alumni become part of our Faculty of Expert Witnesses (the 'FEW'), which aims to promote high quality expert witnesses to subscribing law firms, medico-legal agencies and insurance companies.
Our lead course tutors are practising Barristers and Solicitors in both English and Scottish law. The Medico-Legal course range currently includes live and recorded events including Medico-Legal Essentials (Personal Injury), Clinical Negligence, Advanced Expert Witness and Court Room Skills courses, as well as training in Mediation skills.

Please see our full course range and dates here:

https://www.specialistinfo.com/course-calendar

ASSISTING THE CORONER - UNDERSTANDING THE INQUEST PROCESS AND POTENTIAL OUTCOMES.

By Dr Clare Stapleton FRCP FRCA FFICM RCPath ME, Medicolegal Consultant, Medical Protection
www.medicalprotection.org Clare.Stapleton@medicalprotection.org

Receiving a letter from the Coroner's office or the Trust legal team requesting a statement for an inquest is likely to cause some apprehension in many doctors. In 2019 in England and Wales 40% (210,900) of registered deaths were reported to the Coroner and in the same year an inquest was opened in 14% (30,000) of deaths. It is common for doctors (to some extent depending on their speciality) to have some professional involvement in an inquest at least once in their career. The following article will explain the role of the Coroner, the process of an inquest and the obligations and responsibilities of a doctor involved in a professional capacity.

The office of Coroner was first introduced in England in 1194 shortly after the Norman conquest. Their original role was a pecuniary one to ensure that any taxes owed to the Crown were identified and collected. The coronial duties included investigation of deaths due to suicide, as the assets of the deceased were then owed to the King, and Treasure trove, (which remains within a coroner's role today).

In current times the Coroner's role is more focussed on investigating deaths when the deceased's body is found within their jurisdiction. There are certain circumstances of a death which will obligate a Coroner to open an inquest, including a suspected violent or unnatural element to the death, a death that occurs in state custody, including detention under the mental health act, and when the cause of death is unknown following a post-mortem examination.

Reporting a death

There is a statutory duty for a doctor to refer a person's death to the Coroner when there is reason to believe that any of the above circumstances exist. The Notification of Death regulations (2019) sets out this obligation and includes a list of circumstances where a death must be referred for the Coroner's consideration.

Following a referral to the Coroner there are several actions that the Coroner may take:

- When there are no concerns about an unnatural element, and the cause of death is known, the Coroner may issue a form 100A which indicates to the registrar that the cause of death has been discussed with him/her and has been agreed with the certifying doctor.
- The Coroner may request a post-mortem.
- The Coroner may open an investigation.

Should a post-mortem reveal a natural cause of death and there are no concerns, the investigation may conclude at that stage without an inquest hearing.

An inquest may be opened when no post-mortem has been conducted in a situation where the cause of death can be established without a post-mortem but there remains another reason for the death to be investigated by the Coroner. In 2019, 41% of inquests did not involve a post-mortem.

A death from apparent natural causes may be deemed unnatural if the Coroner has reason to suspect that an element of care or treatment contributed to the death and particularly if there is a suspicion of culpable human failure in the care of the deceased. This extends beyond medical professionals and may apply to carers or other professionals such as the police or an employer.

Opening an Inquest

When the Coroner opens an investigation, they will gather the information required to establish the answer to four questions: Who died; Where they died; When they

died; and how they came about their death. The focus of the investigation and subsequent inquest is the last of these four questions. How the deceased came about their death is not simply the medical cause of death but by what means the person came to their death.

When there is reason to suspect that a death resulted from the State breaching its duty to protect the deceased against a known human threat or other risk, an Article 2 (referring to the European Convention of Human Rights; Article 2 being the right to life) or an enhanced inquest will be heard. This will often but not always require a jury. The circumstances in which a jury is mandatory are set out in guidance from the Chief Coroner. The scope of an Article 2 inquest is wider and includes the broader circumstances leading to the person's death.

