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The charity for patient safety and justice

Lawyers Service Newsletter

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Editorial

Lisa O'Dwyer
Director, Medico-Legal Services

AvMA is excited to refer you to our ambitious five year strategic plan: www.avma.org.uk/about-us/avmas-2024-29-year-strategic-plan/. Do also take a look at our first impact report: www.avma.org.uk/about-us/our-impact/.

From time-to-time AvMA works with independent organisations or projects to support and/or evaluate improvements in patient safety and care. We are currently supporting the **Maternity Investigations and Review Tools process evaluation (MATREP)**. MATREP is evaluating the progress and resourcing of the Maternity and Newborn Safety Investigations (MNSI, formerly HSIB Maternity investigations) and National Perinatal Mortality Review Tool (PMRT) programmes to see if they have improved the experience of families, and maternity safety. The project will explore what resources are required for families and services to make these programmes effective. If you or anyone you know has experience of the MNSI or PMRT process and would like to become involved with this research, details can be found here: www.avma.org.uk/wp-content/uploads/MATREP-Evaluation.pdf

The MBRRACE report "Saving lives, improving mothers' care" published in October 2023 noted (see causes and trends section of the summary) that there was "*a nearly four-fold difference in maternal mortality rates amongst women from Black ethnic backgrounds and an almost two-fold difference amongst women from Asian ethnic backgrounds compared to White Women*". The reasons for this difference are complex and multifactorial, we are pleased to reproduce **Afiya Amesu**'s important article on "***The nature of cultural bias and its implications for clinical negligence proceedings***", Afiya is a barrister practising at No 5 Chambers, Birmingham.

The forthcoming election has brought with it some welcome respite from responding to consultations and there have been a number of them recently. AvMA's response on various issues from the duty of candour to reforming the law on apologies can be found here: www.avma.org.uk/policy-campaigns/briefings/.

Details of the government's response to the supplementary consultation on disbursements in FRC in lower damages clinical negligence claims was published on 8th May. As we are now in purdah pending the election we

will not have any further information on FRC although published minutes from the Civil Procedure Rules Committee indicates that they were on track to introduce FRC for low value claims in October.

Given that all of the main parties are pledging support and improvements for the NHS, change seems inevitable, the use of private healthcare providers will likely form part of the solution to alleviating waiting lists especially amidst a staff recruitment and retention crisis. Public and private healthcare will almost certainly continue to operate together and so too will the question: ***"Public-private Healthcare – Where does liability lie?"***. **Dominic Ruck Keene** barrister at 1 Crown Office Row tackles this difficult question and offers some practical tips on how to approach these cases.

More practical tips are offered on the difficult question of assessing your client's mental capacity in ***"Mental Capacity and clinical negligence – Recent developments, practical issues and traps for the unwary"*** by **Matthew Stockwell** of Exchange Chambers.

Section 57 of the Criminal Justice and Courts Act 2015 sets out how claims should be managed when there is a finding of fundamental dishonesty in a personal injury claim. It interesting that the statute only recognises a situation where a claimant is fundamentally dishonest, there is no equivalent provision under this Act for a dishonest defendant, so situations where medical notes have been deliberately altered, crucial documents go missing, or evidence is deliberately concealed are not addressed here. There are cases where fundamental dishonesty has been used as a tactic to frighten a claimant into dropping a claim but equally there are times when claimants are dishonest. **Leslie Keegan** of 7 Bedford Row looks at the ramifications of a finding of fundamental dishonesty by examining the courts approach to substantial injustice in ***"When does depriving the fundamentally dishonest claimant of damages cause substantial injustice?"***

Provisional damages are often bought off as part of the overall settlement agreement but as **Lauren Karmel** and **Jimmy Barber** both of St John's Chambers remind us it is important to consider whether this is appropriate, they offer some guidance in ***"Provisional Damages in clinical negligence claims: Practical steps to consider"***.

The UK Covid-19 Inquiry continues and in September will hear evidence on the Impact of Covid-19 pandemic on healthcare systems in the four nations of the UK. In the meantime, **Peter Todd**, Consultant solicitor at Scott-Moncrieff & Associates Limited sets out his experience of representing claimants who have been injured by the Covid vaccine. His article ***"Covid vaccine injury compensation update, May 2024"*** points out that the vaccine damage scheme is a no fault compensation scheme – it is worrying to note that this scheme has not increased the fixed eligibility payment of £120,000 since 2007, allowing for inflation those payments should be worth £200,000 today. Further, that of the 11,022 people making an application only 4,996 cases have received notification of the decision. Even more alarming is that only 492 of those 4,996 cases were considered disabled and after a further whittling only 168 people met the qualifying definition of severe disablement.

The Hughes Report on redress for those harmed by valproate and mesh published in February 2024 described the disadvantages of a full litigation model (p96) to include *"complex to quantify"* and *"limited by litigation categories…excludes most indirectly affected individuals"*. Peter's article demonstrates that while anyone can make an application in fact very few qualify, the fixed award is far from adequate for a severe disabling injury and does not even keep pace with inflation.

At the end of February, we welcomed **Denise Broomfield** as the Medico Legal Department Team Leader, we are delighted that our Inquest Service is now up and running again. AvMA thanks RWK Goodman who took on two cases where we had promised families pro bono representation at inquest. These cases were interesting in that they both involved the London Ambulance Service, patients who were experiencing severe respiratory difficulties, and were classed as category 2 cases (with an expected response time of 18 minutes) in fact the actual response times were well in excess of one hour resulting in the loss of life. While one of the inquests has yet to be heard, coincidentally RWK Goodman had a number of ambulance cases that they were already investigating, do read **Becky Randel**'s article **Improving patient safety through inquest investigations**.

AvMA values the relationship it has with all of its Lawyers' Service and AvMA panel firms. Your support of our charitable aims and objectives is demonstrated in many different ways from hosting AvMA events, to making financial donations. Our thanks to Jacqueline White (Clinical negligence and Court of Protection solicitor) at Pearsons who having been made President of Oldham Law Assocation has made AvMA their charity of the year. If you would like to support us in any way please contact our Communications and Fundraising Officer **Paula Santos** paulas@avma.org.uk.

This is the last Newsletter that our much respected and cherished colleague, **Liz Thomas** will "have" to read before her retirement at the end of August. Liz will be

known to all of our AvMA Panel members, she will have tirelessly and meticulously read through your application, interviewed you and reaccredited many of you. Always there to lend a guiding hand, offer advice on how to improve practice and gently guide on a range of issues from caseloads to readiness to make an application for the AvMA panel. I know you will join me in thanking her and wishing her well in her retirement.

While one-chapter of the AvMA story finishes, another one starts and after many months of searching for the right person we are pleased to announce Liz's replacement, **Jayne Nicols**. Jayne will spend the next few weeks with Liz as she hands over her expertise. Jayne is dual qualified as a nurse and a specialist clinical negligence solicitor; she is committed to improving patient safety and standards for patients.

We are also pleased to announce the recruitment of **Dr Hannah Davies** who has accepted a part time case worker role in the Medico Legal Department. Hannah is equally committed to patient safety, learning lessons from adverse outcomes and improving care, a practising GP who until recently was Deputy Chief Medical Officer for Children and Young People for Hampshire and the Isle of Wight ICB, she has her Masters in Medical Law and Ethics from Kings College London.

Wishing you all an enjoyable summer!

Best wishes

The nature of cultural bias and its implications for clinical negligence proceedings

AFIYA AMESU
NO5 BARRISTERS CHAMBERS

Recently, BBC News reported the tragic and untimely death of a 31-year-old pregnant Black woman at Liverpool Women's Hospital[1]. The incident occurred in March 2023 and the nature of the woman's death has sparked a charged conversation about cultural bias in clinical negligence cases. This article seeks to explore the nature of cultural bias and its implications for clinical negligence proceedings.

On 16 March 2023, a Black patient of Liverpool Women's Hospital died, and the cause of death was recorded as:

1A. Acute intestinal ischaemia; and

1B. Thrombophilia

An independent investigation conducted by the Maternity and Newborn Safety Investigations (MSNI) found that the root cause was:

1. The lack of onsite surgical team and managing the patient in isolation and not 'shared care' with other acute specialties; and

2. The lack of co-location of LWH with acute trust

Further, it was reported that *"ethnicity and health inequalities impacted on the care provided to the patient, suggesting that an unconscious cultural bias delayed the timing of diagnosis and response to her clinical deterioration"*[2], alongside challenges arising from low staffing and the junior doctors' industrial action.

The MNSI investigation also found evidence of inaccurate and incomplete pain scoring as well as a failure to take some observations because the patient was 'being difficult'. The clear disparities in her care have raised vexed questions about the adequacy of the care provided to the patient and concerns as to the role that cultural bias may have played in the diagnosis, treatment, or overall response to her medical needs. This, unfortunately, is not an isolated incident. In an independent review of over 1,800 cases of neonatal deaths, stillbirths, maternal deaths and injuries to mothers and babies at the Nottingham University Hospitals NHS Trust, senior midwife, Donna Ockenden FRSA, has uncovered myriad examples of discriminatory and racist behaviour towards patients[3]. These cases arise in the context of research conducted by Mothers and Babies: Reducing Risk Through Audits and Confidential Enquiries UK (MBRRACE-UK) in January 2024 that found that between 2020 and 2022, Black women are over three times more likely to die during pregnancy or immediately afterwards than white women, and Asian women are almost twice as likely[4]. It is also worthy of note that disparities experienced by ethnic minorities go beyond maternal care, extending to mental health services, access to health services and genetic testing[5].

