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Editorial

Lisa O'Dwyer
Director, Medico-Legal Services

Dear Reader,

Welcome to our November 2024 edition of the newsletter. I would like to start by taking this opportunity to remind any of our Lawyer Service and AvMA panel members of notices sent out in August advising that the Clinical Negligence Protocol has now come to an end. The protocol has been replaced by the Clinical Negligence Claims Agreement (CNCA) which became effective on 27.08.2024. We urge you to read the CNCA which sets out the transitional provisions for how the suspension of the limitation period allowed under the protocol is to come to a managed end. For more information please see **here**.

For some years AvMA has been working with the Harmed Patients Alliance to raise awareness of the additional harm caused to patients who have to fight to get to the truth. Patients are too often batted away at the complaint stage with assurances that there was nothing wrong with the care provided, only to discover after turning to litigation that their initial instincts were right all along. That defensive approach causes the patient additional harm, often referred to as compounded harm, it is avoidable, unnecessary and wrong to put a patient or their family through that just to test their mettle. The Harmed Patient Pathway offers trusts and other healthcare providers a way to at least minimise and hopefully eliminate this harm. AvMA has been consulting on this, the consultation closes on 2nd December so please use the link to give your feedback on the **Harmed Patient Pathway**.

In September AvMA and the Medical Defence Union (MDU) published articles for the Journal Personal Injury Law (JPIL) sharing our respective views on four key areas (i) the state of NHS Resolution's payouts for clinical negligence claims (ii) Why a no fault compensation system would be detrimental to patient welfare (iii) Repeal S2(4) Law Reform (Personal Injury) Act 1948 (iv) commentary on the effect of FRC in low value clinical negligence claims. Unfortunately, I am unable to share the articles with you as they sit behind a paywall, but if you subscribe to JPIL then **please do read them**, you may be surprised to read that despite the MDU's previous stance on no fault compensation it appears they no longer see this as an answer to current system.

This edition of the Newsletter has a wide variety of articles to consider. ***"Medical Assistance Required – Recent caselaw on expert medical evidence"*** is a really helpful review of mainly caselaw from 2024 highlighting the courts determination to strictly apply the expert's duty to the court. As its author, **Jonathan Godfrey**, barrister at Dere Street Barristers points out *"any clinical negligence case is only as good as the expert medical evidence supporting it"* and as such this article is highly recommended reading.

Beatrice Baskett and **Louise Asprey** both barristers at St John's Chambers have written ***"A review on causation in the coroner's courts"*** with reference to the inquest touching the death of Mr Dymond, a vulnerable man who died following his experience of participating in the Jeremy Kyle show.

We are very pleased to feature two articles from Tees Law, both highlighting issues relating to costs. In ***"The pitfalls of claims against private practitioners & professional indemnity insurance"*** by **Alison Hills**, Senior Associate at the firm a compelling case is made for changes to CPR to ensure mutual exchange of notices of funding at the point of the Letter of Response. It also reminds us of the difficulties with litigating against private practitioners whose insurance policies may have finite levels of indemnity insurance to cover both any award of damages and costs.

The second article from Tees concerns ***"Overturning the presumption of Part 36 costs consequences for late acceptance by protected parties"***. The article is by **Georgina Wade** and **Sarah Lambert KC** and considers their own experience of how and when the court will use its overriding power to disapply the cost consequences of a Part 36 offer which is accepted out of time.

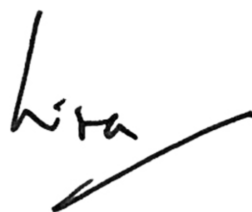
Over the years AvMA has responded to all relevant consultations and reviews on the coroner's service. We have consistently called for better dissemination of the learning points from healthcare inquests, Prevention of Future Death (PFD) reports and Action Plans put before the coroner. The wheels have ground slowly but in May 2021, the **Justice Committee report** on the Coroner's Service made a number of very important recommendations, one of which was the Ministry of Justice should consider setting up an independent office to follow up on actions promised to coroners and to report publicly where insufficient action has been taken. AvMA brought together a **coalition of charities** to campaign for the government to accept these recommendations. This coalition advocated that the creation of a properly funded office with statutory powers to police, monitor and enforce changes identified by Prevention Future Death reports would protect the public, promote learning from inquests and provide the bereaved with reassurance that the risk of the same events happening again have been reduced or eliminated.

Despite the government **rejecting** the committee's recommendation, INQUEST supported by AvMA and many others has undertaken really significant work to promote the introduction of this independent office which is now referred to as a National Oversight Mechanism (NOM). The campaign continues, **Nick Leahy** of Osbornes Law looks at ***"A system for monitoring the outcome of PFD reports"*** which promotes the establishment of a NOM with particular reference to the Grenfell Tower tragedy and explains how if a NOM had been in place lessons may have been learned earlier and the Grenfell tragedy avoided altogether.

Barely a day goes by when the media does not cover a story on adverse outcomes from cosmetic surgery whether at home or abroad. Invasive procedures are too readily carried out without due regard for the patient/client's best interests, **Leslie Keegan** of 7 Bedford Row shares with us a distressing example of the case of ***"XY v Mr. Neale Watson"***. The facts of the case are particularly shocking and highlight the lifelong ramifications for a patient whose elective, radical surgery was carried out without due consideration or investigation into whether such treatment could be considered to be in their best interests.

Thank you to all of our contributors and please do let us know if you have any points of practice, procedure, or legal interest which you would like to submit for future editions of the Newsletter, (for details please contact: **Norika@avma.org.uk**). The festive season is fast approaching, so it remains for me to sign off with wishing a Merry Christmas to all and to all a good night, kicking off with AvMA's Holly Jolly Christmas event on Friday 29th November (which is now sold out), we look forward to welcoming you all there.

Best wishes



Medical Assistance Required – Recent caselaw on expert medical evidence

JONATHAN GODFREY
DERE STREET BARRISTERS

Introduction

It goes without saying that any clinical negligence case is only as good as the expert medical evidence supporting it. Having taught courses to medical professionals in respect of their duties and responsibilities pertaining to CPR 35 and beyond, I hold a great interest in seeing how the theory translates into practice. In the main, it does so perfectly, but every now and again, there are cases that identify issues in expert medical evidence. I have picked out a handful of recent decisions by the courts whereby the focus has been on the expert medical evidence, good and bad.Those chosen are illustrative ,and seek to identify some of the matters regarding expert medical evidence that have recently reach the door of the court.

Caselaw

***Wilson v Ministry of Justice* [2024] EWHC 2389 (KB) HHJ Melissa Clark (sitting as a judge of the High Court).**

This is a personal injury case rather than a clinical negligence case, but identifies the issue of impartiality, sometimes found in clinical negligence cases. The seminal case on impartiality and independence of expert medical witnesses is of course, *EXP v Barker* [2017] EWCA Civ 63.].

The case arose from serious injury sustained by a prison inmate who was attacked by another prisoner. He suffered very serious injuries as a result. The issue revolved around the physiotherapy evidence, upon which there was initially quite common ground. Following the disclosure of video surveillance evidence however, the Defendant's physiotherapy expert produced a supplementary report, which led the judge to conclude that the expert could not reach the conclusions that she had from the surveillance evidence. One of the conclusions reached in the supplementary medical report was that the claimant had reduced reliance on a self-propelled wheelchair, notwithstanding that there was no use of a self-propelled wheelchair in the surveillance evidence. On questioning, the expert said that she was looking at the "*general picture*" of how he had presented in her original assessment of him and how he appeared in the surveillance evidence.

The judge considered that the defendant's expert was *"cherry-picking what she mentioned and failed to mention in order to paint a positive and improved picture of [the claimant] which was not one that could fairly be drawn from the video surveillance"* and that in producing her report she has "*departed from her fair and independent approach to [the claimant's] case as illustrated by her initial report and joint statement , to one which veers into a partisan approach*".

The matters do not end here. This was a myriad case. In respect of other aspect medical evidence, the judge had to consider the evidence of expert spinal surgeons, and in doing so, she did not accept that the evidence of the defendant's expert was given in accordance with CPR Part 35. The surprising feature of the case, was that in cross-examination, the expert agreed that he had lost all independence and objectivity in the case (before later trying to resile). The Judge stated that she found the expert "*to be a partisan witness who, unusually agreed quite early on in his cross-examination...... with the contention that had lost all independence and objectivity in this case... I then asked [the expert] whether he understood that he had just accepted that he had not provided independent and objective evidence in accordance with his Part 35 duties to the Court, and he said that he did.......... Although [the expert] sought to resile from this in re-examination I am satisfied that his earlier answers were the true and correct ones*".

All in all, not a good day at the office for the defendant experts.