The Coroner also has a role in improving patient safety and must identify and report any problems with systems or processes that continue to exist and risk future deaths or harm. While the Coroner does not apportion blame, in exceptional circumstances, they may also report a practitioner to their regulator if they have serious concerns about the practitioner's involvement in the care of the deceased or concerns about the practitioner's conduct at the inquest itself.

The information the Coroner gathers include the medical records, a statement from the family of the deceased, statements from the treating clinicians and any other professionals such as the police or ambulance staff. The Coroner may instruct an expert to opine on the facts of the case, particularly where they are complex.

Writing a statement

A statement for the Coroner should be a factual account of a doctor's involvement in the care of the deceased, set in the context of their medical history. The Coroner will usually give a reasonable time frame in which to provide a statement, on average 6 weeks.

Doctors have a professional obligation to assist the Coroner with their inquiry as set out in Good Medical Practice, paragraph 73. *"You must cooperate with formal inquiries and complaints procedures and must offer all relevant information while following the guidance in Confidentiality."*

The Coroner has statutory powers within the Coroners and Justice Act (2009) to compel a doctor to provide a statement or give evidence. Failure to do so without reasonable explanation can result in a referral to the GMC or criminal prosecution, although the latter is highly unusual.

There are some general points to consider when writing a statement for the Coroner:

- Ensure that the medical records and any other pertinent information, such as a Serious Incident report, is available to you.
- Be clear on what is being asked of you, for example a factual witness account of your involvement, an overview statement or presenting of a relevant investigation report.
- The Coroner may provide a statement or list of questions from the deceased's family, and these should be considered and addressed where relevant to your involvement in the care.
- Don't delay, give yourself adequate time to prepare your report in good time.
- Take advice from your Trust legal team and/or Medical Defence Organisation (MDO) early. They are likely to provide you with a template and/or a structure to assist you in drafting a clear concise statement.
- Be aware that your statement will be available to the family of the deceased.
- Avoid medical jargon and explain all complex medical terms including prescribed medication.
- Consider asking your MDO to review your statement.

The Inquest Hearing

In some inquests the Coroner will hold a Pre-Inquest Review Hearing (PIRH). This is an opportunity for the Coroner to hear representations from the parties involved, establish the scope of the inquest and confirm the witness list. The PIRH is usually attended by the interested persons (see below) or their legal representatives.

When issuing a summons to attend an inquest the Coroner's officer will usually notify witnesses of their status at the inquest.

A Witness of Fact attends to give a factual account of their involvement in the care of the deceased. A Witness of Fact cannot question any of the other witnesses, is not entitled to legal representation at the hearing and does not receive advance disclosure of the evidence available to the Coroner.

An Interested Person (IP; formally referred to as Interested Party) is an individual or an organisation who the Coroner believe has sufficient interest in the outcome of the Inquest, or whose involvement is pivotal to the case. An IP may question other witnesses, has the right to legal representation and is entitled to receive advance disclosure. The family of the deceased are usually recognised as an IP.

There are advantages to being granted IP status; however it may also indicate that the Coroner has a particular interest in an individual professional, or they may have contributed to the death, which could result in a criticism surrounding the care the practitioner or organisation provided.

Giving Evidence

As a professional witness, a doctor's role is to set out the facts of their involvement in the care. When giving evidence the Coroner will usually take the witness through their statement asking questions or points of clarification. Following the Coroner's questions the witness will be asked questions by all other IPs including the deceased's family or their legal representative. As an IP, a witness's own legal representative will usually be the last to ask questions. This will be an opportunity to cover any relevant points which have not been clearly addressed beforehand or clarify any areas of contention.

The GMC have set out relevant guidance within Acting as a witness in legal proceedings - GMC (gmc-uk.org). All doctors should be aware of their professional obligations when involved in an inquest.

The Coroner has the statutory power to compel a witness to give evidence at the hearing. If a doctor is too unwell to attend or is unavailable for another unavoidable reason, they should notify the Coroner's office/Trust legal team as soon as possible.