Understanding Cultural Bias

Cultural bias as defined by the American Psychological Association is *'the tendency to interpret and judge phenomena in terms of the distinctive values, beliefs, and other characteristics of the society or community to which one belongs. This sometimes leads people to form opinions and make decisions about others in advance of any actual experience with them'*[6]. Cultural bias causes us to make assumptions about a group based on our cultural background which then influences how we view and engage with said group. Cultural bias in healthcare refers to the influence of cultural factors on medical decision-making, treatment plans, and patient outcomes. It can manifest in various forms, from subtle assumptions

1 *BBC News Liverpool, "Ethnic bias' delayed care before Liverpool woman's death'* www.bbc.co.uk/news/uk-england-merseyside-68300655

2 *Liverpool Women's Hospital, Trust Board, 8 February 2024,* https://liverpoolwomens.nhs.uk/media/5289/2024-02-08-trust-board-public-v1.pdf

3 *BBC News England, 'Nottingham: New mums report racism in hospitals, says maternity lead',* www.bbc.co.uk/news/uk-england-nottinghamshire-68431157

4 *MMBRACE-UK, Maternal mortality 2020-2022,* www.npeu.ox.ac.uk/mbrrace-uk/data-brief/maternal-mortality-2020-2022

5 *Kapadia, Dharmi et al. '*Ethnic Inequalities in Healthcare: A Rapid Evidence Review*', NHS Race & Health Observatory (2022)*

6 *American Psychological Association* https://dictionary.apa.org/cultural-bias

to overt stereotypes that may impact the quality of care delivered. For example:

1. Queries around consent/miscommunication due to language barriers

2. A lack of understanding about how different illnesses/diseases appear on darker skin

3. Myths around pain tolerance for ethnic minorities

4. Assumptions that some symptoms are more or less serious based on a patient's cultural background

5. Differing levels of access to healthcare services

The case in Liverpool, and indeed other incidences of poor care in similar circumstances, demands our attention and reminds us of the urgent need for a comprehensive and systematic examination of cultural biases within the healthcare system. In addition, in order to address these concerns, hospitals and legal institutions should consider:

1. Representation in Medical Staff:

Considering how diverse and representative is the staff body within the NHS, in particular, at decision-making levels and to what extent might the lack of diversity contribute to cultural bias.

2. Training Programs:

Implementing ongoing training programs to raise awareness of implicit biases and provide healthcare professionals with the tools to address them.

3. Cultural Competence Standards:

Establishing and enforcing standards for cultural competence in medical diagnoses, treatment plans, and overall patient care.

4. Legal cases:

Heightening an awareness of cultural bias in order to ensure it is properly accounted for.

As we grapple with the aftermath of this incident, it is crucial to confront the uncomfortable reality of cultural bias in the care of Black and minority ethnic patients. By raising our awareness of these issues, we can better understand the factors that might be at play in clinical negligence cases and better serve our clients.

Public-private Healthcare - Where does liability lie?

DOMINIC RUCK KEENE
1 CROWN OFFICE ROW

Claims against private healthcare providers often raise complex questions as to the extent of any vicarious and non delegable duties of care.

However, where treatment has been entirely provided on a private basis (i.e. the clinicians are not acting in any NHS capacity, no NHS facilities or supporting staff such as nurses or radiographers are involved), there are usually only at most two potentially practicable Defendants – the clinician (assuming they have appropriate MDO or commercial insurance in place) and/or any organisation under whose aegis they have provided treatment (e.g. a BUPA Hospital or a private clinic). An additional level of complexity is added due to the line between public and private healthcare provision being ever more blurred. There is now a wide variety of circumstances in which patients will receiving a course of treatment may end up receiving healthcare that is 'private' at least in part. Some of the most common include:

• NHS trusts offering private healthcare services that are provided by NHS employees, using NHS facilities;

• Third party (i.e. non NHS trusts) providing specific 'on site' services to NHS trusts such as Urgent Treatment or Care Centres (often physically located within NHS Accident and Emergency Departments) as well as 'off site' services such as scan and other investigation reporting.

• NHS trust funded treatment performed in its entirety by a third party(s), using third party contractors/employees and generally third party facilities (albeit there can be NHS surgical lists where the NHS trust pays the surgeon a fee per procedure). Typically this is a result of efforts to reduce NHS wait lists by using private healthcare providers. This could also be following a patient requesting an elective referral under Regulation 39 of the NHS Commissioning Board and Clinical Commissioning Groups (Responsibilities and Standing Rules) Regulations 2012 and being referred to a 'health service provider' with whom any NHS Integrated Care Board has a commissioning contact. To note some of the third parties who provide NHS funded treatment on this basis are charities. Generally, but not always, the relevant contract will provide for an indemnity on the part of the NHS trust.

• A blend of treatment received – for example, a NHS secondary care review (at which treatment options are discussed for the purpose of informed consent) followed by subsequent treatment funded by the patient (or their employer or medical insurance company) performed in its entirety by a third party(s), using third party contractors/employees and third party facilities. Alternatively, a third party review funded by the patient followed by treatment delivered entirely by NHS employees using NHS facilities.

When a client is seeking to bring a possible claim and where some part of their treatment having been provided at least to some extent on a private basis, the first priority is seek to establish as far as possible at the pre-action stage the precise factual context. That includes in particular:

• Who paid for the treatment.

• Does the client have any relevant invoices or receipts.

• Which individual clinician or organisation provided which treatment.

• Did the client have any input or choice in how or where or when the treatment was provided, and who by.

• Was the client at the time aware of whether the particular treatment was being provided by a clinician or organisation that at the material time was not acting or purporting to act as a NHS clinician or healthcare provider.

As early as possible at the pre-action stage, and ideally even before sending a Letter of Claim, the next priority is to try to seek confirmation from the potential Defendants as to whether they accept legal responsibility for the treatment(s) in question (on either a direct, non delegable duty of care basis or due to vicarious liability), and if not, who do they consider to be the person or entity with legal responsibility. The two priorities are (1) to ensure that there is a Defendant who is capable of satisfying any award of damages and (2) avoid issuing and then having to discontinue against a Defendant. This can be

frustrating and result in a somewhat depressing (though unsurprising) 'buck passing' exercise. I have had in the past a claim with 5 potential Defendants – the NHS trust under whose aegis the relevant pre-operative review took place, the integrated care board who contracted for surgery to be performed on a private basis, the charitable organisation who provided the facilities and support staff, a local 'MSK partnership' of very unclear legal status and practical involvement, and the surgeon himself. By a process of elimination the claim ended up proceeding solely against the surgeon as being the only potential Defendant who admitted they were potentially liable.

The exercise of identifying the correct Defendant(s) is often complicated by a lack of all the information as to the practical and commercial realities 'behind the scenes' on which to reach a full assessment as to the potential likelihood of establishing direct and/or vicarious liability. A pre-action disclosure application seeking to confirm a potential Defendant's insurance or indemnity position is unlikely to be successful. A back stop practical alternative can be to issue, staying against a particular Defendant(s) while proceeding solely against the relevant clinician as the one Defendant who definitely is potentially liable, and then seeking an agreement from any Defendants who subsequently are not required to discontinue with no order as to costs.

With regards to the relevant legal principles, each case is of course highly fact specific, however, it should be noted that:

• An clinician providing treatment will have a personal duty in tort to provide appropriate care (applying *Bolam/ Bolitho*). If there is a contract between the patient and the clinician (rather than between the patient and the private healthcare organisation – which in practice is often unclear), the clinician will also have a concomitant duty in contract to provide appropriate care.

• In an informed consent case, there are two potential points at which the cause of crystallises – one is the pre-operative review or discussion at which the relative risks and benefits of the proposed treatment and any reasonable alternatives are discussed, and the other is when the treatment itself is provider. If one of those occasions is on a private basis and the other NHS, then there is likely to be a case as against both the clinician (and/or any private treatment organisation) and against the NHS trust.

• With regards to any direct non delegable duty of care on the part of an organisation (whether a NHS trust or a private healthcare organisation), English law does not as a general rule impose liability on a defendant for injury or damage to the person or property of a claimant caused by the conduct of a third party. In *Michael v Chief Constable of South Wales* [2015] UKSC Lord Toulson held at [97] that: *"…there were two well recognised exceptions, one of which was "where D assumes a positive responsibility to safeguard C" This referred to the "relationships in which a duty to take positive action typically arises,"* which included "*health professional and patient*."

• There have been numerous judicial dicta over the years to the effect that a 'hospital' assumes a direct positive duty of care to 'patients' as a vulnerable class of persons to provide them with reasonable care and treatment and thereby protect their health regardless of the employment status of the person who treats them – e.g. *Gorringe v Calderdale Metropolitan Borough Council* [2004] 1 WLR 1057 at [38], *A(A Child) v MOD* [2005] QB 183 at [32,34, and 40], *Farraj v King's Healthcare NHS Trust* [2010] 1 WLR 2139 at [68-70, 81, 84, 88, 92, 103], *Woodland v Swimming Teachers Association* [2014] AC 537 at [7, 14-15, 19, 23], *Armes v Nottinghamshire County Council* [2017] UKSC 60 at [32], and *CN v Poole BC* [2019] UKSC 25 at [82].