***Biggadike v El Farra & Anor* [2024] EWHC 1668 (KB) HHJ Carmel Wall (sitting as a judge of the High Court).**

The Claimant had attended upon each of the Defendant Urogynaecologists concerning firstly, TVT-A implementation, and subsequently, exorcism of the mesh. The matter proceeded to trial and each of the parties relied on expert evidence. The judge heard evidence

from three expert urogynaecologists , each of whom was considered to be well-qualified and experienced in that specialisation.

During the course of cross examination, two of the experts , Mr Toozs-Hobson and Mr Robinson (to a lesser extent) were subjected to cross examination attacking their integrity as independent experts, it being suggested that they had some personal, professional and/or financial interest in the outcome of the trial. One area in particular, however stands out in terms of the allegations made, namely the attendance at and speaking at a seminar for urogynaecologists during the course of the trial. The seminar had been planned in advance of the trial and due to changes in the trial timetable, Mr Robinson was in the process of giving his evidence when the weekend seminar took place. Mr Toozs-Hobson had still to give evidence. Each of the experts indicated that they had told their respective legal teams of their commitment, but neither had informed the Court, nor the second defendant, or her lawyers.

The judge considered that it would have been preferable, in the interest of transparency, if the commitment had been volunteered to the court, and to the second defendant, but specified that had it been done, it would have been dealt with as a reminder to the experts not to discuss the case between themselves, and that Mr Robinson, who was in the process of giving evidence, should not discuss his evidence with any person. As matters transpired, the former was exactly what was done. The judge recognised that the sub-specialist world of urogynaecology is a small one (as is often the case in many medical sub-specialisms) and considered that "*it is entirely artificial to think that the organisation and attendance at the weekend seminar would have any efect or impact on their evidence I reject the suggestion that either Mr Robinson or Mr Toozs-Hobson has approached the task of giving evidence in this trial other than in accordance with the duties owed by an expert to the court*". Indeed, the judge went further in endorsing what was termed Mr Toozs-Hobson's "*pithy response*" to cross-examination attacking his independence, when he replied that "*this case isn't about me*".

An interesting and novel example of what could occur in the narrow world of medical sub-specialisms, where the clinicians are limited in number.

***Woods v Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust* [2024] EWHC 1432 (KB) Lambert J.**

A practical application of the trial judge's preferring one expert's views over the other based, to a large extent, on the deficiencies of the defendant's expert report.

The case involved alleged negligence during the claimant's birth and in particular the consideration of two traces, the latter becoming the focus of the claim when brought in 2021. The defendant's expert acknowledged in evidence that his report of 2023 had been prepared by him without a recent review of the second trace, but had imported into that report the section from his earlier 2007 report ,which had set out his then interpretation of the second trace, which had then not been the subject of criticism, and albeit that a better and more legible copy of the second trace was now available.

The judge considered she was "*reluctantly driven to the conclusion that , in this case, [the defendant expert's] preparation has lacked the attention to detail which the case demanded [and] that I regret to say that the overall impression was of a rather casual approach to the issues in the litigation this is in stark contrast to Mr Hare [the claimant's expert] who gave the impression of having considered the issues in the case with real care and who provided thoughtful and measured responses to the questions posed*".

This case highlights the objective criteria that a trial judge will use to analyse the respective positions adopted by the experts in weighing up which evidence is to be preferred.

***PXE v University of Birmingham NHS Foundation Trust* [2024] EWHC 2025 (KB) HHJ Sarah Richardson sitting as a High Court Judge.**

This case is salutary in that there is no criticism of expert evidence that was placed before the court. Quite the opposite in fact. The claimant's claim failed not because of any misapplication of the CPR or the duties owed by an expert, but because the trial judge while recognising that each expert held logical and defensible positions, preferred the evidence of the defendant's expert, for a large part, because his practical experience of the circumstances and locus concerning the alleged negligence more closely aligned with the events that took place.

This was another birth delivery case . The case centred on a failure to classify the claimant's mother's pregnancy as high risk in that (1) she had a recorded history of cystitis: kidney scarring, (2) a failure to perform growth scans from 28 weeks and (3) to have delivered him earlier. Unfortunately, as events unfolded, the claimant suffered

foetal growth restriction, which was not recognised and addressed prior to delivery, and he suffered periventricular leukaemia and now has permanent brain damage.

The obstetric evidence on liability was provided by Mr Denbow on behalf of the claimant and Mr Tuffnell, on behalf of the defendant. Each were described by the trial judge as "*thoughtful and considered expert witnesses*" with a wealth of experience and each approached their tasks from their respective clinical backgrounds. Mr Denbow had always been a consultant in a large teaching hospital and acknowledged that he had a greater depth of resources available to him. Mr Tuffnell was a consultant in a large District General Hospital and was "*clearly more familiar with the working conditions that [the treating clinician] was facing in 2008 than Mr Denbow, who expressed genuine surprise in the witness box about the information that Mr Tufnell shared with him at the experts' joint meeting about the lack of scanning and other resources …… in a District General Hospital in 2008*".

Without going into each of the matters considered and determined by the trial judge on the expert evidence, the trial judge considered that for all the reasons that she had given the opposing views held by the liability experts amounted to a genuine difference of opinion. The view of Mr Tuffnell was logical and the conclusions reached defensible. It followed that the view taken by the treating clinician when reviewing the claimant's mother's case and agreeing that it "*was suitable to be managed on the low risk pathway was reasonable and was one that it was open to a reasonably competent obstetrician working in a District General Hospital in 2008 to make. In all the circumstances, the claimant must fail on establishing breach of duty ….*".

This is an interesting case in that it promulgates consideration of instructing an expert conversant with the circumstances and setting of the alleged negligence.

Final Thoughts

Expert evidence and the duties owed by experts in its presentation will continue to involve the courts. While at first blush CPR Part 35 seems to effortlessly set out the duties owed by experts, its practical application is sometimes not quite so accommodating. Clinical negligence cases are not immune to issues involving experts duties, and will continue to be. In the main however, the vast majority of clinical negligence cases are seamless in the application of duties performed by hugely knowledgeable and vastly experienced experts, of which the ***PXE*** case presents as a prime example.

A review on causation in the Coroner's Court

BEATRICE BASKETT AND LOUISE ASPREY
ST JOHN'S CHAMBERS

At the recent inquest touching the death of Steve Dymond, HM Area Coroner Jason Pegg concluded there was no clear and reliable causal connection between Mr Dymond's unfortunate death and his recent appearance on the ITV Jeremy Kyle Show. It was concluded that whilst "*possible*" the experience added to his distress it was not "*probable*", reiterating the often-nuanced complexities of causation in the Coroner's court.

Mr Dymond's inquest

The widely publicised facts of Mr Dymond's inquest confirm that he attended the Jeremy Kyle Show on 2 May 2019 to undertake a lie detector test, hoping to prove that he had not cheated on his partner.[1] Failing the lie detector test, he was visibly upset and believed that his relationship had irretrievably broken down. Mr Dymond sadly died on 9 May 2019, and the Jeremy Kyle Show was permanently cancelled on 15 May 2019.[2]

The inquest was a *Jamieson* (non-Article 2) inquest with the findings handed down on 10 September 2024. The Coroner recorded a short-from conclusion of suicide. ITV report that the Coroner explained as follows: "*Having considered the evidence carefully there is an absence of reliable evidence that demonstrates that Steve Dymond's appearance on the Jeremy Kyle Show probably caused or contributed to his death to do so would be speculative… Steve Dymond had a history of a diagnosed personality disorder and mental illness which presented on a number of occasions before any appearance of the show and resulted in self-harming or displaying thoughts of suicide.*"[3]

Causation and findings at an Inquest

When considering the Coroner's determination and contents of the Record of Inquest, the starting point for many practitioners will often be the Chief Coroner's Guidance No.17, which re-iterates that "*the coroner (or the jury, if there is one) is required, having heard the evidence, and in addition to deciding the medical cause of death, to arrive at a conclusion by way of a three-stage process.*" The three-stage process can be summarised as follows:

(1) "*To make findings of fact based upon the evidence.*

(2) *To distil from the findings of fact 'how' the deceased came by his or her death and to record that briefly on the Record of Inquest in Box 3.*

(3) *To record the conclusion, which must flow from and be consistent with* (1) *and* (2) *above, on the Record of Inquest in Box 4.*"[4]

Any finding or conclusion, must pass the Galbraith Plus test, as per Haddon-Cave J in *R (Secretary of State for Justice) v HM Deputy Coroner for the Eastern District of West Yorkshire* [2012] EWHC 1634; [2012] A.C.D. 88: "*when coroners are deciding whether or not to leave a particular [verdict] to a jury, they should apply a dual test comprising both limbs or* "schools of thought" *[as discussed in* R v Galbraith *[1981] 1 WLR 1039], i.e. coroners should (a) ask the classic pure Galbraith question* "Is there evidence on which a jury properly directed could properly convict etc?"*… plus (b) also ask the question* "Would it be safe for the jury to convict on the evidence before it?".[5]

