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Lawyers Service Newsletter

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Contents

Editorial

Lisa O'Dwyer
Director, Medico-Legal Services

At this time of year, AvMA is particularly busy preparing for the annual conference; we look forward to welcoming you to Leeds on 22nd – 24th June for what is going to be a very topical and interesting couple of days.

This year, the conference will be addressing everything from the effect of the discount rate, claims for accommodation and adaptations, to mediation. As ever, all of our presentations are by the leading practitioners in the field of medical negligence. If you have not yet booked, but want to please contact the conference team.

Fixed recoverable costs continue to cause concern

The consultation for fixing costs in low value clinical negligence claims closed on 2nd May and the Rapid Resolution and Redress scheme (RRR) closed on 26th May; AvMA's response to both consultations is available in full from our website www.avma.org.uk/responses-to-consultations.

We were pleased to be able to append a report we commissioned from Colin Campbell to our fixed recoverable costs (FRC) consultation response. Colin Campbell is a former permanent Costs Judge at the Senior Courts Costs Office where he continues to sit as a deputy. He has experience of assessing both high-value clinical negligence claims and cases valued at less than £25,000. He is also a costs mediator with Costs Alternative Dispute Resolution (CADR) group.

AvMA has consistently made the point that the FRC consultation is premature; the savings made following the introduction of the Legal Aid Sentencing & Prohibition of Offenders Act (LASPO) in April 2013 have yet to be fully assessed. AvMA considers that the starting point should be to examine the factors that give rise to increased costs and then tackle the causes; we have repeatedly made it known that we consider conduct to be a significant factor. Colin Campbell's opinion resonates with this view, in his report he says: *"...defendant conduct where there have been late admissions of liability or settlements immediately before trial are significant issues in this context".*

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Another of AvMA's key concerns has been that the FRC proposals simply push the cost of litigation onto the client, making low value claims economically unviable. Not only does that result in a lack of access to justice in real terms but it will also result in trusts ceasing to be accountable for failings in the care they provide as well as a loss of opportunity to address those failings and make necessary improvements. Colin Campbell comments: *"...That will lead either to injured parties being unable to recover compensation where something has gone wrong with their care or to an increase in the number of litigants in person who lack legal training to bring claims at proportionate expense, leading to a climate that is even more adversarial than it is now".*

Not only does Colin Campbell share many of the concerns raised by AvMA but he also says that the time suggested to undertake litigation tasks is grossly underestimated; the estimates do not, as asserted by the Department of Health (DH), reflect a case of average complexity. He calls the time estimates unrealistic and inadequate, and comments that they are likely to result in both dissatisfied clients and lawyers risking a claim in negligence.

National Audit Office report delayed

We have recently received news from the National Audit Office (NAO) that their report into whether the DH and NHS Resolution (formerly NHS LA) understand what is causing the increase in clinical negligence costs is to be delayed. The NAO report was originally expected at the end of July but, owing to the purdah brought on by the election, we are told that the report will not now be published until this autumn.

Safe space update

The safe space consultation response was published on 21st April. By way of recap, safe space aims to create an atmosphere which encourages staff to feel confident in coming forward to discuss serious and sensitive concerns about their practice. It aims to do this by preventing the disclosure of information provided in the safe space setting. The expectation is that patients and families will feel reassured that as a result of the safe space safety investigation, they can learn the facts of their, or their loved ones' care and what could be done to improve the safety of that care. The only way that disclosure might be obtained is by way of an order of the High Court; however the court should only make such an order where it is satisfied that it is in the interests of justice or where there is an immediate risk to patient safety or the commission of a criminal offence.

The response maintains that 60% of respondents were in favour of creating a safe space for the Health Safety Investigation Board (HSIB) investigations. The good news is that safe space is NOT going to be rolled out to local investigations at this stage, however this is likely to be revisited: *"In time...at the point where the principles of safe space have been tested and trusted ...we will consider extending the adoption of safe space to investigations undertaken by and on behalf of ...NHS funded care".*

The response makes it clear that whilst it currently cannot subject disclosure of material under an HSIB investigation to a general prohibition, the DH does remain open to considering legislation to give effect to this. This is an area that is likely to develop and AvMA is watching it carefully to ensure that patients can and do have access to relevant information and that safe space operates in a way that does not offend the statutory duty of candour.

Rapid Resolution and Redress

AvMA has welcomed the principle of a voluntary alternative to litigation for children who have experienced severe avoidable birth injury. We particularly welcome the RRR proposal to extend eligible claimants to include children who would have avoided harm if treatment had been performed to the standard expected of an 'experienced specialist'. The consultation suggests that an extra 40 children per annum may be eligible to claim under the 'avoidability' test. However, of equal importance is the focus on learning from mistakes and improving patient safety by (hopefully) reducing the number of birth injuries that occur.