• Nevertheless, there is a critical distinction between a non delegable duty of care to provide a patient with appropriate treatment or only to arrange, supervise and pay for it.

• In *Farraj*, it was reiterated by Lord Justice Dyson at [68-70] that the general rule was that an employer is not in general liable for the negligence committed by an independent contractor, and at [92] held that there was a significant difference between treating a patient who admitted to hospital for that purpose and carrying out 'off site' tests on samples provided by a person who was not a 'patient' – in the latter case there was no duty of care on the part of the Hospital. In *Hopkins v Akramy* [2020] EWHC 3445 (QB), Clarke J. considered a preliminary issue in a claim arising out of alleged failings in treatment at a clinic run by a third party provider of out of hours primary medical services to NHS patients. Having reviewed the relevant caselaw, and considered whether the applicable statutory duty under which the 'primary medical services' in question were provided by the Primary Care Trust, he held at [65-75] that the PCT had only a duty to provide or secure the provision primary, which could satisfied by exercise reasonable care in selecting the independent contractor.

• In *Hughes v Rattan* [2022] 1 WLR 1680, the Court of Appeal considered a claim brought in respect of care given by three 'self employed associate dentists'. The court referred to the General Dental Services Contract

in place with the PCT, and held there was a direct non delegable duty towards any 'patient' of the practice.

Accordingly, in addition to the case specific factual context, the relevant statutory framework is key when determining whether any 'outsourced' treatment funded by the NHS nevertheless still entails a direct non delegable duty of care:

• 'Primary medical services' are likely to be solely care provided by a GP as opposed to secondary care, albeit there is no definition within the NHS Act 2006, however, see e.g. in *GMC v Udoye* [2021] EWHC 1511 (Admin) at [20] 'provision of primary medical services' was said to be "*essentially work as a GP*." Similarly, in *Latimer-Saunders v St James Hospital Trust* [2009] EWHC 1479 (Admin) at [8] primary medical services for the purposes of s.83 of the 2006 Act were said to be "*those traditionally provided by family and community doctors.*" If the care therefore was that provided on any secondary or tertiary basis, *Hopkins* is likely to be distinguishable.

• Further, *Hopkins* is arguably incorrectly decided. The judgment in *Hopkins* misapplies the caselaw and principles concerning when a common law duty may be grounded in the exercise of a statutory duty to the issue of whether what is on the strength of the dicta cited an extant common law duty is excluded by the possibility of the statutory duty being delegated. The existence of a common law duty here does not appear to fall under the prohibition outlined in *CN v Poole BC* [2019] UKSC 25 at [65] of being inconsistent with the relevant legislation. There would not for example be potential conflicts of interest as between the interests of the child and the parent as was a potential issue in the statutory context of *Poole*.

• The more a private healthcare organisation looks like a hospital the higher the chance that the judicial dicta concerning patients and hospitals is likely to bite and there be a non delegable duty of care in addition to vicarious liability (which post *Barclays Bank* may well be more problematic to establish). It is also worth as a Claimant noting the statutory context and arguing that any common law duty should be at least as extensive as the relevant statutory duty. Section 9 of the Health and Social Care Act 2008 defines health care as including all forms of health care provided for individuals. Under a Section 10 of the same Act, a 'private hospital' is required to register as a service provider before providing regulated activities involving or connected with the provision of health care, the supply of staff who were to provide such care and the provision of advice in respect of such care. Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 imposes statutory duties to ensure that the care and treatment is provided in a safe way to the Claimant. Pursuant to Regulation 2 of the 2014 Regulations employment includes "*the grant of practising privileges by a service provider to a medical practitioner giving permission to practice as a medical practitioner in a hospital managed by the service provider.*" Pursuant to Regulations 9 and 11, and as a registered person carrying out a regulated activity, a private healthcare provider is required to provide care and treatment to our client that was appropriate, met his needs and reflected his preference. Further, the provider is required to ensure that a patient gives informed consent.

Mental capacity and clinical negligence

EXCHANGE CHAMBERS

MATTHEW STOCKWELL
EXCHANGE CHAMBERS

Recent developments, practical issues and traps for the unwary

With the blessing (or occasional curse) of a slightly unusual practice, litigating a mix of neurologically orientated trauma and clinical negligence claims whilst maintaining a complimentary practice in the Court of Protection, I have encountered lots of odd, interesting and unexpected mental capacity issues. Professional experience and reported cases suggest that identifying and successfully managing such issues can present particular challenges for the clinical negligence practitioner. This article is intended to signpost some of those issues, and provide an aid memoir and practical guide for when you next encounter one.

Initial Considerations

Some clinical negligence practitioners may have limited experience acting for a client with a brain injury or other cause of cognitive impairment. Initially, it is important to consider the following:

• Identify the client, accepting that the initial introduction may be made by a relative or carer (who may or may not be acting in a representative capacity).

• Take instructions from and advise the client directly, confirming the involvement of any intermediary.

• Ensure that the client can give instructions freely and is not under the influence of another person (whilst this is more commonly an issue in private client work, clinical negligence practitioners must also be alive to the potential for undue influence or financial abuse).

• Identify any potential conflicts of interest at an early stage (again, whilst this is more commonly an issue in private client work, it is good practice here).

• Include within any initial checklist, consideration of whether the client has capacity to conduct the claim as initially envisaged, keeping the issue under timely review.

You will find the full Mental Capacity Act (MCA) Code of Practice (a comprehensive guide to the MCA and its intended application) and other helpful resources here:

www.gov.uk/government/collections/mental-capacity-act-making-decisions

Particular care must be taken in relation to communication:

• Every effort must be made to overcome any difficulties of communication (as required by section 1(3) of the MCA).

• Adopt appropriate interview strategies (this may include particular care about timing, explanation of legal concepts or documents, review of topics etc – above all be patient).

• Be careful not to assume understanding.

• Make detailed attendance notes.

• If there is any doubt regarding the issue of capacity, follow the 'golden rule' and seek confirmation from an appropriately qualified medical practitioner.

Recognition and Overlap

So, how do we identify mental capacity as a potential issue? What are the clues to prompt you to investigate further?

The most important thing to emphasise is the need to start with the raw material and consider ALL the available evidence. The landscape for clinical negligence litigation has changed fundamentally over the last two decades and the scope of documentary disclosure, in particular, has expanded beyond recognition (prompted by migration of practices from the large loss insurance sector and the greater prominence of dishonesty allegations). On a case-by-case basis, ALL the available evidence may include (and this is not an exhaustive list):

• Medico-legal reports.

• Clinical records.

• Care and case management records.

• Education, other health and social welfare records.

• Occupational, HMRC, DWP or other public records – any interaction.

• Reports or witness statements from the appointed case manager and support workers.

• Reports and notes from treating therapists.

• Witness evidence from family members (and friends and colleagues as appropriate).

• The client's social and domestic interactions and digital footprint.

The documentation or other evidence must be obtained, collated, shared (i.e. with counsel and experts, so everyone has the same, complete picture) and tested or cross-referenced for consistency. It can be an enormous exercise, must be done carefully in each case, and is something that is commonly underestimated (by practitioners and Judges alike) for the purposes of budgeting.

Once you have the benefit of all the available evidence, what might you be looking for within it? My favoured approach is to be alert to possible brain injury (or other impairment or disturbance of normal functioning) adopting a high index of suspicion. Brain injury can manifest itself in an infinite variety of ways, with the following effects commonly reported:

Physical effects

• Movement and coordination.

• Balance and dizziness.

• Dyspraxia.

• Loss of sensation / sensory impairment.

• Altered sense of smell and taste.

• Fatigue and tiredness.

• Headaches and other pain.

• Speaking and swallowing disorders.

• Epilepsy.

• Bladder and bowel incontinence.

Cognitive effects

• Memory.

• Attention.

• Concentration.

• Speed of processing.

• Executive function (planning, organising and problem-solving).

• Spatial and perceptual difficulties.

• Language difficulties.

Emotional and behaviour effects

• Agitation.

• Anger and irritability.

• Lack of insight and awareness.

• Impulsivity and disinhibition.

• Emotional blunting.

• Emotional lability.

• Self-centredness.

• Family abuse or dysfunction.

• Apathy and poor motivation.

• Depression.

• Anxiety.

• Inflexibility and rigidity.

• Sexual problems.

Mental capacity is a more obvious issue when a client presents with one or more cognitive difficulties, but an injured person exhibiting physical or behavioural changes may have an undiagnosed brain injury which in turn impacts on cognition, i.e. if an insult has been sufficient to result in impairment in one aspect of functioning it may well have caused damage to others.

Of course, some or all of the effects listed above may be attributable to other factors, but the important thing is to investigate a potential neurological cause if the client's presentation is not otherwise adequately explained.