1 *BBC live reporting from the inquest:* https://www.bbc.co.uk/news/live/cx293v0dy3kt

2 *Press release, Bindmans LLP for the family :* https://www.bindmans.com/knowledge-hub/news/hm-coroner-concludes-that-stephen-dymond-took-his-own-life-after-appearing-on-the-jeremy-kyle-show-on-2-may-2019/

3 https://www.itv.com/news/meridian/2024-09-10/no-causal-link-found-following-death-of-guest-on-the-jeremy-kyle-show

4 *Paragraph 8, Chief Coroner's Guidance No.17*

5 R (Secretary of State for Justice) v HM Deputy Coroner for the Eastern District of West Yorkshire *[2012] EWHC 1634; [2012] A.C.D. 88, H8*

When applying the Galbraith Plus test to issues of causation, whether an event or conduct is causally connected to death may be safely concluded in the affirmative where there is evidence upon which the Coroner (or jury if applicable) could properly and safely find that on the balance of probabilities the acts or omissions in question more than minimally, negligibly or trivially contributed to death.[6]

Put simply, the enhanced investigative duty is engaged under Article 2 of the Human Rights Act in certain circumstances automatically and in other cases, where there is an arguable breach of Article 2 by a public authority. The engagement of Article 2 affects the findings at an inquest in three main ways. Firstly, section 5 of the Coroners and Justice Act 2009 provides that the purpose of an inquest is to ascertain: "(*a) who the deceased was; (b) how, when and where the deceased came by their death; and (c) the particulars (if any) required under other legislation to be registered concerning the death*".[7] In a non-Article 2 inquest '*how*' means "*by what means*", however, when Article 2 is engaged the '*how*' question addresses not only by what means, but also "*in what circumstances*" the deceased came by their death.[8]

Secondly, non-Article 2 narrative conclusions should be brief, neutral and factual, whereas Article 2 narrative conclusions may be judgemental conclusions of a factual nature, as long as no issue of criminal or civil liability is addressed.[9]

Finally, on the issue of causation, as explained within the Chief Coroner's Guidance No.17, "*the coroner has a power in an Article 2 inquest (but not a duty) to leave to the jury, for the purposes of a narrative conclusion, circumstances which are possible (i.e. more than speculative) but not probable causes of death. A narrative conclusion may also (but does not have to) include factual findings on matters which are possible but not probable causes of death where those findings will assist a coroner in a Report to Prevent Future Deaths*".[10]

Dove v Assistant Coroner for Teesside [2023] EWCA Civ 289 re-affirms the appropriate causation test specifically in a case of suicide. This case considered the unfortunate death of Ms Whiting. By way of background, Ms Whiting had been in receipt of welfare benefits from the Department for Work and Pensions (DWP) which were withdrawn in the weeks prior to her death. At the initial inquest, the Coroner stated it was not her role to question decisions made by DWP and that this was outside the remit of the Coroner's Court. However, the Court of Appeal confirmed the importance of considering Ms Whiting's state of mind in the lead up to her unfortunate death stating: "*causation… encompasses acts or omissions which contribute (more than trivially) to death and that it is open to a coroner in a suicide case to consider the extent to which acts or omissions contributed to the deceased's mental health deterioration, which in turn led them to take their own life.*"[11]

Comment

Against the above background, the relevant case law and the Chief Coroner's Guidance, a number of interesting observations on causation may be made about the inquest into the death of Mr Dymond.

Considering Mr Dymond's appearance on the Jeremy Kyle Show during the course of the inquest itself is an example of an application of the principles consolidated by the Court of Appeal in *Dove*, specifically that when considering a death by suspected suicide events in the lead up to the death may be relevant to the question of scope, as the Coroner considers a deterioration in mental health.

Furthermore, given the Chief Coroner's Guidance stipulates that in Article 2 inquests narrative conclusions may include factual findings on matters which are "*possible*", had Article 2 been engaged in Mr Dymond's inquest, it would have been at the discretion of the Coroner to record possibly causative factors, specifically the view that it was "*possible*" the experience on the Jeremy Kyle show added to his distress.

Following the inquest Jeremy Kyle's spokesperson issued the following statement:

"*Jeremy Kyle is pleased that His Majesty's Coroner has found clearly and unequivocally that he did not in any way cause or contribute to the tragic suicide of Steve Dymond*".[12] Had this been an Article 2 inquest, the position could have been far less clearcut.

6 R (Childlow) v HM Senior Coroner for Blackpool and Fylde *[2019] EWHC 581, 36,52, citing* R (Tainton) v HM Senior Coroner for Preston and West Lancashire *[2016] 4 WLR 157.*

7 *Section 5, Coroners and Justice Act 2009*

8 *Paragraph 8, Chief Coroner's Guidance No.17;* R v HM Coroner for North Humberside and Scunthorpe, ex parte Jamieson *[1994] 3 W.L.R. 82*

9 R (Middleton) v HM Coroner for West Somerset *[2004] 2 AC 182, 37.*

10 *Paragraph 33, Chief Coroner's Guidance No.17*

11 Dove v Assistant Coroner for Teesside *[2023] EWCA Civ 289; 69.*

12 **https://www.phb.co.uk/article/decision-of-his-majestys-coroner-in-the-inquest-of-steve-dymond/#:~:text=%E2%80%9CJeremy%20Kyle%20is%20pleased%20that,name%20has%20finally%20been%20cleared**

The scope, findings and purpose of an inquest differ greatly to the approach taken in an inquiry, with the distinction between the two not always being immediately clear to the public. The Digital, Culture, Media and Sport Committee launched the Reality TV inquiry following Mr Dymond's death, specifying: *"The inquiry will consider production companies' duty of care to participants, and ask whether enough support is offered both during and after filming, and whether there is a need for further regulatory oversight in this area. The DCMS Committee's decision to launch the inquiry into reality TV comes after the death of a guest following filming for The Jeremy Kyle Show and the deaths of two former contestants in the reality dating show Love Island."*[13]

Chair Damian Collins reiterated throughout the inquiry the different jurisdictions, for example stating prior to the questions relating to the Jeremy Kyle Show: "*I welcome the witnesses for this evidence session of the Digital, Culture, Media and Sport Select Committee as part of our inquiry into reality television. Before we start the questions and the evidence session, I remind Members that in accordance with the House's sub judice resolution, reference should not be made to matters before the coroner's court and, therefore, the inquest into the death of Steven Dymond should not be referred to. However, discussion of the wider issues relating to "*The Jeremy Kyle Show*" and other shows is permissible. I state that for the record."*[14]

The inquiry considered in detail the reliability of lie detector tests. Lie detector tests are not admissible as evidence in criminal proceedings in the UK.

Following the evidence, the Chair to the inquiry comments: "*We've shown this recording to expert advisers who are deeply concerned at ITV's apparent failure to prioritise the welfare of participants over the demands of the show, exploiting their vulnerability for the purpose of entertainment... What we've seen demonstrates a failure on the part of ITV studios in its responsibility towards contributors and makes a mockery of the* 'aftercare' *it has claimed to provide."*[15]

The findings in both the inquest and the inquiry need to be considered in the correct context. An inquest must remain focused on the death of the deceased and is limited to answering the four statutory questions. An inquiry is far broader in its purpose.

However, the Coroner does have a regulation 28 duty to make a report to prevent future deaths if anything revealed by the investigation gives rise to a concern that circumstances creating a risk of other deaths will occur, or will continue to exist, in the future.[16] This extends the role beyond the immediate remit of the inquest and provides an important safeguard for the public.

13 https://committees.parliament.uk/work/6345/reality-tv-inquiry/publications/

14 https://committees.parliament.uk/oralevidence/9470/pdf/

15 https://committees.parliament.uk/work/6345/reality-tv-inquiry/news/103545/committee-publishes-written-submission-regarding-the-jeremy-kyle-show/

16 Regulation 28 of The Coroners (Investigations) Rules 2013; Schedule 5 paragraph 7(1) Coroners and Justice Act 2009

The pitfalls of claims against private practitioners & professional indemnity insurance

ALISON HILLS
TEES LAW

Background to claim

Tees were instructed on behalf of a Claimant in a claim for clinical negligence against three private dentists. This related to allegedly negligent dental treatment which was provided in early 2017.

The Claimant (now in her 40s) is married and lives with her husband and two young children. Prior to the events in question, she was a qualified nurse who was employed as a locum A&E nurse at a local hospital.