On the face of it, the scheme may offer some positive improvements to the current system but it is not without its difficulties. Of particular concern is how the scheme can actually meet the needs of this group of severely injured children; the proposals suggest that successful applicants would receive 90% of the average litigation award. The average litigation award is identified as £6.25M.

AvMA is clear that any scheme of this nature must be underpinned by the provision of specialist legal advice. Further, RRR should not be introduced at the expense of the injured child, that is, by essentially deducting 10% from the average litigation award. No additional money is to be made available for this scheme. The consultation states *"All costs and savings are derived from NHS budgets as no additional funding is to be provided for the policy*

at this stage from HMT". It goes without saying that any alternative scheme must be able to genuinely meet a child's needs. The DH perceives RRR as an opportunity to strike *"... the balance between under-provision (leading to litigation) and over-provision (paying as much as is currently provided through litigation)...".* This may suggest that the DH does not appreciate that the court does not put a claimant in a better position than they would otherwise have been. It simply aims to put an injured person back in the position they would have been in had the negligence never occurred.

AvMA's underlying approach to both consultations has been that if the newly formed NHS Resolution does what it is set up to do, namely: *"keep cases out of the courts wherever possible, minimise legal costs and deliver resolution in its broadest sense, which is about more than just money",* then all clinical negligence cases should be investigated as soon as possible, early admissions of liability made where appropriate and cases resolved swiftly. This change of focus, if genuine, will enable the NHS to make considerable cost savings and learn lessons early on.

In this issue

As ever, we have a number of articles to help you with everyday practice, and in this edition of the LS Newsletter we are grateful to our authors: **Jennifer Newcomb of 9 Gough Square**, looks at the case of *Darnley v Croydon Health Services NHS Trust [2017]* and the scope of the duty owed by reception staff at A&E departments.

Fear of missing the limitation period is something that has kept most lawyers awake at night at one point or another; less attention might be given to whether the correct issue fee has been paid! **Andrew Roy of 12 KBW** looks at the recent case of *Wells v Wood* and asks: does payment of the incorrect court fee give rise to a limitation defence?

The negative discount rate and the Roberts v Johnstone conundrum is yet to be resolved. **Henry Pitchers and Jamie Gamble, both of No5 Chambers**, look at the difficulties with accommodation claims with particular reference to *JR v Sheffield Teaching Hospitals NHS Foundation Trust [2017].*

We are pleased to include **Dr Peter Ellis**' views on *"Medical Examiners and Death Certification Reform: Still in the Long Grass",* Peter practises at 7 Bedford Row; he also sits as an Assistant Coroner in London.

We include **Christopher Moran of Park Square Barristers, Leeds** write up on an AvMA case of the inquest touching on the death of BT. Dr Ruth O'Sullivan of AvMA was the case handler involved in this case.

I also take this opportunity to highly recommend a book by **Serjeants' Inn Chambers "Medical Treatment: Decisions and the Law"** an AvMA review of this book is included in this edition of the Newsletter.

We look forward to seeing you at the annual conference later this month.

Best wishes

Lisa O'Dwyer
Director Medico-Legal Services.

We would like to hear from you with any examples (redacted if necessary) of cases where disclosure has shed a very different light on the facts of the case as represented by the trust.

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Articles

A&E waiting times, receptionists and the provision of information to patients

Darnley v Croydon Health Services NHS Trust [2017] EWCA Civ 151

Is there any duty for receptionists to provide patients with accurate information about waiting times in A&E?

Background

On 17 May 2010, C was the victim of a violent blow to the head. He presented himself at an A&E department soon after, in considerable pain. The receptionist took his details and told him that he would have to wait for up to 4-5 hours before being seen. She did not say that a triage nurse would see him within 30 minutes, despite it being normal practice to do so. C waited 19 minutes before leaving unannounced. Tragically, his condition deteriorated, an ambulance was called to his mother's home and he was taken back to the A&E. Damage resulting from an extradural haematoma caused permanent injury and long term disabilities.

At trial, it was either found or agreed that a) had C been told he would be triaged in 30 minutes, he would have waited, b) triage nurses came to find him soon after he left, and c) had C been present when called for triage, his treatment would have been prioritised and he would have made a full recovery.

The claim for damages was brought predominantly on the basis of (1) negligence of the reception staff, in failing to take reasonable care to give accurate information to incoming patients about likely waiting times and (2) negligent failure to assess C within 15 minutes of arrival, as per NICE Guidance on patients with head injuries.