An inquest is a public hearing and as such may be attended by members of the press depending on the nature of the case. The prospect of giving evidence often induces apprehension in doctors, particularly if they are unfamiliar with judicial proceedings. However, an inquest is not an adversarial process, there is no prosecution or defence. That said, anxiety is a natural response, there are some practical steps that a witness can take to place them in the best position at the inquest hearing:

1. Seek the advice and support of colleagues and your MDO.
2. Be well prepared, read your statement and be familiar with the facts within it.
3. Read the medical records and have them available at the hearing itself.
4. Arrive at court in good time and try to avoid being on call the night before the hearing.
5. Dress appropriately for the formality of the occasion.
6. When giving evidence, listen to the question, answer the question and the wait until the next question is asked. Straightforward as this advice sounds, witnesses can cause difficulty for themselves by anticipating questions or attempting to answer questions that they have not properly understood. There is no problem in asking for the question to be repeated or clarified. Periods of silence often occur between questions, for example while the Coroner is taking notes. A witness is not required to fill these silences, continuing to speak when the question has already been answered may result in a witness making poorly considered and potentially unhelpful comments.
7. Do not stray into expert territory or step out of your area of knowledge or expertise. The Coroner may request your opinion on matters unrelated to your involvement. There may be criticism of a witness for expressing an unfounded opinion or one that is outside their knowledge or experience. The Coroner is less likely to be critical of a doctor who does not know the answer than one who attempts to construct a reply outside of their expertise.

8. Do not engage with any journalists who may be attending the inquest to report on it – if media approach you, direct them to your MDO.

Outcome of an inquest

Once the evidence has been heard, the Coroner will determine the facts and reach a conclusion. This can be a short form conclusion such as natural causes, accident or suicide, but the Coroner may also provide a narrative to explain the circumstances by which the death came about.

A Coroner can add a rider of neglect to an inquest conclusion. Neglect has a narrow definition in law and does not have the same meaning as negligence.

Following the inquest hearing the Coroner can write a Prevention of Future Deaths Report in cases where the evidence suggests that further avoidable deaths could occur and that, in the Coroner's opinion, preventative action should be taken. The report will be sent to the person or authority which may have the power to take the appropriate steps to reduce the risk and they have a mandatory duty to reply within 56 days. These reports are now routinely published.

The Coroner is not permitted to make any determination of civil or criminal liability. An inquest conclusion however may contain a neutrally worded criticism of a professional. For example, *"the GP did not examine Mr A when he complained of abdominal pain"*.

A doctor is obliged to inform the GMC of criticism received during the course of an inquest as set out in paragraph 75 of Good Medical Practice:

"You must tell us without delay if, anywhere in the world:

> *a. you have accepted a caution from the police or been criticised by an official inquiry…."*

The GMC clarifies within its guidance that "official inquiry" includes an inquest and a doctor should inform the GMC of such criticism that calls their fitness to practise into question. In some instances the criticism is unambiguous and the decision for a doctor to refer the matter to the GMC is straightforward. However this is not always the case and discussion with the legal team or the doctor's MDO may be helpful.

Following an inquest

Involvement in an inquest should be discussed within a doctor's appraisal. It is wise to reflect on the case and the inquest hearing itself. Many doctors are concerned about the consequences of documenting detailed reflections. The recording of a doctor's reflection within an appraisal can be restricted to broad themes of learning and should not contain patient identifying information.

Summary

An understanding of the inquest process and a sound knowledge of the relevant professional obligations will place doctors in a better position when involved in a Coroner's investigation. Support from colleagues and expert medicolegal advice from the practitioner's MDO can ease the burden of stress as well as reduce the risk of an adverse outcome for a doctor assisting the Coroner.