The Claimant attended the Dental clinic in January 2017 to seek a second opinion upon treatment options for her UL6. She was advised against Root Canal Treatment (RCT) on the basis that it can cause cancer or tumour formation and it was toxic, unsafe and should be avoided. She subsequently underwent an extraction of her UL6 in February 2017, which resulted in an oro-antral fistula and a number of other symptoms including fever, facial pain and blood clots.

Her condition did not improve, and she subsequently underwent a number of other procedures, including a Caldwell-Luc procedure, removal of the UL7, surgery for closure of her fistula, nerve cryotherapy and micro-vascular decompression surgery.

She ended up with significant facial pain and was subsequently diagnosed with trigeminal nerve neuropathy with a poor prognosis.

The allegations of negligence arose from three specific dates between February and March 2017 and included:

• a failure to present the option of RCT as a reasonable alternative treatment option for the UL6 (and providing misleading and incorrect information regarding the risks of this procedure).

• a failure to adequately explain to the Claimant the risks of removal of UL6 and UL7, including the risk of root fracture

• subjecting the Claimant to unconventional and unnecessary dental procedures.

As a result of the Caldwell-Luc procedure and failure to correctly consent the Claimant for RCT, it was alleged that the Claimant developed trigeminal neuropathy with persistent (and debilitating) pain. As a result of her debilitating levels of pain, the Claimant had to stop working as a nurse. A seven-figure claim was pleaded.

Proceedings

Letters of Notification were sent to the Defendants in October 2018, with the formal Letter of Claim then being served in June 2019.

The Defendants maintained full denials of liability and Court proceedings were issued in February 2020; initially against all three of the private dentists involved. Proceedings were subsequently discontinued against two of the Defendants, when it came to light that they were entirely uninsured and had no assets against which to enforce any judgement.

The Defence was served in December 2021 when once again, full denials of liability were maintained. The parties exchanged witness evidence of fact in February 2023, with liability experts' reports being exchanged in August 2023. However, the Defendant's expert reports failed to address the core allegations of negligence and so we served several Part 35 requests, which led to significant concessions being made by the Defendant's nominated experts.

The Claimant served her Schedule of Loss and evidence in support of condition, prognosis and quantification of damages in September 2023, with the Defendant's condition and prognosis evidence, and counter-schedule of Loss being served in February 2024. The Counter-Schedule was meaningless and, largely pleading nil throughout on the basis that liability was denied.

The trial was listed for November 2024.

Liability

The experts reached agreement on a number of issues in the joint statements. In particular, it was noted that the dental experts agreed that RCT was a "*safe and effective form of treatment*" and that it would be a breach of duty for a dentist to convey to a patient (as the Defendant did) that RCT can cause cancer or tumour formation or that it was toxic, unsafe and should be avoided. They also agreed that the Claimant should have been advised of the option of RCT and that had this been performed instead of extraction, then she would have had a long-term successful outcome.

The maxillofacial experts agreed that if the Claimant had undergone successful RCT, then she would have avoided both the need for the UL7 extraction (which was not clinically justified) and that the Caldwell-Luc procedure (the cause of the Claimant's trigeminal nerve neuropathy and pain) would have also been avoided.

However, despite this, the Defendant continued to deny liability in full.

Professional indemnity insurance problems

Throughout the claim, we made multiple requests for details of the Defendant's professional indemnity insurance. These were denied.

Eventually, in November 2023 (which was five years after the claim was notified, three years after proceedings were issued, now only eight months before trial and almost two years after the costs budgets had been approved), the Defence informed us that the Defendant had a limit of indemnity under his professional indemnity insurance of £1million.

Thereafter, we asked for disclosure of the professional indemnity insurance policy on several occasions, but this was again, refused.

We attempted to identify whether the Defendant had any assets against which any judgement could be personally enforced, but nothing of note was identified in the UK. We were also unable to identify any assets outside the jurisdiction.

In July 2024 (now only four months before trial), the Defendant's legal representatives made a derisory global offer to settle. At the same time, they dropped a bombshell - not only did the £1million indemnity limit under the Defendant's Professional Indemnity Insurance have to cover the Claimant's damages, but it also had to cover both sides costs. The Defendant's Solicitors had also spent nearly £500,000 of this sum (notwithstanding that the Court approved budget had restricted costs to just over half of that number). Therefore, the maximum available under the insurance policy to satisfy the Claimant's damages, and all of her legal costs and disbursements was circa £500,000.

This placed us and the Claimant in a very difficult position - the Claimant's case had been valued at seven figures and the Claimant's approved costs budget exceeded £500,000. This therefore also posed the potential for a conflict of interest between us and the Claimant.

Tees assembled an "*advisory team*" which included lawyers from our risk and compliance, dispute resolution and commercial teams, as well as costs counsel. We burned the midnight oil to see what we could do to try to maximise the sum available to the Claimant and considered a number of questions:

1. Was the Defendant entitled to pay themselves out of the indemnity policy before the case had been resolved?

2. Did the Claimant have grounds to question the Defendant's solicitors overspend on the budget (whereby they had effectively reduced the indemnity available to the Claimant)?

3. Was there was a way to try and claim the Claimant's costs outside of the indemnity limit so that the Claimant's compensation could be maximised?

4. Were there any other steps that we could take to protect the Claimant's position?

Was the Defendant entitled to pay themselves before the claim resolved, thereby eroding the limit of indemnity available to the claimant?

Yes. The Defence finally agreed to disclose a copy of the Defendant's insurance policy. This confirmed that the policy was an eroding policy, such that the Defendant was entitled to pay their legal costs from the policy before the case was resolved, thereby reducing the amount available to settle any claim at the conclusion.

Did the Claimant have grounds to question the Defendant's solicitors overspend on the budget (whereby they effectively reduced the indemnity available to the Claimant)?

No. Court Approved budgets only affect inter partes costs, not solicitor and own costs.

However, if a judgement debt were obtained, the Creditor (i.e. the Claimant) could put the Defendant into bankruptcy and then essentially "*stand in his shoes*" to challenge the legal costs spent on his behalf under the

Insurance policy, with a view to recovering the difference between the Court Approved Budget and those actually spent.

Was there a way to try and claim the Claimant's costs outside of the indemnity limit so that the Claimant's compensation could be maximised?

Yes. It would be possible to seek a non-party costs order against the Defendant's insurers under *s.51 Senior Courts Act 1981*, on the basis that the insurers were the "*real Defendant*". If this were successful, the Insurer would be primarily responsible for the Claimant's costs of the action, regardless of any limit of indemnity under the Defendant's policy. In the Court of Appeal case, *TGA Chapman Ltd v Christopher* [1998] 1 WLR 12, the Court of Appeal upheld a non-party costs order against a Defendant's insurers following a judgment for damages which exceeded the limit of indemnity.

Were there any other steps that we could take to protect the Claimant's position?

There was no jurisdiction to make an application for security for costs or similar (requiring the Defendant to pay the balance of the Insurance indemnity into Court as security for the Claimant's costs).

Heaping the pressure on the Defence camp

We decided to ramp up the pressure on the Defendant and throw a conflict of interest into the Defendant's camp. Therefore, we:

1. Made a well-pitched Part 36 offer that we were confident would be beaten at trial, thereby entitling the Claimant to the benefits of Part 36 provisions.

2. Notified the insurers that we intended to seek a third-party costs order under *s.51 Senior Courts Act 1981* and that we felt that this was a case where *TGA Chapman Ltd v Christopher* [1998] 1 WLR 12 would be applied because:

• the Defendant had no assets and therefore no judgment could be enforced upon him personally

• the insurers had pursued the defence to protect their own interests i.e. to avoid or reduce their liability to the Claimant to pay a sum in excess of the limit of indemnity.

• If the case were to go to trial and we were to win, they would not only be paying out the full £1million under the insurance policy, but they would also be paying out the Claimant's legal costs on an indemnity basis.

3. Notified all parties that should the case proceed to trial, such that we secured a judgement, we would seek to enforce that judgement. We would put the Defendant into Bankruptcy which would then enable us to challenge the costs that the Insurer had spent on legal representation through solicitor and own client assessment, thereby returning more money to the Claimant's "*pot*".

The Defence Response

The Defendant's legal representatives

The Defendant's legal representatives made a significantly increased offer, albeit still not at a level which exhausted the insurance policy limit of indemnity.

The Defendant's insurer

The Insurers instructed different legal representatives to respond to the Third-Party Costs Order Notification and disputed the basis for any such application, arguing that the defence had been conducted in the personal and professional interests of the Defendant. It was he who had chosen his legal representatives and the claim was being defended so that he could return to practice (he had been unable to obtain insurance to practice since this claim).

The Insurer's legal representatives also advised that if the Claimant did not accept the Defendant's settlement proposals, then the Insurer would transfer the entire remaining limit of indemnity to the Defendant; the Defendant would spend that money running his Defence to trial, thus leaving the Claimant with nothing.