The claim was dismissed after trial. HH Judge Robinson concluded that the failure to triage within 15 minutes was not a breach of duty in the circumstances, having heard expert evidence that in a busy A&E with finite nursing staff, a triage within 30 minutes would not have been unreasonable. Further, it was not part of the reception staff's duty to give information about waiting times and there was no breach of duty in failing to provide accurate information or providing inaccurate information. There were good policy reasons for not imposing liability. C had to accept responsibility for his decision to leave.

C appealed.

The appeal

In dismissing the appeal in relation to an alleged failure to triage within 15 minutes, the Court of Appeal upheld the judge's conclusions on the evidence: in the circumstances, the 19 minutes it took the triage nurses to come and find C did not amount to a breach.

The scope of any duty owed by reception staff at A&E (or of D acting by its reception staff) to patients split the court. Jackson LJ and Sales LJ concluded that there is no general duty upon civilian receptionists to keep patients informed about likely waiting times. McCombe LJ, dissenting, reasoned that C was given incomplete and inaccurate information, imparted negligently, and that in the very particular circumstances of this case, there had been a duty which was breached.

The majority of the court was concerned in particular about matters of policy: that a duty to provide information about waiting times would open the floodgates, and lead to defensive practices of healthcare providers closing down this area of risk altogether by instructing reception staff to say nothing to patients apart from asking for their details.

Jackson LJ, giving the first judgment, considered the case of *Kent v Griffiths [2001] QB 36*, in which it was held fair, just and reasonable to impose a duty on the ambulance service to act in reasonable time after a member of their telephone service staff accepted a request for an ambulance to attend a call immediately. Jackson LJ distinguished that case on the basis that it is the function of ambulance telephonists to pass information to paramedics or patients, so that people can act on that information. However, the function of an A&E receptionist was to record details about a patient, tell them where to wait and pass on relevant details to triage nurses. It was appropriate for a duty to be imposed in the former case but not the latter *(Struggling with that distinction? You're in good company: McCombe LJ described it as "a distinction which I find myself unable to accept")*. Sales LJ put the difference another way: a person waiting for an ambulance would be induced to wait in the wrong place for medical assistance by a telephone assistant accepting

the call; a patient in A&E is already in the right place if his condition deteriorates.

Jackson LJ went back to first principles. Although it was reasonably foreseeable that a person who believed it may be 4-5 hours before they will be seen by a doctor may decide to leave, that was not enough to give rise to a duty to provide information about waiting times. It was not fair, just and reasonable to impose such a duty. Although C's complaint was not a failure to inform but the giving of incorrect information, it did not amount to an actionable misstatement. Sales LJ agreed that there was no positive misstatement by the receptionist, but rather a failure to speak and explain. In any event, according to Sales LJ, the case should not depend on subtle differences of language: information is provided as a matter of courtesy and out of a general spirit of trying to be helpful, and is not a matter of legal duty.

However, as McCombe LJ noted in his dissenting judgment, courtesy and a general spirit of helpfulness did not appear to be the motivation of this receptionist. C told the receptionist that he could not wait 4-5 hours because he felt he was about to collapse. She told him that if he did collapse, he would be treated as an emergency, and then pulled down the shutter at the reception. The information given could only have given the impression, McCombe LJ said, that C would not be seen or assessed by anyone sooner than 4-5 hours, short of something like a collapse, and was given in a manner that was both uncaring in tone and untrue. The functions of the hospital could not be divided up into those of receptionist and medical staff. If a hospital has a duty not to misinform patients, the duty is not removed by interposing non-medical reception staff as a first point of contact. It is the general duty of the hospital not to provide misinformation to patients.

Comment

McCombe LJ's dissenting judgment in this case is persuasive: his analysis of the particular facts demonstrates that it could have been decided differently without leading to litigation about who said what to whom in A&E waiting rooms becoming *"a fertile area for claimants and their representatives"*, or creating a *"new head of liability for NHS Trusts,"* as Jackson LJ feared it would. Would it be too onerous for hospitals to put up a sign on the wall about usual waiting times? Or provide a leaflet on arrival? Or as a matter of course explain the triage system on arrival, as was acknowledged to be usual practice at this A&E?

Perhaps the result of this case is best understood in light of the Supreme Court's conclusions in the case of *Montgomery v Lanarkshire Health Board [2015] UKSC 11*: patients are capable of accepting responsibility for the taking of risks affecting their own lives, and living with the consequences of their choices. In an age where patients are expected to be able to make fully informed decisions about their medical care, this case decrees that they ought also to take responsibility for decisions not to wait for that care, regardless of how long it might take to receive it. In his concluding remarks, Jackson LJ noted that *"there comes a point when people must accept responsibility for their own actions. The Claimant was told to wait. He chose not to do so. Without informing anyone of his decision, he simply walked out of the hospital"*.