Resources

- Coroner Statistics Annual 2019, England and Wales. Office of National Statistics

  Publication Date: Thursday 14th May 2020

- Good medical practice - ethical guidance - GMC (gmc-uk.org)
- Notification of Deaths Regulations 2019 guidance - GOV.UK (www.gov.uk)
- Coroners and Justice Act 2009 (legislation.gov.uk)
- Chief Coroner's Guidance, Advice and Law Sheets | Courts and Tribunals Judiciary

PICKERING V CAMBRIDGE UNIVERSITY HOSPITALS NHS FOUNDATION TRUST: WHERE EXPERT WITNESSES MAKE ALL THE DIFFERENCE

By Flora McCabe, Head of Advocacy and Risk Management Healthcare, Senior Vice President, Lockton Companies LLP, London EC3A 7AG
T: 0207 933 2516 E: Flora.McCabe@lockton.com www.global.lockton.com

'Wisely and slow. Those that stumble run fast' (Romeo and Juliet, Act II iii 101). At last year's conference, I focused on cases where expert witnesses had failed in their duties to the Court. Unfortunately, despite much recent focus on how to improve expert witness reports, we continue to see examples of expert witnesses who, if not in actual breach, certainly leave much to be desired in terms of their ability to perform as credible expert witnesses, often appearing rushed and under prepared, even forgetting to bring the correct supporting evidence to Court. Whilst instructing solicitors need to bear some responsibility for this, more work needs to be done by the experts giving evidence. Judgment in *Pickering v Cambridge University Hospitals NHS Foundation Trust* was handed down just last month and the case is a salutary tale for aspiring and current expert witnesses alike, a reminder of the need to:

- think carefully about the articles and research you choose to support your assertions and ensure that you produce them, can quote from them accurately and understand them completely;
- take a logical, well -reasoned approach at all times, whilst remaining open to opposing arguments;
- take time to answer questions and be able to withstand interrogation in Court

Background

In the evening of 24 September 2015, the Claimant, then 52, noticed that she had pins and needles in her foot. Of note, she suffered from a pre-existing heart condition (Atrial Fibrillation) that left her susceptible to blood clots. Her right foot became cold and white, which lasted for a few minutes before returning to normal, but then happened repeatedly. The Claimant attended A&E at Addenbrooke's Hospital where she was examined and discharged without anti-coagulation treatment - in this case Heparin. It was agreed by both parties – only after the Defendant's A and E expert witness was had provided evidence - that the failure to provide Heparin was a breach of duty by the Trust.

She was sent to the out of hours GP, before being sent back to A&E and then home the next day. Over the next two days, the Claimant felt relatively normal and simply called her GP to 'check in', but on 27 September very sadly suffered a "massive stroke".

The Court had to determine whether, but for the Defendant's negligence, the Claimant would not have suffered a stroke had she been treated with Heparin within the 48 hours in question. The medical literature does not offer definitive evidence in respect of treatment in an emergency setting of atrial fibrillation with a clot in the left atrium or LAA which has already fired off an embolus; obviously there is no ethical way of obtaining data for comparison purposes. As such, the ability of the experts to clearly explain their perspective on the issue in question was perhaps even more important than usual. The Claimant maintained that treatment with Heparin would have had a front loaded effect and avoided the stroke. The Defendant's expert, whilst accepting that Heparin was over 90% effective in preventing DVT and PE within 2-3 days of treatment, maintained his position that the efficacy of Heparin in those scenarios was not applicable in

this case, and that the beneficial effect of Heparin would have only kicked in after 30 days. Notably, both experts accepted that Heparin prevents new clot growth and the propagation (growth) of existing clots. The rest of the article will focus on the performance of the key experts in this matter, and how that affected the Judgment.

The Experts

The evidence on breach

The Judge found the evidence of the Claimant's expert witness consultant in A&E medicine, 'persuasive, logical and clear' that no reasonable A&E clinician would have let the Claimant leave without offering her advice on the *"significant risk of further embolisation"* and advising her that she needed Heparin *"to reduce the risk of further embolic events"*.

By contrast, the Defendant's A&E consultant expert, demonstrated an inability to support his own opinion when under cross examination; his performance is a reminder to all expert witnesses of the need to be able to evidence assertions. Whilst he initially advised the Court that it was entirely reasonable not to treat the Claimant with Heparin because there was no evidence of ongoing leg ischaemia, during live cross examination he could not explain why it would be safe to make the Claimant wait for anti-coagulation when the Defendant's clinicians had Heparin in the fridge and a simple injection would start the protective process. Indeed, in the Judge's words, "he came so close [to agreeing with the Claimant's expert] as to be indicating to the Court that he was relenting."