Equally, some or all of these features may be characteristics of a client's pre-injured state or personality traits. So, it is important for clinical negligence practitioners to consider the before and after position by reference to information from e.g. family, friends and colleagues. Do they behave differently? Do they now cope less well with some tasks or in some circumstances? Is there a difference between the client's assessment of their functioning and that of others? This question, in particular, is relevant to 'insight' and a central part of the useful BINI (Brain Injury Needs Indicator) tool developed by Brainkind. **https://brainkind.org/for-professionals/brain-injury-needs-indicator-bini/** In my experience, in many cases where there has been a delay in identifying mental capacity as a potential

issue, some degree of overreliance on the self reported competency of the client is a factor. So tools like BINI are a useful safeguard.

Why is mental capacity a particular challenge for the clinical negligence practitioner? And how can you meet it?

Firstly, there is increasing recognition that brain injuries and other cognitive disturbances are under reported within the general population with many, if not perhaps most, going without formal investigation or diagnosis.

We start investigating cases on the basis that a client suspects inadequate care (or, at least, is looking for answers) so it is at least possible in each case that a hospital or treating doctor has missed e.g. an acquired brain injury, say because of focus on other physical injury or illness, even if delayed diagnosis and management of a neurological disorder is not the primary basis for the client's complaint.

This problem is so widespread that Headway have produced an invaluable resource for GPs, who might be the first clinician to whom a person with a brain injury presents. **www.headway.org.uk/about-brain-injury/professionals/gps/resources-for-gps/**

Of course, an acquired brain injury is not the only reason why a person's cognition or mental capacity may be impaired, and physical and/or psychiatric injury or illness (or the pharmaceutical management of these) may cause or contribute to the picture. It is no surprise problems are missed and some people fall through the cracks given the current pressures on both acute and primary care.

Secondly, on a linked basis, if a problem has not been formally investigated or diagnosed it will not feature in clinical records and it is unlikely to be fully understood or appreciated by the client, if at all. It is also unlikely, through lack of insight or other factors, that relevant information will be volunteered by the client. Given the modern practice of taking instructions by telephone, questionnaire or other forms of remote communication, face-to-face contact is more limited than it used to be. Equally, we typically place initial reliance on desktop reports when considering breach of duty and causation in clinical negligence cases, and years may pass before in-person assessments for the purposes of condition and prognosis.

Where circumstances and funding permit, there is no substitute for face-to-face attendance with clients at an early stage. My caseload is exclusively made up of high value claims, and I consider it invaluable to have the luxury of this facility with each client I help. It is much easier to spot potential problems in this way, it gives a much better understanding of the client's circumstances and, most importantly, improves their experience and participation.

If this facility does not exist, be mindful of the limitations of remote communication and employ strategies to guard against false assumptions. Some or all of the following may serve as useful 'red flags' in the course of client interactions, whether your contact is remote or face-to-face:

- Prior or supervening illness: traumatic or non-traumatic ABI (e.g. stroke and CP), LD, neurodivergence, mental illness, or progressive neurological conditions etc.
- Variable or delayed instructions.
- Constant need for reminder or reassurance.
- Perseveration or rigidity.
- Unwise actions, e.g. spending.
- Illogical, inconsistent or flawed decision-making.
- Behaviour or physical presentation (esp. changes).
- Refusal to follow advice.
- An inability to recognise or explain some or all of the above.

Mental capacity presents a trap for the unwary. Whilst it has been stated that *"...the courts should always... investigate..."* the issue of capacity at the earliest opportunity (see *Masterman-Lister v Brutton & Co* [2002] EWCA Civ 1889), in reality responsibility rests firmly with the client's adviser. Applications for the appointment of a litigation friend in good faith are unlikely to attract censure (see *Folks v. Faizey* [2006] EWCA Civ 38), but late recognition of capacity as a potential issue will not be as well received.

As mental capacity and the assumptions or evidence on which assessments have been based can change, make sure, on a timely basis, that the issue of litigation capacity is reviewed. This should certainly take place when any major decisions are made in the litigation process (for example, the commencement of proceedings or compromise of any issue), the nature of the litigation changes (remembering that litigation capacity is subject matter specific: see *Dunhill v. Burgin* [2014] UKSC 18) or at any time there is reason to believe that a previous assessment may be invalid (for example, if there has been a deterioration in the client's health or a significant change in his or her engagement or presentation).

Instruction of experts

There are two main considerations when instructing an expert on capacity. Firstly, it is necessary to identify an expert with the requisite experience and expertise. A firm's usual choice of psychologist or psychiatrist to assess an injured person may not be best placed to address the issues relevant when dealing with a complex mental capacity dispute. Consideration should be given to instructing an expert with specific experience of acquired brain injury or other relevant discipline.

Secondly, the expert must be familiar with the correct legal principles applicable to the assessment of capacity. It is imperative that experts are familiar with both the assessment of capacity in practice and the relevant statutory tests. Make sure that sufficient attention is paid to this issue when selecting experts and in preparation of the letter of instruction.

Absence of Litigation Capacity: some practicalities

It is not possible to give an exhaustive list of ways in which the absence of litigation capacity may impact on management or settlement of a case, but these are the common ones to be mindful of:

• Need for greater client explanation and information in support (with implications for budgeting resources, mindful of the PD1A changes regarding vulnerability).

• Need for the report of an IFA in appropriate cases [see *IB v CB* [2010] EWHC 3815 (QB)].

• Need for approval before judgment can be obtained on any partial admission and for the purpose of administering any interim payments.

• Need to consider anonymity and whether any application should be made prospectively on commencement of proceedings (i.e. is the case sufficiently sensitive that the issue cannot await consideration at the first CMC?).

• And, likewise, with Coles v Perfect type approvals [see *CTQ v King's College Hospital NHS Foundation Trust* [2023] EWHC 2975 (KB)].

• Need to consider the information given to (or withheld from) some clients regarding the settlement sum, e.g. *PSG Trust Corporation Limited v CK and Anor* [2024] EWCOP 14.

Part 21 changes: recent and forthcoming

The Civil Procedure Rules Committee are part way through an exercise to simplify the Rules and consolidate the relevant parts of any Practice Direction, to avoid the need for two documents. This exercise was completed in respect of Part 21 in April 2023, including the importation of PD21, para 2.2(c) to CPR 21.5(6):

"Where the grounds for believing that a protected party lacks capacity to conduct the litigation are based on expert opinion, a copy of such opinion must be served, either with the certificate of suitability or separately."

This advice was observed more in the breach as a Practice Direction, but is now mandatory (besides simplicity, this is one of the practical effects of including the text in the Rules, as Practice Directions have only ever been advisory).

There is also an important and very helpful change to PD16 11.1(3): *"where [the defendant disputes any part of C's served evidence and] the defendant has obtained their own medical report, attach it to the defence"*.

These procedural changes underline the need to consider litigation capacity early (and discretely, as with the Court of Protection eg. in completion of a COP3). It is also good practice to assess, agree or resolve issues early with Defendants, avoiding reliance for limitation purposes on section 28, LA 1980: see e.g. *Aderounmu v Colvin* [2021] EWHC 2293 (QB).

We may be getting more guidance and substantive rule changes soon. The Civil Justice Council issued a Consultation in December 2023 on behalf of the 'Procedure for Determining Mental Capacity in Civil Proceedings Working Group'. The Group is looking at identified shortcomings in the Rules in relation to the procedure for determining capacity to conduct proceedings and inconsistencies in practice between different civil disciplines. The Consultation closed on 17 March 2024, so watch this space. **www.judiciary.uk/related-offices-and-bodies/advisory-bodies/cjc/current-work/procedure-for-determining-mental-capacity-in-civil-proceedings/**

Pointers

• Never underestimate the significance of a finding on mental capacity (one way or the other) for the client and the litigation.

• There is no substitute for reading judicial determinations, e.g. *Dunhill, Aderounmu and Loughlin v Singh & Ors*

[2013] EWHC 1641 (QB), to help your understanding of the Court's likely approach to these questions.

• Be ever mindful that a loss of mental capacity:

- Can be the reason for or subject matter of the litigation (e.g. COP, ABI), but it may not.

- Can happen independently (a supervening event or progressive condition).

- Can occur prior to, during or after litigation.

- Is not entirely predictable or manageable, despite all care.

• Be suspicious.

• Investigate early and thoroughly.

• Obtain and scrutinise every potential document or piece of evidence.

• If in doubt, check (with colleagues, counsel and experts etc).

• Select experts carefully and scrutinise the evidence they provide.

• Do not expect to get things right all of the time, much less on your own; this can be a complex area, best approached as a team.

When does depriving the fundamentally dishonest claimant of damages cause substantial injustice?

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In *KWH v Associated British Ports Holdings Ltd* [2024] EWHC 806 (KB), Ritchie J helpfully set out eight factors for assessing whether depriving a fundamentally dishonest claimant of damages would lead to "*substantial injustice*" (SI). The judgment brings much needed clarity to the meaning of S.57(2) of the Criminal Justice and Courts Act 2015.

On the facts of *KWH*, Ritchie J found it would not be substantially unjust to deprive the Claimant of all of her damages. However, the eight factors he outlined will encourage judges to consider all the facts, factors and circumstances of each case when reaching a conclusion about SI. Specifically, this includes consideration of how a claimant is impacted by their genuine disabilities, the subsequent costs of denying damages to the NHS and the benefits system, and the extent to which each claimant can pay back any interim payments already received, among other factors.