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Articles

Payment of the incorrect court fee; does it give rise to a limitation defence? (Answer: almost certainly not)

Wells v Wood, Lincoln County Court, HHJ Godsmark QC 9 December 2016, 2016 WL 07330089

Introduction

In the professional negligence case of *Lewis v Ward Hadaway* [2015] EWHC 3503 (Ch); [2016] 4 W.L.R. 6 several claims were held to be statute barred as a result of underpayment of court fees.

Lewis has generated no small amount of enthusiasm on the defendant side and anxiety on the claimant side. These reactions have proved misplaced.

Subsequent reported attempts to deploy *Lewis* have not been successful. The most recent of these, *Wells v Wood*, makes clear that the scope for its application in personal injury cases is vanishingly small.

Lewis

In this case the claimants (as in their solicitors) delivered the claim forms to the court just before the expiration of the limitation period. However, they deliberately understated the value on the claim forms in order to defer paying the full court fee (which, had they decided not to serve, would never have been paid). They subsequently amended shortly before service to reflect the claims' true value, paying the appropriate fee at that later time.

Mr John Male QC held that, although this conduct constituted an abuse of process, it would be disproportionate to strike the claims out on that basis. This was notwithstanding that the same solicitors had been subject to heavy criticism by other judges in earlier cases for precisely the same practice.

However, the same discreditable behaviour led to some of the claims being subject to summary judgment on the basis that the failure to pay the appropriate fee meant that they had not been brought within the limitation period.

The distinction between proceedings being "brought" rather than "issued" is important. The issuing of proceedings is an act of the court. Bringing proceedings is an act of the claimant preparatory to the court issuing them. Proceedings can therefore be brought on a date earlier than that upon which they are issued. See **CPR PD 7A 5.1**:

5.1 Proceedings are started when the court issues a claim form at the request of the claimant (see rule 7.2) but where the claim form as issued was received in the court office on a date earlier than the date on which it was issued by the court, the claim is 'brought' for the purposes of the Limitation Act 1980 and any other relevant statute on that earlier date.

The general effect of this was confirmed in *Barnes v St Helens MBC* [2006] EWCA Civ 1372; [2007] 1 W.L.R. 879. The Court of Appeal held therein that where a claimant took the steps required to enable the proceedings to be started that was sufficient. It reasoned that expiry of the limitation period was fixed by reference to something that the claimant had to do, rather than something which someone else such as the court has to do. Once the claimant had taken all reasonable steps to set the process in motion, the risk of any delay was transferred to the court and not visited upon the claimant. Therefore, if a claimant established that the claim form was delivered in due time to the court office, accompanied by a request to issue and *the appropriate fee*, that was sufficient to stop the limitation clock running.

In *Lewis* it was held that, although the claim form was delivered in due time to the court office, accompanied by a request to issue, it was not accompanied by the appropriate fee. Paying "the appropriate fee" did not cover the payment of a fee in circumstances where the act of payment was an abuse of process. This followed *Page v Hewetts Solicitors* [2013] EWHC 2845 (Ch); [2014] W.T.L.R. 479 where it was held that the underpayment of the court fee due to inadvertent miscalculation precluded a claimant from arguing that proceedings were brought before they were issued. A fortiori, by adopting a manner of fee payment which was an abuse the claimants had not done all that they reasonably could do to bring the matter before the court for its process to follow so that the claimants' risk would cease. Therefore, those claims in which proceedings were not issued before limitation expired were statute barred notwithstanding that the claim forms were delivered to court before the expiry date.

Subsequent cases

The first reported case in which *Lewis* was deployed, *Bhatti v Asghar* [2016] EWHC 1049 (QB); [2016] 3 Costs LR 493, was inconclusive. The claimant brought claims for breach of trust, breach of contract and misrepresentation. The damages claimed were a little under £1 million. Proceedings were issued close to the expiry of the limitation period for the breach of contract claims. The defendants applied for summary judgment or the striking out of the breach of contract claims but did not set out the basis upon which this was sought until 3 weeks after the application notice had been served. This was only shortly before the hearing of the application, which was itself only a month before trial was due to be heard (and 18 months after proceedings were issued).

The basis for the applications, as eventually stated, was that the claimants had not paid the correct court fees, with the result that the action had not been properly brought and the limitation period for the breach of contract claims had expired. They submitted that the first claimant should have paid an additional £680 and that the second claimant should have paid an additional £480.