Settlement

It was clear to see that this was not going to be an easy battle and given that half of the indemnity limit had already been eroded by the Defendant, we, and the Claimant, were keen to try and resolve matters without escalating costs and eroding the limit even further.

Negotiations therefore continued to try and achieve settlement in what were very difficult circumstances, as we knew that both the Claimant's damages, and our costs would have to be significantly reduced. It was also clear that going to trial simply was not an option given that the entire indemnity limit would have been eaten up by legal costs.

A few offers went back and forth between the parties, and we eventually agreed settlement in the global sum of £500,000 (i.e. as much as was left under the limit of indemnity [LOI]). This was enough to allow our client to obtain the future treatment that she needed but was insufficient to meet our costs and disbursement liabilities,

which meant that we had worked on this case for the best part of seven years entirely pro-bono.

GDC

Following the settlement, a complaint was filed with the GDC against the Defendant, as it was concerning that:

(a) He was advising patients that RCT on the basis that it can cause cancer or tumour formation, and it was toxic, unsafe and should be avoided

(b) He was still a registered practitioner, despite having clearly insufficient indemnity insurance in place (a breach of GDC requirements and s.26A of the Dentists Act 1984)

(c) He intended to return to practice after this claim was resolved.

Justice?

Going forwards, this really does serve as a warning to Claimant lawyers to request a copy of the professional indemnity insurance at the outset to ensure that you and the Claimant are not in this difficult situation. The difficulty is that the law is not with us, and if the Defendant refuses, the Court will not order them to disclose this.

It is clear that things need to change and that there is a wider public interest point in situations like this. It is entirely unjust that private practitioners can undertake medical treatment either without insurance at all, or with wholly inadequate insurance which serves only to protect the interests of the Defendant and not the injured party. Such a situation provides no protection for the injured party – in fact they cause further harm.

If Defendants are not going to collaborate and are going to adopt a "*litigation by warfare*" approach, a change in the CPR is needed to facilitate mutual exchanges of notices of funding at the point of service of the Letter of Response/Defence. This would then not only put the Claimant on notice of any potential indemnity problems, but also focus the parties' minds on ADR much sooner.

Obviously, this is not the outcome that we would have wanted but I am extremely proud to be a part of a team who really pulled together when needed, and all the research that we undertook into the third-party costs orders and insurance litigation certainly was not made in vain as we managed to increase upon the Defendant's original offer by over £400,000.

We also achieved the best outcome that we could for our client in very difficult circumstances which allows her to finally have the treatment that she desperately needs, and I am extremely proud to be a part of a team who will always put their clients first, even if this is at a significant detriment to the recoverability of legal costs.

Overturning the presumption of Part 36 costs consequences for late acceptance by protected parties

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… (and a reminder of the difference between claims issued pre and post 6 April 2023 in respect of CPR 44.14).

When might a court use its overriding power to disapply the provisions of Part 36 of the Civil Procedure Rules (CPR) where there has been late acceptance of a Part 36 offer?

In this article, we will consider the rules under Part 36 of the CPR, the facts of a specific case and the insight of High Court Master Stevens.

Part 36 Rules – the basics

The consequences of late acceptance of a Part 36 offer are well known to all involved in contentious litigation. The primary aim of CPR Part 36 is to encourage parties to settle claims by providing protection of the offeror's legal costs. Part 36 comes into effect when an offeror makes reasonable settlement offers that are not accepted within the relevant period and impose penalties on offerees who reject reasonable offers.

Usually, costs consequences following acceptance are agreed, but if the parties do not agree that the "*usual consequences*" apply, the Court will decide the incidence of costs ;- Rule 36 (13)(4) states

Where—

… (b) a Part 36 offer which relates to the whole of the claim is accepted after expiry of the relevant period; … the liability for costs **must be determined by the court** unless the parties have agreed the costs.

CPR Part 36.17(5) then grants the court overriding discretion to waive the Part 36 costs consequences if it deems their application to be unjust.

(5) Where paragraph (4)(b) applies but the parties cannot agree the liability for costs, the court must, **unless it considers it unjust to do so**, order that—

(a) the claimant be awarded costs up to the date on which the relevant period expired; and

(b) the offeree do pay the offeror's costs for the period from the date of expiry of the relevant period to the date of acceptance.

(6) In considering whether it would be unjust to make the orders specified in paragraph (5), **the court must take into account all the circumstances of the case** including the matters listed in rule 36.17(5).

What factors will the court consider when deciding if Part 36 application is "unjust"?

The court must consider all the circumstances of the case, including under 36.17(5),:

(a) the terms of any Part 36 offer;

(b) the stage in the proceedings when any Part 36 offer was made, including in particular how long before the trial started the offer was made;

(c) the information available to the parties at the time when the Part 36 offer was made;

(d) the conduct of the parties with regard to the giving of or refusal to give information for the purposes of enabling the offer to be made or evaluated; and

(e) whether the offer was a genuine attempt to settle the proceedings.

BVO (a child by their mother and Litigation Friend XYZ).

In the recent High Court case, *BVO (a child by their mother and Litigation Friend XYZ)* (the Claim), Master Stevens was asked to consider the provisions of Part 36 when approving settlement on behalf of a minor protected party.

The case revolves around the tragic death of the Claimant's father, who died suddenly at home from an undiagnosed type A aortic dissection. The Claimant found the Deceased lying face down in their back garden and witnessed the failed attempts at resuscitation. The Claimant was nine years old at the time and was diagnosed with Post Traumatic Stress Disorder.

The Defendant Trust admitted liability for the death but denied that it owed a duty of care to the Claimant as a secondary victim. A Part 36 offer of settlement was made by the Defendant on 16 November 2022 (the Offer) which was not accepted by the Claimant. The Offer was not withdrawn by the Defendant, and the claim was issued on 8 December 2022.

Following the Supreme Court judgment in *Paul and another v Royal Wolverhampton NHS Trust* [2024] UKSC 1 which effectively closed the door on all secondary victim claims in a clinical negligence setting, on 11 January 2024, the Claimant immediately accepted the Defendant's still open Part 36 offer, before the Defendant, as it would be expected to do, withdrew it in light of the decision in *Paul*.

As the Claimant was a minor protected party, settlement required court approval under CPR 21.10.

Prior to the listing of the approval hearing the Defendant indicated its position that (i) the Claimant should bear the Defendant's costs in relation to the late acceptance of the offer from the date of expiry, and (ii) it would be seeking an order that such costs be set off against the Claimant's costs or damages under CPR 44.14. On behalf of the Claimant we resisted both limbs of that request, firstly arguing that it would be unjust for the "*usual order*" to apply, and secondly pointing out that the second limb of what the Defendant sought (set off) was not available in law, the Claim having been issued on 08 December 2022 and hence prior to the inception of the current CPR rule 44.14.

Submissions

At a hearing before Master Stevens on 26 June 2024, the Claimant sought their costs on the standard basis, submitting that it would be unjust to make the orders set out in CPR 36.13 (5), and in particular it would be unjust to deprive the Claimant of their costs from expiry of the Offer. The Claimant hence both resisted payment of the Defendant's costs and pursued full recovery of their own costs.

Submissions were made on BVO's behalf that:

1. The Claimant is a vulnerable protected party who had appropriately taken written Advice from Counsel in connection with the Offer. Counsel advised in detail, in a seven-page Advice, and on the basis of expert (i) psychiatric and (ii) educational psychology evidence (available to the Court) advised that the Offer not be accepted. Counsel advised instead that the Claimant make an offer higher than the Defendant's Part 36 offer. To have accepted it would potentially have been negligent and exposed the Claimant's solicitor to an allegation of under-settlement. Additionally, this being a protected party claim, where approval was needed, prior to *Paul* such approval would not have been forthcoming in the face of Advice from Counsel that the offer was too low. Accordingly in practice, the offer could not have been effectively accepted.

2. The Offer was accepted at the time that it was, purely as a result of the decision of the Supreme Court in *Paul*. This is a controversial decision and one which simply closed the door on Claimants in BVO's position. This is in effect an "*Act of God*", helpful to Defendants in future claims, and to some extent a windfall, but not a matter which ought to prejudice this Claimant or benefit the Defendant in effect retrospectively within this Claim's chronology.

3. Secondly, and in any event, the Claimant resisted payment of the Defendant's costs. No such costs can be enforced by way of set off at all. The Defendant's stance was wrong in law because;-

- The Claimant was a protected party.

- The Claimant had QUOCS protection in place.

- This Claim was issued on 08 December 2022 and hence prior to the inception of the current CPR rule 44.14.

- Claims issued before 6 April 2023, which this was, continue to come under the previous QOCS regime, and only claims issued after 6 April 2023 follow the new CPR 44.14 rules.