Following the evidence of the Defendant's expert, the Defendant conceded both breach of duty and the fact that the Claimant would have taken the advice to start Heparin. It was then necessary to consider the issue of whether administering heparin at the time of the first appointment at A&E could have avoided the stroke suffered by the Claimant.

Causation

Four medical experts reported on causation. Taking the first pair, the Claimant instructed an eminent consultant neurologist, whilst the Defendant instructed a consultant in general medicine, geriatrics and strokes. It can always be a little challenging when the parties instruct experts in different fields, but they reached some agreement, stating in their joint report that:

- The Claimant was at significant risk of further emboli after she had suffered the first blood clot in her leg;
- The benefits of administering Heparin to the Claimant outweighed the risks;
- The stroke the Claimant eventually suffered was caused by an embolism from the clot in the heart.

The Defendant expert deferred to the haematologists but thought that anti-coagulant would not have saved the Claimant. The Claimant expert maintained that Heparin would have prevented the stroke and relied on a paper by *Weitz et al* published in 1997. Unfortunately, the Claimant's expert was cross-examined on the content of this article, and it transpired that he had misquoted from it in the joint report. As such, he had to admit his error, confirming that he was summarising a different paper whose name he could not recall, and which he had not shown to either the Defendant's expert or to the Court. Situations like this, although in this instance not fatal for the case, can create real problems and unnecessary stress for all those concerned and should be avoided.

Expert Haematology evidence

Turning to the key evidence, the Claimant's haematology expert asked the question *"Would Heparin have prevented the stroke?"* He relied on the following points to support his argument that it would:

- Heparin is recommended:
  - for the treatment of acute presentation with a systemic embolic event relying on a paper by *Bekwelem et al* published in 2015;
  - for acute new onset atrial fibrillation by NICE;
  - for acute onset atrial fibrillation by the American Heart Association and the American Academy of family physicians;
  - by the American College of Chest Physicians in their evidence based clinical practice guidelines for situations where there is acute onset atrial

fibrillation or acute thrombosis, relying on the paper published in 2012 by *Guyatt et al*;

- by the American College in DVT and pulmonary embolism cases for the prevention of venous thrombo-embolism in non-surgical patients; for patients who require bridging anti-coagulation in the peri operative period; for patients with atrial fibrillation undergoing cardioversion, especially if urgent, and in patients who are hemodynamically unstable, and for patients with acute limb ischemia due to arterial emboli or thrombosis.

He also confirmed that Heparin is an effective anti-coagulant in the emergency setting which the Claimant was presented with on 24 September. By contrast, the Defendant's expert argued:

"In my opinion Heparin would have been ineffective in preventing the Claimant's stroke, similar to the lack of effectiveness demonstrated in high risk AF patients in the two high quality phase three AF trials (where the mechanism of stroke and nature of embolising atrial thrombus would have been identical)."

He explained that with anti-coagulation the body's natural thrombolysis system results in "*clot organisation and resolution*" (his words) over time but advised that it takes three to four weeks for thrombi in the atrium to organise or resolve during the anti-coagulation treatment. He opined that the stroke potential still exists during those three to four weeks, despite anti-coagulation, probably because the pre-existing, fresh left atrial thrombus has not yet "*organised or resolved*". It appeared to the Judge that the Defendant's expert was advising the Court that despite atrial clots reducing in size and resolving over 3-4 weeks of anti-coagulation, they do not become "*organised*" over that period so that their potential to fire off emboli remains the same as they decrease in size. The Judge "struggled to understand the logic of that in the face of the Defendant expert's own struggled evidence that with anti-coagulation the body's natural thrombolysis system results in "*clot organisation and resolution*" (his words) over time"