Applying *Page* and *Lewis*, Warby J held that an action was only "brought" for the purposes of limitation where a claimant had done all it could to set the claim in motion, including paying the court fees. However, the Judge also noted that, in principle, a failure by the court itself could result in a claim being brought without the correct fee if court staff had made an incorrect calculation which was not the claimant's fault; in that case the claimant would have done all it could reasonably do.

Because the defendants had not raised limitation in their Defence or in their written application, the claimants had not had the opportunity to address the issue of whether they had in fact done everything in their power to bring the claim and to produce any evidence to show that the miscalculation of court fees had been the court's fault. Accordingly, the defendants' application was dismissed and the question of whether the failure to pay the correct fees meant that proceedings had not been brought for the purposes of limitation was left for the trial.

There is no report of the subsequent trial. The matter presumably settled. Given that the earlier application was in fact dismissed, Warby J's remarks as to the scope of *Page* and *Lewis* must be obiter.

An argument that an amendment to increase the value of the claim fell foul of limitation in light of *Lewis* was dismissed in *Glenluce Fishing Co Ltd v Watermota Ltd* [2016] EWHC 1807 (TCC); [2016] 5 Costs L.R. The claimant issued professional negligence proceedings close to limitation. The amount claimed was c. £69,000. The court fee appropriate to that amount was paid. The Particulars of Claim served after the expiry of limitation pleaded damages of £162,000. The claimant sought permission to amend the value on the claim form to reflect this, volunteering to pay the increased fees. The defendant resisted this amendment on the basis that the higher court fee should have been paid on issue and that as a result the amendment was outside the limitation period.

Mr Roger Ter Haar QC allowed the amendment. He held that, insofar as the amendment produced a new claim, it was not a new cause of action but merely an alteration to an existing head of claim. There was no prejudice to the defendant. There was no abuse of process.

The deputy judge's reasoning is instructive. At [39] he expressed scepticism at the result in *Page*, supra:

Some might find it surprising that because of a bona fide error by the claimants' solicitors as to the calculation of a court fee by a few hundred pounds, the claimants found themselves unable to pursue a claim which they contended was worth six figures, thus being thrown onto the tender mercies of a battle with their solicitors and the professional indemnity insurers behind those solicitors – this in a case where the whole basis of their claim was that they had been wrongly treated by their previous solicitors.

In respect of limitation, he observed at [40] that "*In the context of claims where the claimants had deliberately flouted the rules of court, that decision is understandable*". However, he then said at [47] that *Page*, *Lewis* and *Bhatti* had:

... developed a somewhat hard edged principle as those cases have been applied at first instance whereby a claimant whose lawyers miscalculate the fee due, or absentmindedly pay the wrong amount, may cause a claimant to lose his or her right to bring an otherwise meritorious claim to court. At present it seems that the fact that the Defendant has suffered no prejudice and indeed may receive an unexpected benefit finds no place in the principle, and there appears to be no relief from sanction available from the court. It may be that as this principle is discussed and developed in future cases, those hard edges will be softened.

Unsurprisingly, then, he was unwilling to extend this principle to applications to amend.

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An even more ambitious argument was advanced in *Dixon v Radley House Partnership* [2016] EWHC 2511 (TCC); [2017] C.P. Rep. 4. It was argued here that, following *Lewis*, that an amendment to increase the value of the claim gave retrospective rise to a limitation defence even when proceedings had been issued in time.

Mr and Mrs Dixon brought professional negligence claims against the defendants. They delivered claim forms seeking damages of less than £50,000 together with the appropriate court fee for that amount. The court issued proceedings. In respect of some, but not all, of the causes of action limitation had not yet expired by the time of issue. The Particulars of Claim subsequently served claimed increased damages. The claimant sought permission to amend the value on the claim forms to reflect this, volunteering to pay the increased fees. The defendants sought permission to amend their defences to plead limitation relying upon *Lewis*.

Stuart-Smith J refused permission on the basis that the proposed amended defences had no real prospect of success. He observed at [24] that:

Neither defendant alleges that the claimants' behaviour was abusive procedural conduct. It follows that, if the defendants are right, any and every claimant who has issued proceedings without paying the fee that may retrospectively be seen to be appropriate for the claim it articulates, either at the time of issue of proceedings or subsequently, has failed to stop time running for the purposes of [limitation].

He rejected the argument that the ambit of *Lewis* was so wide, or should be expanded. He held at [33]:

There is no statutory provision, either in the relevant orders or elsewhere, which either states or implies that issued proceedings are in any sense invalid or ineffective if the court issues them in the normal way but having accepted a fee which either is or becomes less, than the proper fee for the claim. It is, in my view, obvious that the payment of fees is primarily the concern of the court, which looks to the payment of fees as a source of revenue.