In July 2018, the 27-year-old Claimant in *KWH* was injured in a fall from the Defendant's breakwater in Port Talbot. There had been press reports of bioluminescent plankton in the sea along nearby Aberavon Beach, and the Claimant, who had been drinking, visited its concrete pier with her family to see them. The safety railings that had run along one edge of the pier had been removed, and as she walked back in the dark away from the end of the pier, she tripped or stumbled and fell off the edge, down 4-5 metres to the rocks and sand below.

The Claimant suffered moderately severe brain damage, with skull fractures requiring craniotomy and cranioplasty; hearing loss; fractures to her pelvis and left ankle, and; depression and anxiety. She was able to return to work as an analyst for an insurance company four months later, but only part time.

At trial, it was found that the Claimant had made a very good physical and cognitive recovery. Liability was settled two thirds in her favour and judgment was entered by consent in March 2022. Interim payments were provided to fund private rehabilitation.

The Claimant then alleged that her condition had deteriorated, so much so that she stopped work in October 2022 and was medically retired in November 2023.

The Defendant applied for the claim to be dismissed on the basis of fundamental dishonesty. When assessing the application, Ritchie J summarised the three legal issues as:

1. whether the Claimant had been fundamentally dishonest within S.57 of the Criminal Justice and Courts Act 2015;

2. how the quantum of the claim should be assessed correctly on the evidence, and thirdly;

3. if the Claimant had been fundamentally dishonest, whether dismissing the claim under S.57 would cause SI to the Claimant.

After an 11-day quantum trial, Ritchie J found that the Claimant had been fundamentally dishonest and set out detailed reasoning for his finding. He assessed quantum as being £895,001 gross of liability.

When assessing whether SI was apparent, Ritchie J disagreed with Knowles J in *London Organising Committee of the Olympic and Para Olympic Games v Sinfield* [2018] EWHC 51, (LOCOG) and *Woodger v Hallas* [2022] EWHC 1561 (QB), where Knowles J had held that SI must mean more than the mere fact that the Claimant will lose his damages for those heads of claim that are not tainted with dishonesty.

Ritchie J found that "*The plain words of the Act tie the responsibility to assess any resulting SI to the dismissal of the claim. In my judgment it is the dismissal of the claim for damages that is the trigger for the analysis of whether a substantial injustice will occur if no damages are awarded. One cannot ignore the very thing which S.57(3) takes away when considering the injustice of the taking away. I accept, of course, that the aim of the section is*

to punish dishonesty by the dismissal of the claim. But this is tempered by Parliament's inclusion of S.57(2). This section gives the Judge discretion which, is to be exercised fairly and only if a threshold with two parts is reached. Part one is a finding of injustice to the Claimant. Part two is a finding that the injustice is a substantial finding of injustice to the Claimant. Part two is a finding that the injustice is substantial."

He set out a list of relevant factors to take into account when deciding whether a substantial injustice has occurred:

(1) The amount claimed when compared with the amount awarded.

(2) The scope and depth of that dishonesty found to have been deployed by the claimant.

(3) The effect of the dishonesty on the construction of the claim by the claimant and the destruction/defence of the claim by the defendant.

(4) The scope and level of the claimant's assessed genuine disability caused by the defendant. If the claimant is very seriously brain injured or spinally injured, then depriving the claimant of damages would transfer the cost of care to the NHS, social services and the taxpayer generally and that would be more unjust than if the claimant had, for instance, a mild or moderate whiplash injury. The insurer of the defendant (if there is one) has taken a premium for the cover provided. Why should the taxpayer carry the cost?

(5) The nature and culpability of the defendant's tort.

(6) The Court should consider what the Court would do in relation to costs if the claim is not dismissed.

(7) Has the defendant made interim payments, how large are these and will the claimant be able to afford to pay them back?

(8) Finally, what effect will dismissing the claim have on the claimant's life? Would she lose her house or have to live on benefits, being unable to work?

Although in this case Ritchie J found that depriving the Claimant of her damages would not be substantially unjust, the list of relevant factors he set out could assist in other cases where claimants face being deprived of their damages because of fundamental dishonesty.

Provisional Damages in Clinical Negligence Claims: Practical Steps to Consider

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Introduction

Provisional damages claims can arise in clinical negligence claims, as in any other claim for personal injury. Orders for provisional damages are an exception to the usual principle that compensation is awarded on a 'once and for all' basis.

The twin aims of such awards, which are two sides of the same coin, are (a) to avoid over-compensating a claimant for the small risk of a serious deterioration in their condition which might never arise and (b) to avoid under-compensating the unlucky claimant who does in fact develop a serious deterioration by permitting them to return to court to seek further damages.

A warning about the need to consider claims for provisional damages

The importance of giving proper consideration to whether it is appropriate to bring a claim for provisional damages cannot be overstated. If there is a prospect of bringing a claim for provisional damages, it is vital for this to be communicated to the claimant. It should come as no surprise that the failure to advise a claimant of the prospect of provisional damages has given rise to claims for professional negligence.

In the recent case of *Witcomb v J Keith Park Solicitors* [2023] EWCA Civ 326, the Court of Appeal held that the claimant was not out of time in his professional negligence action against his former solicitors in respect of their failure to advise him about the prospect of a claim for provisional damages.

The claimant in *Witcomb* had suffered serious injuries to his right leg and foot in a motorcycle accident. Post-settlement on a full and final basis, his condition deteriorated markedly and much more quickly than had been anticipated and he was advised that he needed a below knee amputation of the right leg. It was only when the claimant sought further advice about re-opening his claim and was disabused of the notion that a lump sum payment in full and final settlement had been the only option available to him, that he was deemed to have had the requisite knowledge for limitation to begin running.

Meanwhile, in *Dunhill v W Brook & Co (1) Crossley (2)* [2016] EWHC 165 (QB) a claim was brought against the first defendant firm of solicitors and the second defendant counsel by the pedestrian victim of a motorcycle collision who suffered a serious closed head injury. The court held on the facts of that case that the claimant had not been advised negligently, given that the defendant's lawyers in the personal injury claim would not have agreed to settle on any other than a full and final basis.

What is the test?

The Court may award provisional damages where such a claim has been pleaded, and where the Court is satisfied that the conditions of Section 32A of the Senior Courts Act 1981 or Section 51 of the County Courts Act 1984 have been met.

The wording of section 32A(1) of the Senior Courts Act and s.51(1) of the County Courts Act are in identical terms:

"*This section applies to an action for damages for personal injuries in which there is proved or admitted to be* ***a chance*** *that at some definite or indefinite time in the future the injured person will,* ***as a result of the act or omission which gave rise to the cause of action****, develop some* ***serious disease or suffer some serious deterioration*** *in his* ***physical or mental condition***" (emphasis added).

A couple of examples in reported clinical negligence cases include *Yale-Helms v Countess of Chester Hospital NHS Foundation Trust* [2015] 2 WLUK 482, in which Blake J allowed an appeal against a district judge's decision not to allow the claimant, who had been born with cerebral palsy due to the defendant's negligence, to amend her particulars of claim to include a claim for provisional damages for the risk of developing epilepsy; and *AB (by his litigation friend CD) v Royal Devon & Exeter NHS Foundation Trust* [2016] EWHC 1024 (QB), in which Irwin

J (as he then was) awarded provisional damages (which were not contested) to a claimant whose developing spinal abscess had been negligently missed by the defendant, for the small but lifelong risk of syringomyelia.

What should we look for when considering whether there is an arguable claim for provisional damages?

The leading case interpreting the statutory provisions giving the court the power to award provisional damages is *Curi v Colina* [1998] EWCA 1326, approving the three-stage test set out by Scott Baker J (as he then was) in *Willson v Ministry of Defence* [1991] ICR 595:

1) Is the chance of the Claimant developing some disease or suffering some other deterioration in physical or mental condition measurable rather than fanciful?

2) Can the disease or deterioration in physical or mental condition be described as serious?

3) If the answer to the questions above are answered in the affirmative, should the Court exercise its discretion to award provisional damages?

To qualify as a 'chance' there must be a '*measurable rather than fanciful*' risk of serious deterioration. Provided it is quantifiable, the percentage risk does not need to be high for the Court to exercise its discretion of award provisional damages.

For example, in the case of *Kotula v EDF Energy Networks & Others* [2011] EWHC 1546 (QB), Irwin J (as he then was), made an order for provisional damages when the risk of the Claimant developing really serious consequences from a syrinx was as low as 0.1%; likewise, in *Mitchell v Royal Liverpool and Broadgreen UH NHS Trust* (unreported, 17.07.06), Beatson J permitted an amendment to plead provisional damages in respect of a 0.15% risk of serious consequences of syringomyelia.

The question of seriousness is a question of fact depending on the circumstances of the case, including the effect of the deterioration on the claimant. In the authors' view, it should usually be obvious if this criterion is likely to be met but, given the subjective element to the test, it is sensible to canvas in conference the anticipated impact of a specific deterioration on the specific claimant's activities, capability, life expectancy or financial position.