In reaching his decision that he preferred the evidence of the Claimant's haematology expert, the Judge took into account the fact that "[the Defendant's expert] had a tendency to be rigid and then to produce rather extreme opinions". To illustrate his viewpoint, the Judge pointed to the fact that the Defendant's expert had asserted in cross examination that the scans in a paper he relied upon were unrepresentative "because the clinician who chose them may have been *trying to prove his point*". The Judge claimed that "this assertion was unworthy of [the Defendant's expert]". The Judge was also unimpressed by the Defendant's expert's refusal "in his live evidence to descend into the detail as to why and how Heparin's great success in abolishing the risk of emboli from blood clots in DVT and PE should be occurring so quickly and why it is irrelevant to the atrial clots in this case."

Overall, the Judge found that Heparin would have prevented new clot formation, prevented mother clot propagation (of the existing clot) and would have enabled the Claimant's body not only to reduce the size of the mother clot in the Claimant's LAA but also to make it less friable and more stable.

Conclusion

All expert witnesses should read the Judgment in full for this case[1] in order to understand the factors informing the Judge's views - which in fact also included an implicit criticism of the Claimant expert haematologist for 'lecturing' from the witness box – and work hard to make sure that their opinions in the future are firmly based in logic, well tested and easily explainable. In Shakespeare's words, 'things done well and with a care, exempt themselves from fear; things done without example, in their issue. Are to be fear'd.' (Henry VIII Act 1, II).

Reference:

[1] https://medicalnegligencenow.files.wordpress.com/2022/05/phoebe-charmaine-pickering-v-cambridge-university-hospitals-nhs-foundation-trust-2022-ewhc-1171-qb-17-may-2022.pdf

MEDICO LEGAL

CONFERENCE 2023

20TH JUNE 2023,
CONGRESS CENTRE, LONDON

specialist info ICONIC MEDIA SOLUTIONS

SCAN TO BOOK YOUR TICKET

BOOK YOUR PLACE EARLY AND **SAVE 30%**

www.medicolegalconference.com

The **Medico-Legal Conference** has now firmly established itself as the UK's leading event bringing together medico-legal professionals, industry experts, and suppliers. Attend to experience our high-level programme of speakers, interactive exhibition zone, and networking.

The conference takes place at Congress Centre, London on Tuesday 20th June 2023. Book now and benefit from our 30% off early bird offer.

Benefits of Attending:

- Be updated on the latest medico-legal developments, reforms and issues
- Hear from the lawyers involved in some of the most recent high profile cases
- Learn about the increasing role of mediation in settling medico-legal claims
- Gain insight into writing medico-legal reports and avoiding difficulties
- Enjoy excellent networking opportunities, including a Champagne reception

6 Hours CPD

Essential for Doctors, Lawyers and all those involved in the Medico-Legal Profession

For more information and to book your place please visit:

www.medicolegalconference.com

Grow Stronger

Looking for an expert?

We have a proven track record of delivering outstanding service and results - our expertise lies in our experience.

About our debt collection services:

- 12% commission rate for EWI members
- 'No collection, no commission'
- 200+ expert witness clients
- FCA authorised and regulated

We are here to help your credit control process and improve your cash flow.

Get in touch today and quote 'EWJ5' to receive a discounted commission rate of just 5% on your first case.

REDWOOD COLLECTIONS

Call us on **020 8080 2888** or email **info@redwoodcollections.com**

REDWOODCOLLECTIONS.COM

MEDICO -LEGAL NEWS:

By Lisa Cheyne,
Medico-Legal Manager,
SpecialistInfo

A round-up of news in the industry for second quarter of 2022.

NEWS

Informed Consent case after Reflex DNA test fails to detect Edwards Syndrome in high-risk pregnancy

Barts NHS Health Trust, which administered an experimental Reflex DNA test at 16 weeks to a high-risk pregnant 39-year-old with epilepsy, and which also failed to detect any fetal abnormalities through a routine ultrasound scan at 20 weeks, has admitted and apologised for failings at the Royal London Hospital in 2016.