- In terms of enforcement of costs, the previous incarnation of CPR 44.14 provided; "*... orders for costs made against a claimant may be enforced without the permission of the court but only to the extent that the aggregate amount in money terms of such orders does not exceed the aggregate amount in money terms of **any orders for damages and interest** made in favour of the claimant.*"

- Previous caselaw also applies to this claim.

- The Court of Appeal in *Cartwright v Venduct Engineering Limited* [2018] EWCA Civ 1654 has decided that (i) settlements reached by Tomlin Order or (ii) by

the Claimant's late acceptance of a Part 36 offer are not "*orders for damages and interest*".

- The Supreme Court in *Ho v Adelekun* [2021] UKSC 43 then decided that Defendants cannot offset costs awarded in their favour against costs awarded to the claimant upon settlement of the case.

- The Court of Appeal in *Harrison v University Hospitals of Derby & Burton NHS Foundation Trust* [2022] EWCA Civ 1660 then clarified that compensation payable as a result of a settlement (whether Part 36 or otherwise) is not an "*order for damages and interest*" within the meaning of CPR 44.14 and cannot be subject of a costs set off, **even if recorded or referred to in a court order (for example because permission is required to accept it or some order is required to give effect to the settlement)**.

4. As a result, there was no legal basis for the Defendant's asserted intention to seek set off, either against damages or against costs.

5. It would hence be entirely inappropriate to make an order for costs, in circumstances where it cannot be enforced, and would simply be a paper Order onerous to the Claimant and of no assistance to the Defendant.

6. The just Order in respect of costs was that the Defendant do pay the Claimant's costs, on the standard basis.

The Defendant submitted that:

1. The Court does not have unfettered discretion under Part 36 and should not look to the details of the claim when deciding on the application of Part 36, relying on the judgment in *Briggs -v- CEF Holdings Ltd* [2017] EWCA 2363 (Civ) "*...it is very important not to undermine the salutary purpose of Part 36 offers. It is important too that in considering often attractively advanced submissions as to uncertainty the court should not be drawn into microscopic examination of the litigation details.*"

2. The law as it was at the time did not permit secondary victim claims, following the Court of Appeal ruling in in *Paul and another v Royal Wolverhampton NHS Trust*. In any event, a change in law is not a relevant factor for the Court to consider when applying Part 36 rules.

3. The offer made in November 2022 was a genuine attempt at settlement.

4. In not accepting the offer, the Claimant "*chose to take a gamble, for which they lost*". That cannot be a reason to depart from the usual costs order.

5. The fact that any order would be unenforceable should not be a factor relevant to the Court in consider whether an order should be made in principle.

Findings of Master Stevens

Master Stevens was satisfied that it would be unjust in the circumstances to award the Defendant its costs following expiry of the relevant period.

Master Stevens highlighted the following factors relevant to the decision:

• Throughout the entire CPR, there is an additional duty to exercise caution and avoid ordering deductions when a party has protected party status.

• Conduct of the parties is relevant:

o Based on Claimant's Counsel's valuation at the time the Offer was made, the Offer represented just half the full value of the claim, which represents nothing more than a '*sitting on the fence*' offer. Part 36 obligations are not just one sided; the Defendant did not increase their offer and did not make any further offers. Neither did they withdraw the offer. The Offer was nothing more than a "*holding offer*".

o The Defendant was not in receipt of supportive expert evidence at the time in which base their valuation. The Claimant was.

o The Claimant acted promptly and reasonably once the Supreme Court judgment in *Paul and another v Royal Wolverhampton NHS Trust* was handed down.

• The Defendant has added protection that costs will be assessed by the Senior Courts Costs Office who can take a view on the reasonableness of work undertaken.

Master Stevens held that it would be "*unjust in these unusual circumstances*" to prejudice the Claimant with an adverse costs order.

The Claimant was also awarded their full costs of the claim contrary to the legal presumption in CPR 36.17(5).

Reflections

The first point to take from this is to check the date of issue of the Claim you are dealing with. The Defendant's claim for set-off was wrong in law from the start. Much waste of time and energy could have been saved had they recognised this sooner than during the approval hearing itself.

In respect of Part 36, this is also a cautionary tale for parties- review your offers and make sure that if you no longer wish them to be open for acceptance - withdraw them. Had the Part 36 offer been withdrawn, the Claimant would have had no remedy and no damages recovery.

In terms of the Part 36 discretion, Master Stevens' order underscores the flexibility and fairness embedded within the Civil Procedure Rules, particularly concerning the disapplication of Part 36 costs consequences where there is a protected party. The decision illustrates the court's willingness to consider the unique circumstances of a case, with particular consideration being given to the need to guard protected parties from adverse costs orders. Counsel's Advice can be crucial- a failure to accept an offer, based on advice not to accept, is prima facie reasonable. This is particularly so in a protected party claim because Counsel's Advice would be needed for approval to be given.

In this instance, despite the general presumption under Part 36, the court recognized the exceptional nature of the case, including the implications of recent legal developments and the conduct of the parties.

The ruling reaffirms that while Part 36 provides a structured framework for managing settlement offers and associated costs, the Court maintain absolute discretion as to the application of the rules to ensure that it does not lead to an unjust result, particularly for vulnerable parties who may be adversely affected by rigid adherence to procedural norms.

Remember that there are two separate elements to consider; (i) Defendant's costs and (ii) Claimant's costs. Remember to address both. Here (i) were denied and (ii) were awarded, but there may in other cases be room for different permutations.

Master Stevens' decision is a poignant reminder that the principles of fairness and equity are integral to the administration of justice, even within the structured confines of generally accepted procedural rules, and that both the particular facts and the current law deserve our considered attention when pursuing or resisting costs in any case.

BVO was represented in the approval / costs arguments by Janine Collier and Georgina Wade of Tees Law and Sarah Lambert K.C. of Counsel.

A system for monitoring the outcome of PFD reports

Osbornes | Law

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As many will have already seen, in September 2024 the Grenfell Tower Inquiry published its Phase 2 Report. The inquiry was created to examine the circumstances leading up to and surrounding the fire at Grenfell Tower in London on 14 June 2017.

The Phase 1 Report was published in October 2019, and dealt with the events on the night of the fire. Phase 2 investigated the wider situation. The Phase 2 report found that every death on that tragic day in June 2017 was avoidable, and that the residents of the tower had been badly failed over many years by the people responsible for ensuring their safety and the safety of the building they lived in.

One particular conclusion of the Phase 2 report which will be of note to those interested in patient safety was the Chairman's finding that the Department for Communities and Local Government had failed to treat the recommendations of the coroner following the 2009 fire at Lakanal House in South London with any sense of urgency or importance. Those of us representing families in the coroners' courts on a regular basis will be all too familiar with recommendations being made by coroners, particularly under Regulation 28 of the Coroners (Investigations) Regulations 2013 (so called '*Prevention of Future Death Reports*' or 'PFDs'), only for such recommendations to be effectively ignored. This is evidenced by the fact that the same issues seemingly present themselves over and over again at inquests.

Once a coroner has made a PFD report, there is nothing in the legislation giving them the power to follow up on the recommendations they have made, to ensure changes have been made in response to concerns which they have highlighted. Whilst Paragraph 7 of Schedule 5 of the Coroners and Justice Act 2009 directs "*A person to whom a senior coroner makes a report …must give the senior coroner a written response to it*", there are no statutory provisions enabling the coroner to ensure positive action has been taken in an attempt to prevent future deaths. However, the coroner's role is deliberately an investigatory one, and the Chief Coroner himself in a lecture addressing the past, present and future of the coronial service in November 2023, commented "*That is as it should be, for they are judges, not regulators*".

It therefore remains a particular concern of inquest lawyers, patient safety organisations such as AvMA, and many of the bereaved families that we represent, that there is a lack of proper oversight following the issuing of a PFD report. The importance of these reports has been emphasised previously by Parliament (in upgrading PFDs from a rule (Rule 43 of the Coroners Rules 1984) to part of the Coroners and Justice Act 2009 (para.7, Schedule 5)) and by changing the coroner's discretion to make a report to a duty to make a report where a concern is identified during an inquest. However, once a PFD report has been made and following the conclusion of the coroner's inquest, very little else is often heard and it is difficult for lawyers and bereaved families to learn precisely what action has been taken in response to such reports, beyond the statutory duty for an initial written response to the coroner. There is no formal framework in place to monitor compliance or actions taken following inquests (whether a PFD is issued or not), and the same applies to public inquiries (such as Grenfell), investigations and official reviews. The potential for future deaths to occur, as a result of the same often systemic problems, is obvious.