He further held that the issue of proceedings stopped time for the purpose of limitation, and the fact that time could be stopped before then under **CPR PD 7A 5.1** did not change that. *Page* was authority for what a claimant had to do to stop time running before issue. It was not authority for the proposition that proceedings being issued did not stop time running because the court fee was insufficient.

The deputy judge agreed with the result in *Lewis* on its specific facts, but held that it did "*not say or imply that a non-abusive under-payment of a fee means that the issuing of the claim form by the court is ineffective to stop time running*". Indeed, in *Lewis* those claims issued in time survived. That distinction appeared not to have been taken by the claimants in *Bhatti*.

That left the causes of action in which proceedings were issued after the expiration of the limitation period. The question here was whether they were nevertheless brought in time. That turned on what constituted "an appropriate fee"

The deputy judge observed that *Page* did not address what would be the position if the relief sought was something other than a single identified liquidated sum (for which the correct court fee could not be disputed). It was worth pausing to note that this is a point of distinction between *Page* and virtually all personal injury claims.

The deputy judge was not persuaded that the appropriate fee could not simply be determined by reference to what a claimant had offered and the court had accepted. He held that the appropriate fee should be that as required by the relevant order (i.e. by reference to the value of the claim). However, he held at [53-55] that this was not to be judged retrospectively:

... the "appropriate fee" should be determined by reference to the terms of the claim form that is issued (or, if particulars of claim are issued simultaneously, the claim form and particulars of claim combined) ...the fact that the quantum of a claim or claims is subsequently increased is irrelevant to the calculation of the fee payable on issue, assuming always that the claimant's behaviour is not abusive ... In the absence of abusive behaviour, it is not to be determined by reference to claims which are articulated later, whether or not the later claims are ones which the claimant hoped or even intended to bring later at the time of issuing proceedings.

The defendants arguments here therefore failed with a thump. The judge confirmed in a subsequent costs ruling ([2016] EWHC 3485 (QB)) that he:

... thought that the point being taken by the defendants on the application was thoroughly bad. Whether it is right to describe it as an unarguable [sic] *when Miss Lee manfully argued it for most of the day is another question, but it seems to me that it was as close to being unarguable as one is likely to get*

Wells

Mr Wells was injured in a road traffic accident on 27 September 2012. Proceedings were issued 5 September 2015, and thus in time. The claim form certified that the value of the claim was no more than £15,000. Accordingly, the correct fee was £675, but the claimant inadvertently paid only £455. The Particulars of Claim, which were served in December 2015, indicated that damages were expected to exceed £25,000. The evidence was that this increase reflected difficulties in valuing the claim accurately. The claimant obtained permission to amend the claim form's value certificate to £25,000 with effect from 24 April 2016, and paid the increased court fee. The defendants alleged that failure to pay the correct fee meant that the claim was statute barred even though it had been issued in time.

HHJ Godsmark QC rejected the defendants' "far-reaching submission" on a number of grounds:

There was no satisfactory explanation for the status of the proceedings if that were the case. There was no suggestion that the claim was invalid for all purposes, only for the purposes of limitation. Thus the suggestion seemed to be that proceedings issued with the wrong court fee are valid unless limitation is pleaded, and therefore in effect voidable at the defendant's option. This in turn gave rise to the position where there are multiple defendants some of whom plead limitation and others do not.

It was legitimate for a claimant deliberately to decide to limit the value of a claim: *Khiaban v Beard* [2003] EWCA Civ 358; [2003] 1 W.L.R. 1626 *at [13]. If the position changed, on the defendants' argument such a claimant would be barred from seeking to amend the claim or vulnerable to an application to strike out.*

The payment of the appropriate court fee was a matter between the paying party and HMCTS. It was undesirable that it be subject to inter partes scrutiny, possibly at an advanced stage in the litigation or in cases where the fee has been remitted.

In some instances proceedings had to be issued before quantum could be ascertained, and thus before the correct fee could be identified.

CPR 7.2 was clear that proceedings started when the claim form was issued. Neither the rule nor **CPR PD 7A** mentioned fees.

The rules expressly provided for sanctions for non-payment of fees in other circumstances. In particular, **CPR 3.7A** provided that if a counterclaim was filed without the appropriate fee the filing remains effective but the counterclaim was vulnerable to being struck out if the notice requiring payment was not complied with. It would be peculiar if non-payment of fees meant that limitation continued to run on a claim but not a counterclaim.

The judge therefore held at [30] that:

... a claim form issued by a court and sealed is effective for limitation purposes regardless of the fee paid. Issue of the claim form marks the commencement of proceedings. Such an approach provides certainty as to the date of bringing of proceedings (subject to paragraph 5 of Practice Direction 7A). It also avoids what I regard to be the undesirable potential for satellite litigation surrounding what the appropriate fee would have been in particular circumstances around the time of issue.