The Reflex DNA test, as developed and supplied by the Wolfson Institute of Preventive Medicine to detect chromosomal trisomies, was not a recognised alternative to the standard combined test, and not recognised by the National Screening Committee.

After believing that they were carrying a healthy child, the couples' baby was born at full term with severe abnormalities, and Edwards syndrome (trisomy in chromosome 18) was later diagnosed. He died at 10 weeks old from a condition that is known to result in severe disability and very early death. Usually, parents are offered a termination if antenatal tests detect Edwards Syndrome in the fetus, and in this case they would have taken that route had they known.

Leigh Day Solicitors representing the claimants said "They were not provided with appropriate choices regarding screening or proper advice to enable them to make an informed decision about appropriate tests. If appropriate tests had been offered, abnormalities would and should have been detected and the parents should have been given advice about the continuation of the pregnancy."

The trust has modified its procedures as a result of this incident.

Read more: https://www.leighday.co.uk/latest-updates/news/2022-news/reflex-dna-test-failed-to-spot-edwards-syndrome-in-womans-pregnancy/#maincontent


Image: Freepik.com / author fanjianhua

Clinical negligence contempt case results in custodial sentence over £4M fraudulent claim

In North Bristol NHS Trust v White [2022] EWHC 1313 (QB) (26 May 2022) Mr Justice Ritchie said that Holly White should go to prison immediately as a suspended sentence would not get the message across sufficiently strongly that defrauding the NHS is utterly unacceptable. 'Nor would it send out the right message to those currently suing NHS trusts or those who will do so in future.'

The 29-year-old woman who knowingly exaggerated the extent of injuries suffered as a result of alleged NHS negligence during treatment for herniated discs, has been jailed for six months for contempt of court.

She was examined by several expert witnesses and claimed that she could not drive long distances, walk up stairs unaided or take more than 20 steps without needing to use a crutch, and was in constant pain. Video surveillance showed that while White claimed to have mobility issues, she walked normally without assistance and drove up to 40 miles without stopping.

Read more: https://www.bailii.org/ew/cases/EWHC/QB/2022/1313.html

Damages Claims Portal - Civil Procedure Rules amendment postponed indefinitely

An amendment to the Civil Procedure Rules, to be put in place from 2 June 2022, stating that solicitors responding to claims for damages issued via the Damages Claims Portal (DCP) must respond using the DCP, is being postponed indefinitely. An HM Courts and Tribunals Service Tweet on 31 May 2022 has confirmed that this part of the Practice Direction has been revoked before it came into force.

The DCP (Practice Direction 51ZB) is a digital service that allows solicitors to issue and respond to claims for unspecified amounts where a claim has 1 claimant versus 1 defendant. HMCTS is currently refusing to issue proceedings not using the portal, but defendants complain they cannot use the system properly because of unresolved glitches.

Read more: HMCTS weekly operational summary - GOV.UK (www.gov.uk)

The Medico-Legal Conference 2022 takes place this month in London on 28th June 2022.

Alexander Hutton QC, Hailsham Chambers, is Keynote Speaker for the 2022 conference.

Other speakers include:

- **Lorin Lakasing,** Consultant in Obstetrics & Fetal Medicine, NHS
- **Pankaj Madan,** Barrister, Exchange Chambers & 12 King's Bench Walk
- **Flora McCabe,** Head of Healthcare Claims, Solicitor, Lockton LLP
- **Doireann O'Mahony,** Barrister, Bar of Ireland & Normanton Chambers
- **Angus Piper,** Barrister, 1 Chancery Lane
- **Prof Dominic Regan,** City Law School, London. Head of Know-How, Frenkel Topping. Legal Speaker, Writer and Broadcaster. Wine Critic, 'Counsel' Magazine.
- **Clare Stapleton,** Medicolegal Consultant, Medical Protection Society

Please visit the conference website below for more details and to secure a ticket for 2022:
www.medicolegalconference.com

Please contact craig.kelly@iconicmediasolutions.co.uk for further information if you are interested in sponsoring the programme or hosting a stand at next year's event in London on 20 June 2023.