The question of the exercise of the discretion turns on factors including whether there is a clear-cut identifiable threshold (i.e. opposed to a continuing deterioration), the degree of risk and the consequences of the risk, and a weighing up of the possibilities of doing justice by a once-and-for-all assessment against the possibility of doing better justice by reserving the claimant's right to return to court.

The absence of a clear-cut threshold can be fatal, as in *Mathieu v Hinds* [2022] EWHC 924 (QB), in which Hill J held that on the current state of scientific knowledge, a post-traumatic brain injury dementia is often not severable from the consequences of the initial TBI, and thus held it would not be appropriate to exercise the discretion to award provisional damages.

Each of these issues must be considered with your liability and condition and prognosis experts. Can the expert(s) put a figure on the risk of developing the disease or serious deterioration? What impact would the serious deterioration or disease have on the Claimant, should it materialise? Can the expert(s) identify a clear-cut event or series of events, or is the situation one where the Claimant's risk is the deterioration of an already progressing condition? Lastly, provisional damages orders are commonly time-limited: it is important to establish whether the chance of the deterioration will remain for the rest of the Claimant's life expectancy or reduce over time? Given the requirements in PD 16 of the CPR to state the claim for provisional damages within the Particulars of Claim, it is best to iron out the answers to these questions as early as possible.

A claim for provisional damages may succeed in part only

In the case of *Butler v Ministry of Justice* [2015] EWHC 3384 (QB), one of the issues was whether damages should be awarded on a provisional or final basis. The claimant had suffered a "*bizarre and unique*" injury to his right foot. He had subsequently developed chronic regional pain syndrome and amputation had been seriously considered. At the time of trial the claimant had decided against amputation but acknowledged he may need to revisit his decision.

The court declined to make an award for provisional damages in respect of the 25% risk of amputation, given that the claimant currently had a painful, non-weight bearing cold and/or hot discoloured foot and that amputation might provide a 70% improvement in overall symptoms and function. However, the court did exercise its discretion to make an award of provisional damages to cover the 7.5% risk post-amputation of the development of chronic regional pain syndrome or phantom limb pain or the failure of the stump to heal.

Mathieu v Hinds (cited above) is another example of a provisional damages claim succeeding in part only: the claim in respect of the risk of developing epilepsy succeeded in that case, even though the claim for post-TBI dementia did not.

What to do if the claim for provisional damages is settled before the commencement of proceedings

Paragraph 5.50 of the King's Bench Guide specifies that a claim for provisional damages that has been settled before the commencement of proceedings, and in which the sole purpose of the claim is to obtain a judgment by consent, must be issued under Part 8.

Paragraph 8.12 of the KB Guide says that the claimant must state in their claim form that the parties have reached agreement and request a consent judgment, as well as setting out the matters specified in paragraph 4.4 of the Practice Direction to Part 16 and attaching a draft order in accordance with paragraph 4.2 of PD 41A.

Once the claim for provisional damages has been approved, the case file will be electronically stored by the court for the relevant period in accordance with paragraph 3.3 of PD 41A; but beware, as paragraph 3.6 reminds legal representatives that it is their duty to preserve their own case file.

What happens to the claim for provisional damages if the claimant dies?

The question arose recently in *Power v Bernard Hastie & Co Ltd & ors* [2022] EWHC 1927 (QB) of whether the estate of a deceased claimant can take advantage of the claimant's right, under a provisional damages order, to ask the court to award further damages on the grounds that he developed a condition or disease that was specified in the order.

Johnson J disagreed with the defendant's contention that the right to pursue such an application did not survive the deceased's death and approved the decision of His Honour Judge Roberts in the County Court case of *Guilfoyle v North Middlesex University Hospitals NHS Trust* (Central London County Court, 4 April 2018).

The court held that a judgment given for provisional damages gave a claimant a continuing residual right to seek further damages, in accordance with the order and the rules of court, which itself amounted to a continuing course of action. This right, which had vested in the claimant, was transferred to the applicant, the deceased's nephew executor, by operation of section 1 of the Law Reform (Miscellaneous Provisions) Act 1934.

The court further noted that an application for further damages under the provisional damages order was not a claim for personal injuries within the meaning of section 11 of the Limitation Act 1980 and thus there was no limitation period, albeit there may be a specific period within which the application may be brought, as stipulated within the order itself.

Provisional damages and Part 36 offers

Part 36 of the Civil Procedure Rules contains express rules about offers which include a claim for provisional damages.

CPR 36.19 states that where an offeror is offering to agree to the making of an award for provisional damages, the Part 36 offer must also state (a) that the sum offered is in satisfaction of the claim for damages on the assumption that the injured person will not develop the disease or suffer the type of deterioration specified in the offer; (b) that the offer is subject to the condition that the claimant must make any claim for further damages within a limited period; and (c) what that period is.

Do not forget that the claimant must act promptly where such an offer is accepted by an offeree: within seven days of the date of acceptance of the offer the claimant must apply to the court for an award of provisional damages under CPR 41.2.

Conclusion

Provisional damages may be an exception to the usual principle that compensation is awarded on a 'once and for all' basis, but orders for provisional damages are by no means exceptional. It is vital to be acquainted with the relevant criteria and to identify at the earliest possible stage whether there is a viable claim for provisional damages, as well as keeping abreast of the many specific procedural requirements.

Covid vaccine injury compensation update, May 2024

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Vaccination is a crucial part of a developed country's public health programme, and never more so than during a global infectious disease pandemic. By April 2023, 146 million Covid vaccines had been administered[1] in England alone.

Most developed countries have a system of compensation for injury caused by adverse reaction to a vaccine.[2] The UK scheme was established by the Vaccine Damage Payment Act 1979 and is now administered by the NHS Business Services Authority. Covid vaccines were added to the scheme at the beginning of 2021, just before the NHS national Covid vaccine programme was rolled out.

The UK scheme (covering all the devolved nations of the UK) is a non-fault scheme. Applications can be submitted either through a web portal or on a paper application. Once an application is received the scheme collects in all the GP and hospital medical records and the application is assessed for entitlement by a GP. The scheme requires the medical assessor to be satisfied, on the balance of probability, that the applicant has a permanent physical and/or psychological disablement which is broadly equivalent to the level of disablement at the level of 60% on the industrial injuries scale. The disablement therefore must be significant, but perhaps not as significant as many think. So, a person deaf in one ear with mild depression as a result of a vaccine was deemed to have the requisite level of disablement, albeit after a fight.

So how is the scheme dealing with the fallout from the Covid vaccines?

The latest statistics[3] show that as at 2nd April 2024, an initial decision on entitlement had been notified on about 45% (4,996) of the 11,022 applications submitted so far. Of those 4,996 applications, 492 applicants were accepted to be disabled because of a Covid vaccine, but 324 were not considered "severely" disabled and therefore received no compensation. That left 168 which were accepted to be "severely" disabled by a Covid vaccination and each of those have received the fixed £120k compensation payment. A total of £20,160,000 has been paid to date.

Of the 168 severely vaccine injured, 60 were fatalities. I have acted in a number of these fatal cases and my experience has been that in several cases no inquest and sometimes not even a post-mortem was undertaken. Deaths from thrombosis and thrombocytopenia due to the Astra Zeneca Covid vaccine in the early part of 2021 were wrongly considered (by doctors and medical examiners) to be natural occurrences. It was only after these incidents were formally recognised by the Medicines Healthcare Regulatory Authority (the Regulator of UK Medicines) in April 2021 that doctors, medical examiners, and Coroners began to appreciate these were non-natural deaths necessitating an inquest. I am continuing to get inquests opened even now in 2024, as cases overlooked in the early stages continue to emerge. As inquests from deaths in 2021/22 continue to be opened even now, it is likely that there will be more than 60 cases where there are legitimate questions which arise as to whether a death was non-natural and vaccine-related, which would justify an inquest being opened.

According to the recent disclosure from the NHS Business Services Authority, the type of adverse reactions which so far have been accepted to have led to death or severe disablement from Covid vaccination are:

1 https://healthmedia.blog.gov.uk/2023/05/09/vaccine-damage-payment-scheme-media-fact-sheet/

2 *Looker & Kelly, 2011 – a review of international no-fault compensation following adverse events attributed to vaccination* https://pubmed.ncbi.nlm.nih.gov/21556305/

3 *Freedom of information disclosure released by the NHS Business Services Authority* www.whatdotheyknow.com/request/vdps_figures_3?nocache=incoming-2638971#incoming-2638971

- Anaphylaxis
- Bell's palsy
- Capillary leak syndrome
- Guillain-Barré syndrome
- Immune thrombocytopenia
- Myocardial Infarction
- Myocarditis
- Pericarditis
- Pulmonary Embolus
- Stroke/Cerebral Vascular accident
- Transverse myelitis
- Vaccine induced thrombosis with thrombocytopenia, (commonly with or sometimes without Cerebral Venous Sinus Thrombosis)
- Acute allergic reaction
- Bacterial pneumonia, immune response to vaccine, inflammation of lungs
- Vaccine-induced vasculitis
- Bilateral sequential optic neuropathy

Prior to the pandemic the scheme received about 100 applications a year so the influx of 11,000 applications since the Covid vaccines is a huge increase in the volume of work. The number of staff at the NHS Business Services Authority working on processing vaccine injury compensation claims has been increased from four to 80[4]. The numbers of applications are increasing every year and will continue to do so for some time as applications can be submitted up to six years after vaccination.