One proposed solution to this lack of oversight, supported by AvMA and many lawyers working in this area, is the establishment of a National Oversight Mechanism to collate the recommendations from PFDs (as well as other inquiries and investigations) and to ensure that such recommendations are implemented. This would be a new, independent body with the responsibility to collate, analyse and follow up on recommendations made during inquests, public inquiries, investigations and official reviews. The National Oversight Mechanism would include a database of recommendations and responses, which would enable progress with compliance to be monitored, and of equal importance would allow

thematic findings to be shared. This would ensure that once a PFD report has been made following a coroner's inquest, there is accountability for ensuring changes are made and would increase the likelihood of further deaths being prevented.

Earlier this year a coalition of organisations, including AvMA, wrote to the Prime Minister Kier Starmer endorsing this solution, and highlighting that many public bodies simply do not take into consideration recommendations made during post-death investigations, in many cases not even bothering to respond. They called this "*a disservice to bereaved families who look to investigations for the truth, answers, and assurance that future deaths will be prevented*", and it is hard to disagree. Whilst the commitment to patient safety by those working in the public sector should not be doubted, it is safe to assume that many do not respond to or learn from these incidents at present simply because they do not have to. This is a problem that a National Oversight Mechanism would help to alleviate, as there would under the proposed mechanism be a legal requirement to respond. The coalition called for legislation to be brought forward immediately for the benefit of both bereaved families and in the wider public interest.

It is hoped that the new Labour government will respond positively to this proposal, which in the context of patient safety can surely only be a good thing. Those of us working in this area will have identified issues which arise time and again both regionally and nationally, and which have often been the subject of numerous PFDs. I am often asked by bereaved families following an inquest what can be done to ensure the hospital complies with any recommendations which the coroner has made in their case, and how they can be sure lessons are being learned. Too often my response has been that beyond a Freedom of Information Request (which is itself limited in its efficacy and time-consuming), not much, if anything, can be done. It would be helpful to be able to point to a National Oversight Mechanism which has real power, and which can ensure the concerns of bereaved families are taken seriously, with recommendations for change made by coroners being implemented.

Positively, a Private Member's Bill was presented to Parliament by Green MP Carla Denyer on 23 October 2024, calling for the establishment of a National Oversight Mechanism. There is of course no guarantee that this Bill will become law, but practitioners will be keeping a keen eye on its progress.

Are surgeons carrying out too much radical surgery on young women?

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XY v Mr. Neale Watson

We are all aware that treatment such as Botox injections, dermal fillers are increasing in popularity amongst young people and particularly young women who seem to be under even more pressure of trying to look "*perfect*".

The late Mr. Niall Kirkpatrick, a Consultant craniofacial Plastic Surgeon, demonstrated on many occasions how he was called upon to correct cosmetic treatments and surgery that had gone wrong. Too many of the treatments take place in unregulated beauty salons and are performed by unqualified practitioners. However, the case below does not relate to a beauty treatment but demonstrates how some practitioners are willing to perform radical surgery on young women without appropriate investigation as to whether this is in the best interest of the patient.

The Claimant was born on 3rd December 1995 and was therefore 22 years old on 3rd August 2018 when the Defendant carried out a hysterectomy and bilateral salpingo-oophorectomy on her. The procedure obviously rendered the Claimant infertile, and she underwent a premature menopause.

The extraordinary fact in this that the radical surgery was performed on this young woman not because she had any specific gynaecological issue but rather because she was experiencing severe depression which her relatives though and the Defendant decided was attributable to Pre-Menstrual Dysphoric Disorder (PMDD), a very severe form of pre-menstrual syndrome which causes a range of emotional and physical symptoms in the week or two prior to a period.

It was also an extraordinary fact and formed part of a central dispute in the case that it was alleged that the Defendant never actually met with the Claimant until the morning that this radical surgery was actually carried out. It was also argued by the Defendant that in any event a psychiatric evaluation of the Defendant, which was carried out in June 2018 in her home country, supported the contention that she understood fully the implications of the index surgery whereas the Claimant pointed out that the psychiatric evaluation was in fact performed to determine whether the Claimant had the capacity to consent to the index surgery. The Claimant argued throughout the proceedings that her case was a very complex one which required an evaluation by a multi-disciplinary team involving experts from the disciplines of psychiatry and gynaecology, that there was no evidence of her dysphoria being cyclical in nature and that it was not appropriate to perform this radical surgery on this young woman without such an evaluation nor was it appropriate to give her the impression that this radical surgery would provide an answer to her complex emotional needs.

The Claimant had a history of involvement with psychiatric services in her home country from the age of sixteen years old. In 2011 she was missing school, feeling low, not sleeping and self-harming. She attended at A&E on 26th December 2011 and was first seen by a psychiatrist who diagnosed her as suffering with depression.

In May 2014 she had depressive symptoms, anxiety was experiencing suicidal thoughts, self-harming, was struggling with friendships and family relationships and this led to her admission to a psychiatric unit for two weeks. She was discharged from hospital in order to allow her to complete her exams.

Although in May 2014 she completed a programme focused on teaching skills to replace the urge to engage in Non-Suicidal Self-Injury, she was admitted to hospital in November 2014 because she had taken an overdose.

The Claimant continued to experience emotional instability and incidents of self-harm although she managed to complete her third level education and obtain a degree in Health and Nutrition. She received different psychiatric diagnoses at times, including Anxiety, Depression, Emotionally Unstable Personality Disorder (EUPD), and Pre- Menstrual Dysphoric Disorder (PMDD), Cannabis Misuse and Alcohol Misuse, and Attention Deficit Hyperactivity Disorder (ADHD).

In 2017, the Claimant's family, who remained concerned about her emotional stability, contacted Prof. Studd in London. Prof. Studd had strong views that women with mood disorders were often wrongly diagnosed as suffering from psychiatric disorders and that this wrongly led to them being treated with anti-depressants rather than receiving HRT. In October 2017 Prof. Studd met with the claimant and her mother. He initially recommended three months chemical menopause with Zoladex injection together with Tibolone hormonal add back therapy. In January 2018 Prof. Studd reviewed her with her mother and noted severe PMS was present with rages, mood swings, suicide attempts and self-harming. He recommended adjustment of the hormonal therapy.

In March 2018, Prof. Studd had a telephone consultation with the claimant's mother and a discussion took place regarding the possibility of carrying out a hysterectomy to alleviate the claimant's difficulties.

In May 2018, a gynaecologist in the claimant's home country reviewed her and noted the severe mental health issues. It was documented that the claimant felt this was related to menses and it was also noted that she and her mother were requesting hysterectomy and oophorectomy. She wrote to Prof. Studd regarding the claimant's case and stating that she would want a joint discussion with a colleague before performing this surgery. On 15th May Prof. Studd recommended continuing with the hormonal treatment because he accepted that doing a hysterectomy in someone at this age of twenty-two was "*…very early even for me*".

On 25th May 2018 Prof. Studd wrote to the gynaecologist in the Claimant's home country and stated that she was very young and must think carefully about this surgery. He accepted that a hysterectomy and bilateral salpingo-oophorectomy (BSOD) would cure her cyclical depression, but he considered that continuing with the hormonal treatment could provide her with temporary relief.

In June 2018 a psychiatrist in the Claimant's home country carried out an assessment of her but this was primarily directed towards whether she had the capacity to consent to the radical gynaecological surgery and did not in any way make a recommendation that this surgery would deal with the Claimant's psychiatric problems.

On 19th June 2018 Prof. Studd wrote to the gynaecologist in the Claimant's home country. He noted that the claimant had several suicide attempts and both she and her mother wished to have a hysterectomy and BSOD which he considered would cure her problem, assuming that her problems were hormonal and not psychiatric. He referred to the fact that he gathered that she had a recent supporting letter from her psychiatrist.

In reply to Prof. Studd, the gynaecologist in the Claimant's home country stated that she was not reassured by Prof. Studd's change of opinion and that she considered that the decision for this radical surgery should only be taken in a multi-disciplinary setting. She cited the longitudinal nature of the claimant's attendance at psychiatric services versus the psychiatrist's single assessment and she considered that the Claimant required urgent psychiatric support.

The Claimant's mother then contacted senior gynaecologists in her home country to see what assistance could be obtained for her condition and because they were unable to see her for several months, her mother again contacted Prof. Studd's office. Prof. Studd was not available and so the Claimant's mother spoke to the Defendant and explained the situation to him. The Defendant then stated that he would carry out the surgery. Arrangements were made for the claimant to attend at the Spire Thames Valley Hospital for pre-operative checks on 25th July 2018.

When the Claimant attended for the pre-operative checks, she did not see the Defendant as all the necessary checks were performed by an appropriate nurse. Arrangements were then made for the surgery to be carried out on the 3rd August 2018. The Claimant flew to the UK with her father and mother on the evening of 2nd August 2018.