Review of authority did not lead to any different conclusion. As the judge held at [54]:

In none of the cases has it been concluded that a claim form issued and sealed by the court (regardless of fee paid) is not effective to stop the limitation clock.

The authorities do point to what is necessary to bring a claim before the claim form is issued. What is required is that the Claimant do all in his power to set the wheels of justice in motion (including payment of the appropriate fee).

A claim may be struck out as an abuse of process if there is a deliberate decision to avoid paying the appropriate issue fee. However the finding of such an abuse of process and the courts discretionary reaction to it are quite separate from the limitation status of a claim.

He thus concluded that *"the starting of a claim will incorporate the bringing of a claim. I do not accept that a claim form can be issued and thus the claim started without that claim also being brought* [for the purposes of limitation]."

On the same basis he held that the underpayment of the court fee did not make any difference:

In my judgment questions of payment of court fees are primarily between the paying party and HMCTS. Such matters may become of interest to other parties where it is alleged that there is abuse of process or in the particular circumstances of investigating whether a party has done all in its power to set the wheels of justice in motion so as to have brought the claim before issue. It may be that on having a shortfall in payment brought to his or her attention a Judge will stay a claim pending payment of the correct sum but that will be a judicial decision. Otherwise non-payment of the correct fee may well attract the

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operation of CPR 3.7 and 3.7A with notices being sent giving an opportunity to pay before being struck out.

The judge further held that:

He was in any event bound by *Dixon*, which did not conflict with *Page* and *Bhatti*.

If he was wrong and there was a conflict, he preferred the reasoning in *Dixon*.

In any event, even if the claim had been time barred, it would have been equitable to disapply the limitation period pursuant to **s33 Limitation Act 1980**.

Discussion

It is clear from the above that it will only be in a truly exceptional personal injury case that payment of the incorrect court fee will give rise to a limitation defence. There are several reasons for this.

Firstly, the argument will only even potentially be available when the court has not issued proceedings within the limitation period. It is thus limited to cases where the claim form is delivered to court before limitation expires but issued afterwards. This will be a small cohort.

This will be so even if there has been a deliberate or otherwise abusive failure to pay the proper fee. The egregious features in *Lewis* of deliberately adopting an unacceptable practice across many cases despite repeated previous judicial criticism are striking and exceptional. Yet even there the result was only that some of the claims were struck out. The abuse by itself was not sufficient. Those claims that were issued in time survived.

Secondly, even in such cases a claimant will not always be precluded from relying on **CPR PD 7A** to contend that proceedings were brought before they were issued. This will only be so where there is either abusive conduct or otherwise the fee paid is clearly too low at the time of issue. That will only rarely be the case in claims for personal injury where damages are inevitably unliquidated and their level subject to dispute and change.

Thirdly, absent abuse a claimant would often have a good (and in many instances unanswerable) case for relief under **s33**. That is an important distinction with claims such as *Page* where the limitation period was strict and a miss was as good as a mile. Moreover, even in a non-personal injury claim there might be an argument (not apparently explored in either *Page* or *Lewis*) for relief under **CPR 3.9** and/or **3.10**.

That is not to say that claimants' advisers should be casual about paying the correct court fee. It is always unwise needlessly to expose a claimant to a limitation defence, even a weak one. In particular, when up against limitation, claimants should ensure that there is no disjunction between the court fee and the value on the claim form (and Particulars if issued at the same time). It also needs to be borne in mind that "up against limitation" in this context means close enough to the expiration of the limitation period that there is a risk that Court might not issue proceedings within it. This needs to take account of the possibility of delays due to administrative failings, lack of resources, strikes and so forth.

That said, save in extreme and exceptional cases, defendants should be encouraged not take what would be a bad point. If they nevertheless insist in doing so then, save in such extreme and exceptional cases, claimants should feel confident in resisting these arguments.

ARTICLE BY

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What is the future for accommodation claims?

The Roberts v Johnstone approach under a negative discount rate

0n 27 February 2017, the Lord Chancellor (at the time of writing), Liz Truss, announced that the discount rate would be reduced from 2.5% to -0.75%. Since 2001, the discount rate had remained unchanged at 2.5%. It is fair to say that the scale of the change took virtually all practitioners by surprise. For obvious reasons, such a substantial reduction to the discount rate has a very large inflationary impact on many claims for future losses calculated by way of multipliers and multiplicands. Perhaps an unintended consequence was to throw the conventional calculation of accommodation claims into chaos.