Victims of contaminated blood scandal to receive compensation

Up to 30,000 NHS patients contracted hepatitis C, HIV and other diseases after receiving contaminated blood-clotting products in the 1970s and 1980s, and 3,000 are thought to have already died as a result.

Ministers have accepted that there is a "strong moral case" for a taxpayer-funded scheme to compensate those affected by this major NHS treatment disaster.

Details of the compensation plan have been promised before the government responds to a review due in July, led by Sir Robert Francis QC, set up last year to examine a possible compensation framework for the victims and their families.

Francis, was asked to:

Give independent advice to the Government regarding the design of a workable and fairframework for compensation for individuals infected and affected across the UK to achieve parity between those eligible for compensation regardless of where in the UK the relevant treatment occurred or place of residence.

Campaigners are demanding immediate interim payments of £100,000 for victims nearing the end of their lives after 40 years of living with the consequences without compensation.

Read more: https://www.infectedbloodinquiry.org.uk/

NHS Litigation Reform Report released

The House of Commons Committee report, with recommendations to government, was published at the end of April. The Government has two months to respond.

The committee's central recommendation is that "the NHS adopt a radically different system for compensating injured patients which moves away from a system based on apportioning blame and prioritises learning from mistakes. An independent administrative body should be made responsible for investigating cases and determining eligibility for compensation in the most serious cases. Reconstituting the new Special Health Authority, which will take over maternity investigations from HSSIB, would be an efficient way for the Government to implement our recommendation. This would be the most effective long-term way to reduce both the number of tragedies and the cost to the NHS. Changing from a blame culture to a learning culture is not easy but can be accelerated by some simple but important changes to current NHS processes which we encourage the Government to adopt."

Read more: https://publications.parliament.uk/pa/cm5802/cmselect/cmhealth/740/summary.html

Court allows claimant's appeal against finding of fundamental dishonesty

In Jenkinson v Robertson [2022] EWHC 756 (Admin) Mr Justice Choudhury overturned a trial judge's finding of fundamental dishonesty on the part of a claimant who was a litigant in person. Mr Justice Choudhury said:

"A claim that is unreasonable is not necessarily dishonest; it may simply be misconceived. A claim that is exaggerated may be so because of the inclusion of losses that are wrongly believed to arise out of the accident in question. If a defendant wishes to establish that an exaggerated or unreasonable claim is fundamentally dishonest, then the basis on which that dishonesty arises or is alleged to arise ought to be made clear."

This is a judgment that highlights the need for defendants to give clear notice of the matters upon which a claimant is going to be alleged to be dishonest and to particularise its allegations. It also highlights the fact that that a claimant who makes claims that are unreasonable or misconceived is not necessarily dishonest.

Read more: https://www.bailii.org/ew/cases/EWHC/Admin/2022/756.html

Official Injury Claim Portal backlog of thousands of lower-value RTA cases

David Parkin, deputy director of civil justice and law policy for the MoJ, revealed at the Association of British Insurers conference in late May that 185,000 claims are currently active in Official Injury Claim, the portal for handling lower-value RTA cases.

Since the system launched last year, 243,000 claims have been lodged, of which around 50,000 have been settled and or exited. Many are waiting for the medical details to be uploaded, or negotiation between the parties.

Hybrid claims seem to be the main reason settlement cannot be reached, where claimants report both whiplash (covered by a compensation tariff) and other injuries (not covered). Claimant and defendant representatives continue discussions over a potential test case to bring before the court and establish the position on hybrid claims.

Parkin told the conference that the system has worked well for litigants-in-person but this only accounts for around 9% of claims.

He also revealed there are no plans to introduce mandatory alternative dispute resolution in the system, after initial plans for this provision were dropped before the portal went live, saying:

'It would be irresponsible to make it compulsory overnight when the capacity is not there."

Read more: https://www.officialinjuryclaim.org.uk/about/

MEDICO LEGAL

MAGAZINE

www.specialistinfo.com

specialist info