In the latest report, 78 claims had taken over two years to have an initial decision made on eligibility, 168 claims had taken at least 18 months for them to make an initial decision and 492 claims had been waiting over a year.

For cases which are rejected under the statutory scheme, there are procedures for requesting reconsideration and ultimately to appeal to the First Tier Tribunal (Social Entitlement Chamber). The Tribunal will make an independent adjudication on the issues of causation or severity which lie at the heart of questions of eligibility for the statutory payment.

Legal aid is not generally available in the First Tier Tribunal. Exceptional funding possibly might be granted but the statutory charge will of course apply.

A contingency funding arrangement is lawful for such Tribunal proceedings, and the £120k award may be a sufficient prize to make this workable, with or without a success fee.

On 4th May 2024, the Secretary of State for Health and Social Care, Victoria Atkins MP was widely reported in the press to have asked officials in her department to draw up options for reforming the UK vaccine injury compensation scheme. The fixed award of £120k has not been increased since 2007 and would be almost £200k now if it had been indexed to inflation. Perhaps that will be reviewed. It is doubtful however that the current government has enough time available to it to formulate and implement a significant legislative reform to the Scheme before the general election. It is also doubtful that the expected incoming Labour government will consider vaccine injury compensation scheme reform to be a priority, and it is sadly likely that the existing scheme will limp on unsatisfactorily for the foreseeable future. I hope AVMA and other patient stakeholders get involved in this review and lobby for substantive reform. It is important for everyone being vaccinated, that, in the very unlikely event of an adverse event, there is appropriate support via compensation in a fair, speedy and effective legal process. Such a scheme is essential to retain public confidence in mass vaccination and therefore reduce the burden on individuals and society as a whole of preventable disease.

Tort liability as an alternative

The law permits Claimants to pursue claims under the UK statutory vaccine injury compensation scheme concurrently with separate tort claims against manufacturers and medical practitioners. As damages from civil claims are compensatory, a Claimant must give credit for any statutory vaccine compensation payment received against any tort damages claim.

In late 2020 and early 2021 the MHRA, gave temporary emergency authorisation to the supply of Covid vaccines under Regulation 174 of the Human Medicines Regulations 2012. This enabled the MHRA to provide an authorisation to supply the vaccines during a pandemic where a medicine would not normally be authorised e.g. due to lack of safety data. Under Regulation 345 of the Human Medicines Regulations 2012, complete statutory immunity from any civil liability was conferred in respect of any loss or damage resulting from the use of these

4 https://healthmedia.blog.gov.uk/2023/05/09/vaccine-damage-payment-scheme-media-fact-sheet/

vaccines against any manufacturer of the product or any of their agents, employees or officers, or any healthcare professional. This meant that claims against medical practitioners for errors in administration of vaccines or for lack of informed consent were barred by statute, until the vaccines were given a marketing authorisation. A significant proportion of the Covid vaccinations were carried out during the period of temporary emergency authorisation where the statutory immunity applied as the first substantive approvals did not come along until late June/early July 2021.

The immunity conferred by statute did not extend to preventing a claim against the manufacturer under the Consumer Protection Act 1987, on the basis the vaccine contained a defect. Because of this, the supply contracts between the government and the manufacturers all contained complete indemnities for manufacturers so that the risk of any liability under the Consumer Protection Act 1987 would lie with the UK government.

The limitation period is now expiring in 2024 for those who were vaccinated 3 years ago unless court proceedings are commenced (except for minors and those having lost mental capacity). So far only a group of 51 Claimants who suffered vaccine-induced thrombosis (clots) and thrombocytopenia (low platelets) have commenced court proceedings under the Consumer Protection Act 1987 against Astra Zeneca. Astra Zeneca have admitted that in certain circumstances the vaccine can cause thrombosis with thrombocytopenia. These clots have allegedly resulted in strokes, heart attacks, limb amputations and other such injuries both serious and sadly sometimes fatal.

The Astra Zeneca Covid vaccine was retired worldwide in 2022/23 and recently Astra Zeneca applied to formally revoke the marketing authorisation for the vaccine in multiple jurisdictions. But reports in the press have confirmed that liability remains vigorously disputed on the basis that the vaccine is not a defective product but has saved millions of lives worldwide and all medicines involve risks. The Pfizer and Moderna mRNA vaccines also remain in limited use, despite being associated with multiple cases of myocarditis and pericarditis and some rarer adverse reactions too.

No claim under the Consumer Protection Act 1987 against the manufacturer of a vaccine has ever succeeded in this jurisdiction through litigation. Such claims are notoriously complex, expensive and difficult, so it will be fascinating to follow this litigation.

UK lawyers remain cautious about engaging in these claims, which are therefore exceptionally rare. So apart from the pending Astra Zeneca clot claims, indemnities given by the UK government seemingly will not be called upon.

Reform of the statutory compensation scheme, so that full tort damages and costs could be recovered within the scheme would mean that seriously disabled people would no longer need to take on the wholly unfair fight in court against a multinational pharmaceutical company, the modern-day equivalent of throwing Christians to the lions.

Conference news

Forthcoming conferences and events from AvMA

For full programme and registration details, go to www.avma.org.uk/events or email conferences@avma.org.uk

Representing Families at Inquests: A Practical Guide

2-3 October 2024, Exchange Chambers, Manchester

This conference presents a comprehensive guide to the practice and procedures when representing a family at an inquest. You will hear from an excellent programme of speakers, all experienced in their involvement in inquests, who will provide you with case examples to help you to put the theory into practice. You will also learn more about AvMA's important role in representing families. Booking will open in Summer 2024.

Court of Protection Conference

23 October 2024, Hilton Leeds City Hotel

AvMA's Court of Protection conference returns to examine the current state of litigation and the challenges and responsibilities facing those who work in this important area. Booking will open in Summer 2024. Sponsorship and exhibition opportunities now available.

AvMA Specialist Clinical Negligence Meeting

Afternoon of 29 November 2024, Grand Connaught Rooms, London

The annual meeting for AvMA Specialist Clinical Negligence Panel members provides the opportunity to meet, network and discuss the latest key developments and issues facing clinical negligence law. Registration and a networking lunch will commence at 12.30, with the meeting starting at 13.30 and closing at 17.00.

AvMA Holly Jolly Christmas!

Evening of 29 November 2024, Grand Connaught Rooms, London

After the success of the first AvMA Holly Jolly Christmas, the event returns on the evening of 29 November! The evening will commence with a drinks reception followed by a fantastic three-course meal with wine, live music and dancing. It will be the perfect event to entertain clients, network with your peers and reward staff. Booking is now open! Table and sponsorship package also available.

Clinical Negligence: Law Practice & Procedure

10-11 December 2024, Shoosmiths LLP, Birmingham

This is the course for those who are new to the specialist field of clinical negligence. The event is particularly suitable for trainee and newly qualified solicitors, paralegals, legal executives and medico-legal advisors, and will provide the fundamental knowledge necessary to develop a career in clinical negligence. Expert speakers with a wealth of experience will cover all stages of the investigative and litigation process relating to clinical negligence claims from the claimants' perspective.

Cerebral Palsy & Brain Injury Cases – Ensuring you do the best for your client

5 February 2025, America Square Conference Centre, London

This popular AvMA conference is returning to London on 5 February 2024, to discuss and analyse the key areas currently under the spotlight in Cerebral Palsy and Brain Injury Cases so that lawyers are aware of the challenges required to best represent their clients. Sponsorship and exhibition opportunities now available.

35th Annual Clinical Negligence Conference (ACNC)

20-21 March 2025 (Welcome Event 19 March), Bournemouth International Centre

The event for clinical negligence specialists returns to Bournemouth in 2025. The very best medical and legal experts will ensure that you stay up to date with all the key issues, developments and policies in clinical negligence and medical law, whilst enjoying great networking opportunities with your peers. Early bird booking will open in October, with the programme available in December. Sponsorship and exhibition opportunities now available.

AvMA Medico-Legal Webinars

For more information, please contact Kate Eastmond, AvMA Events & Webinar Co-ordinator call 02030961126 or email kate@avma.org.uk

Working on a client file and looking for more information to assist you with your case?

At AvMA, our medico-legal webinars give you immediate access to leading specialists speaking on subjects ranging from interpreting blood test results to medico-legal issues in surgery and many more besides!

When and where you need

The webinars can be watched at a time convenient to you, all without having to leave your office. You can watch the video as many times as you want, and you can download the slides and any extras materials to aid your learning.

Our licensing prices

You can purchase **three different webinar licences** to fit your needs:

Single viewer licence - £49 + VAT

A personal licence allows one viewer access to a webinar title for 60 days. Click on the single viewer button to browse the webinar library to choose your title. You can purchase as many webinar titles as you want.

Multiple viewer licence - £150 + VAT

A group licence allows multiple viewers from the same firm to have access to a webinar for 60 days. Click on the multiple viewer button below and browse the webinar library to choose your title. Once you complete your purchase, you will be able to invite your colleagues to register and watch the content at a time convenient to them.

Webinar subscription - £960 + VAT - 20% Discount Available until Wednesday 31 July 2024 only for Lawyer Service Members

A firm licence allows multiple viewers from the same firm to have access to the entire webinar library for 12 months. Click on the multiple viewer button and select firm subscription.