She attended at the hospital at 8am on 3rd August and the Defendant saw her in her room, went through a surgical consent form with her and she signed it. The allegation was that radical surgery was therefore duly carried out with the Defendant only seeing the Claimant on the morning of the surgery.

The Claimant asserted that there was an inadequate assessment of her condition, by the Defendant, that the decision to perform this radical surgery should have been taken in a multi-disciplinary setting and that there was completely inadequate consent to the surgical procedure, with the Defendant only seeing her on the morning of the operation.

The Defendant contended both in the Defence and in a signed statement to the Court that he had seen the Claimant on the 2nd August 2018 and had gone through the consent process. This was in direct conflict with the statements filed on behalf of the Claimant which contended that she did not arrive in London until the evening of 2nd August and that there was no meeting that evening with the Defendant. A Notice to Admit facts

was served on the Defendant which required him to admit that he had only seen her on the morning of the procedure. Although the Defendant's Response to the NTA did not accept that the first time he met with her was 3rd August, it did accept that neither the Spire Thames Valley Hospital nor the Defendant had any record of an appointment taking place on 2nd August 2018.

A further breakthrough came in the Claim when the Defendant indicated that he would not be filing evidence from an independent gynaecology expert. Judgment on breach was then entered but the Defendant then continued to argue that any breaches by the Defendant did not make a significant difference to the outcome of her condition on the psychiatric front and that the claim by her for surrogacy was flawed because he contended that she would never be accepted as a suitable candidate for surrogacy. The Claimant was prepared to argue this issue of causation, but the Claim subsequently settled a number of weeks prior to trial in the sum of £300,000. Although no breakdown of damages was agreed the estimated value of General Damages was £120,000, surrogacy costs in the sum of £150,000 and £30,000 in respect of treatment.

At the conclusion of the JSM the Claimant was given the opportunity to speak directly to the Defendant's representatives. In a very powerful and emotional victim impact statement, she set out the effect of the whole episode on her which moved those present and gave her empowerment and closure and left little doubt that the legal representatives would convey to the Defendant and all those carrying out radical surgery, the importance of appropriate investigation as to whether such radical surgery is in the best interest of the patient before carrying it out.

Forthcoming conferences and events from AvMA

Look out for details on more AvMA events coming soon!
For full programme and registration details, go to www.avma.org.uk/events
or email conferences@avma.org.uk

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.

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 after a six year absence on 5 February 2025, 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. Booking now open. Sponsorship and exhibition opportunities also 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. The programme this year has a focus on cancer, whilst also covering many other key medico-legal topics. Early bird booking will open by early November, with the programme available in mid-December. Sponsorship and exhibition opportunities 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 - £1,200 + VAT

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:

- Wounds – Prevention, Management & Healing Strategies
- AI & The Future for Lawyers
- Medico-Legal Issues in Invisalign Treatment
- Medico-Legal Issues in Dental Implants
- Arts Therapies within Neurorehabilitation And more….

Download our 2024 – 2022 Webinar List

AvMA Live Webinars in 2024 & 2025

The Aortic Dissection Trust with Graham Cooper and Catherine Fowler – *1 November 2024 @ 10:30am*

We are delighted to be joined by Graham Cooper & Catherine Fowler, from The Aortic Dissection Charitable Trust for a live webinar on Friday 1 November 2024 at

10:30am discussing Aortic Dissection. Over the course of the hour, our speakers will discuss:

- Background to The Aortic Dissection Charitable Trust
- Aortic Dissection explained
- Valerie's Story
- Where issues arise
- Q&A

Book your tickets today: https://www.avma.org.uk/events/avma-live-webinar-aortic- dissection/

Pre-Eclampsia during & after Birth – *10 February 2025*

We are delighted to be joined by Mr Karan Sampat, Consultant Obstetrician and Gynaecologist at Dartford and Gravesham NHS Trust for a live webinar on Monday 10 February 2025 discussing Pre-Eclampsia during and after birth.

Over the course of the hour Sampat will cover:

• Case series including eclamptic seizures

• The significance of a raised urine protein-creatinine ratio

• Placental growth factor, including applications

Further details and booking information will be available later in the year, for now please save the date!

Dispute Resolution in Clinical Negligence Cases –

6 March 2025 @ 10:30am

We are delighted to be joined by Paul Balen and Andrew Hannam, from Trust Mediation for a live webinar on Thursday 6 March 2025 @ 10:30am discussing Dispute Resolution in Clinical Negligence Cases.

Over the course of the hour, they will cover:

• The new landscape for Dispute Resolution:-Churchill, Protocols, Rules and penalties!

• Types of Dispute Resolution:- Mediation; evaluation; adjudication

• Preparation: selection of cases; documents; handling the claimant; extrajudicial remedies

• Trends!

Further details and booking information will be available later in the year, for now please save the date!

Welcome to our new Director of Fundraising, Marketing and Communications

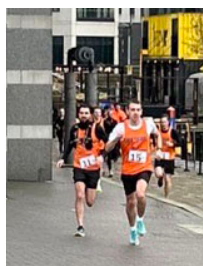
ANNA DEVINE
ACTION AGAINST MEDICAL ACCIDENTS

We are thrilled to introduce **Anna Devine** in the newly created role of Director of Fundraising, Marketing, and Communications at AvMA. Anna brings a wealth of experience and energy to this vital role, where she will focus on developing sustainable income streams, amplifying AVMA's voice and impact in patient safety and justice and expanding our reach to new audiences. Her work aligns with our new strategic plan and driving forward our mission to create safer healthcare for all. Welcome, Anna!

Lawyers' Service Directory

As we look ahead to 2025, we're embarking on an exciting digital transformation to better serve our community and partners. This includes developing a new website and campaign materials to expand our reach, enhance accessibility, and showcase the expertise of those who stand alongside us. In light of this, we have made the decision to discontinue the printed version of our Lawyers' Service Directory to focus on building a dynamic, sustainable online platform that aligns with this vision. Anna has written to firms who have previously advertised in the directory and if anyone requires any further information, please email Anna at:

anna@avma.org.uk



Kickstart #ACNC2025 with a Perfect Run!

Join us for a **5K fundraising run** in Bournemouth on **Wednesday, 19 March** at Meyrick Park, all in support of **AvMA**.

This exciting event is organised by **Circle Case Management** and proudly supported by **Enable Law** and **Clarke Willmott**.

Whether you run, jog, or walk, you'll be making a difference. Let's get moving and raise vital funds together!

Sign up now and #RunForAvMA:

www.avma.org.uk/5kRun

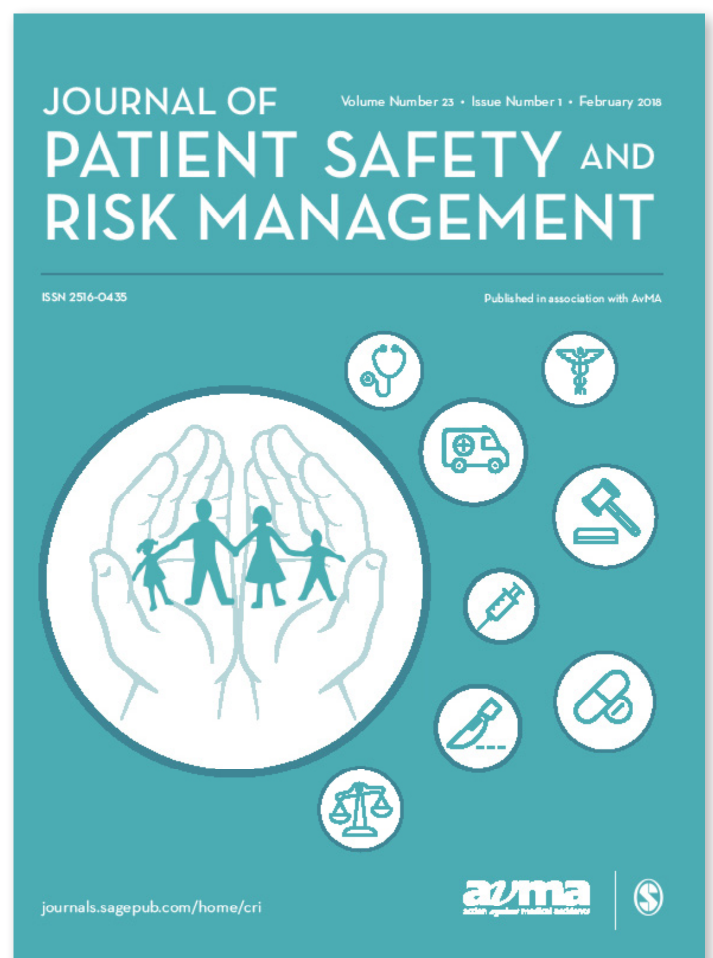
Journal of Patient Safety and Risk Management

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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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".

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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.