Purchase only: **www.avma.org.uk/learning**

Our latest webinar titles include:

- Fixed Recoverable Costs & Other Essential Costs Issues
- Early Delays in Cancer Diagnosis
- Medico-Legal Issues in the Management of Retinal Conditions
- Dento-Legal Issues of Dental Implants
- Medico-Legal Issues in Invisalign Treatment
- Clinical Negligence: Law, Practice & Procedure Conference 2023
- Medico-Legal Issues in Diabetes Conference 2023
- Representing Families at Inquest Conference 2023
- Acute Abdominal Pain in the Accident and Emergency Department
- Bariatric Surgery

And more....

Download our 2024 – 2022 Webinar List

AvMA Live Webinars in 2024

Wounds – Prevention, Management & Healing Strategies with Jane Collins, Apex Health Associates

Wednesday 11 September 2024

Over the course of an hour Jane will cover:

- When is an ulcer not a pressure ulcer
- Explanation of the ASSKIN bundle
- Avoidable vs non avoidable pressure ulcers
- Wound healing strategies.

BOOK NOW

Complex Regional Pain Syndrome with Dr Rajesh Munglanli

Friday 25 October 2024

Over the course of an hour Dr Rajesh will cover:

- Causes
- Diagnosis
- Treatment options
- Pitfalls that result in medicolegal claims

Details and booking information will open in the early summer, for now please save the date.

Aortic Dissection with Graham Cooper MD, FRCS (CTh), The Aortic Dissection Charitable Trust

Friday 1 November 2024

Over the course of an hour Graham will cover:

- A relatives experience
- Details about aortic dissection
- An update on some national initiatives

Details and booking information will open in the early summer, for now please save the date.

avma
action against medical accidents

The charity for patient safety and justice

Join a fundraising event

AvMA / PIC Manchester Curry Night

Tuesday, 9 July

Scene Indian Street Kitchen, 12 Left Bank, Manchester, M3 3AN

Please email emma.woolley@pic.legal for tickets.

AvMA / PIC Leicester Curry Night

Tuesday,10 September

Chutney Ivy, 41 Halford Street, Leicester, LE1 1TR

Please email emma.woolley@pic.legal for tickets.

AvMA / Leigh Day Treasure Hunt, Manchester

Wednesday, 11 September

Rain Bar, 80 Great Bridgewater Street, Manchester, M1 5JG

Book now: www.avma.org.uk/treasurehunt

AvMA / Fletchers Curry Night, Leeds

Tuesday, 15 October

Register your interest: paulas@avma.org.uk

AvMA / PIC Birminhgam Curry Night

Tuesday 10 December

Please email emma.woolley@pic.legal for tickets.

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action against medical accidents

The charity for patient safety and justice

Would you like an opportunity to empower people affected by avoidable medical harm to get the outcome they need?

Your support will help us:

- Expand our reach to serve more communities.
- Empower individuals with compassionate support.
- Eliminate compounded harm following avoidable medical harm
- Build sustainable resources to continue our mission.

Every contribution counts. Join us in reducing the emotional and financial costs of medical harm.

Together, we can ensure that the healthcare system works safely and fairly for everyone, and people who suffer avoidable medical harm get the support and the outcomes they need. Let's make every voice count.

If you or your organisation would like to discuss how you can support our work, we'd love to hear from you; please email Paula Santos, our Communications and Fundraising Officer, paulas@avma.org.uk

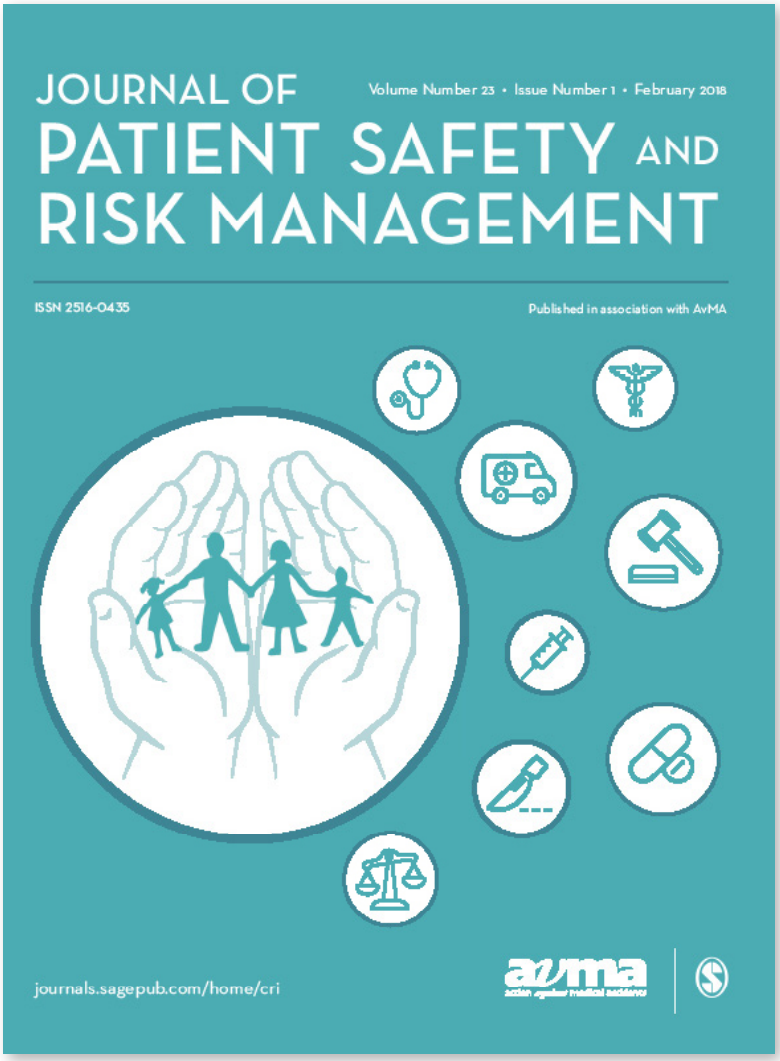
Journal of Patient Safety and Risk Management

The Journal of Patient Safety and Risk Management, published in association with AvMA, is an international journal considering patient safety and risk at all levels of the healthcare system, starting with the patient and including practitioners, managers, organisations and policy makers. It publishes peer-reviewed research papers on topics including innovative ideas and interventions, strategies and policies for improving safety in healthcare, commentaries on patient safety issues and articles on current medico-legal issues and recently settled clinical negligence cases from around the world.

AvMA members can benefit from discount of over 50% when subscribing to the Journal, with an institutional print and online subscription at £227.10 (+ VAT), and a combined individual print and online subscription at £177.22 (+ VAT).

If you would like more information about the journal, or are interested in subscribing, please contact Sophie North, Publishing Editor on

sophie.north@sagepub.co.uk



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2023/24 LAWYERS' SERVICE DIRECTORY

Directory of companies offering services or products to lawyers specialising in clinical negligence

blume

Customer acquisition specialists for the Clinical Negligence sector

Proud supporters of avma action against medical accidents

Blume delivers high quality and relevant clinical negligence cases. Each case is carefully nurtured from first conversation to final conversion by our Customer Care Hub.

Our team is expertly trained in handling complex, sensitive situations to ensure every new customer is pre-qualified and nurtured throughout their journey with Blume.

Blume is committed to delivering a positive experience to customers, regardless of how stressful or trying the legal circumstances may be.

Customer Generation | Data Capture | Lead Generation | Speedy Transfer | Customer Insights

Smart businesses don't just grow.
They Blume.

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partners in costs
Your Costs Experts

Established in 1996, PIC are a nationwide leading firm of Costs Lawyers. We provide dedicated and bespoke solutions, specialising in Clinical Negligence, Catastrophic Injury and Personal Injury.

Our clients are at the centre of everything we do, we listen to our clients' requirements and understand the importance of tailoring our approach to suit.

Our highly skilled Legal Costs Specialists are committed to establishing and maintaining outstanding relationships with our clients and we are proud to be described as "truly experts in our field" and "brilliant".

We provide regular knowledge updates, weekly e-newsletter, free issues of our Partners In Costs magazine, podcasts and tailor-made costs training.

Contact Us

03458 72 76 78
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PIC Legal Costs Specialists

Legal Costs Professionals

What we do

Our team work closely with you to get a real and accurate understanding of your needs and requirements. It is this collaborative and proactive approach that ensures we achieve the best outcome. Our extensive knowledge of costs law enables us to provide tailored advice and litigation.

Our appreciation of the significance and impact that turnaround time has to releasing cash flow, allows us to assist you drive down "lockup".

Introduce new innovative ways of recovering costs such as our Total Timeline + and providing fixed costs advice.

Our focus is to;

1. Help to deliver your financial objectives.
2. Work in collaboration in a fast-changing market.
3. Employ experienced costs experts to maximise recovery of fees.
4. Stand shoulder to shoulder with you, as we understand the pressures you face.
5. Provide clear risk assessments and advice.
6. Keep you fully informed throughout.
7. Proactively drive the recovery process to reduce case lifecycles.
8. Treat your money as we would our own.

We are your Partners in Costs.