It is important that we define the issue under consideration. In the more serious cases, it is commonplace for the expert evidence to establish that a claimant reasonably needs to move to alternative accommodation. That accommodation may be larger, on a single level or otherwise more suitable to meet the long-term demands of the claimant. Invariably, the alternative accommodation will be more expensive.

There are certain aspects of the assessment of such heads of loss which remain conceptually straightforward to calculate under the new discount rate. For example, there will be one-off costs of moving: stamp duty, solicitors' fees, relocation costs etc. There will also be future costs, which can be calculated by the use of a normal multiplier and multiplicand: adaptation costs (subject to any betterment), increased utility bills, higher rates of council tax, additional maintenance expenditure, etc. We will not linger on these parts of an accommodation claim.

The difficulty for the courts will relate to how properly to compensate the Claimant for the *increased capital outlay* for the property itself. To take a simplified example for the purposes of illustration: if a claimant already owns a property worth £250,000, but needs to spend £750,000 to acquire one that meets his needs, how should the shortfall of £500,000 be provided for in his award of damages? We will assume no further adjustment for any betterment arising from adaptations to be made to the property.

In *Roberts v Johnstone* ([1989] QB 878 CA), the Court of Appeal identified the correct approach, which, until 26 February 2017, had become a routine calculation ever since. The court should award a percentage of the net capital cost (i.e. in our example, x% of £500,000) and apply it to the multiplier for life (assuming the housing need would persist for life). So, a notional annual sum or multiplicand should be arrived at. This solution followed years of argument and judicial struggle. Defendants argued that a plaintiff would be overcompensated were they awarded the full capital sum. They would be able to use the money to buy an appreciating asset (the house) and that sum plus its profits would be available for the full benefit of their heirs on their death. The Court of Appeal in *Roberts v Johnstone* regarded buying the suitable property as akin to the purchase of an investment which was secured against the risk of inflation. The claim could be considered more in terms of the lost income and investment which might have been achieved, had the capital sum not been tied up in a property. The rate was set at 2% in that case, but fell into line when the discount rate was set in 2001 at 2.5%.

It is fair to say that there had already been much criticism of the *Roberts v Johnstone* approach, long before the Lord Chancellor set a negative discount rate. It had been criticised by both the Law Commission in 1999 and by the Civil Justice Injury Committee in 2010. Neither of the reports which followed came to a clear recommendation as to a preferable alternative mechanism.

Now that we have a *negative* discount rate - which implies a net loss on capital rather than a profit - it can be argued by defendants that there is no loss on the capital and that no award should be made with regard to that aspect of the accommodation claim. This argument has now been tested in the higher courts. Mr Justice Davis had to grapple with it in *JR v Sheffield Teaching Hospitals NHS Foundation Trust* **[2017] EWHC 1245 (QB).** He was assessing damages in a cerebral palsy claim where the (now 24 year-old) claimant had been left with severe disabilities. It was not in dispute that the claimant's current accommodation was wholly unsuitable and that a new property needed to be purchased which would have to be substantially adapted.

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The defendant submitted, however, that the conclusion that must be drawn from the reduction in the discount rate to -0.75% was that there is, at present, no ability to obtain any positive return on a capital fund based on risk-free investment. There was therefore no need to compensate the claimant for the loss of return on the capital that would be required to purchase the alternative accommodation (the basis for the *Roberts v Johnstone* formula). It was said that the cost of the accommodation could be borrowed from the capitalised loss of earnings figure (which was in excess of £1 million). This "so-called loan" would be repaid to the claimant's estate on his death, by which time it is likely that the property would have appreciated in value (given that the one type of investment which is likely to continue to yield a return in the long term is real property).

The claimant argued that whilst *Roberts v Johnstone* remained binding, that decision was a pragmatic solution to the problem of providing accommodation to those who needed it and the percentage set by the Court of Appeal was "arbitrary". It was submitted that the court should assess the accommodation by reference to a multiplicand based upon a positive percentage, suggested to be 2.5% as had been the previous conventional figure, and to avoid a windfall benefit the sum recovered should be capped at the capital cost of the accommodation to be purchased.

In deciding this issue Davis J felt himself bound by *Roberts v Johnstone* to make a nil award for the cost of special accommodation (other the costs of adapting the accommodation, increased running costs and relocation costs, which were assessed at £840,000). He went on, however, to make some further comments about the approach that might subsequently be adopted which may give claimants some hope in relation to the outcome of the appeal to the Court of Appeal (permission for which was granted):

"49. I consider that the editor of McGregor [on damages] was quite correct when he opined that a fair and proper solution should be found to the conundrum of providing a claimant with the means to purchase special accommodation. He also was correct when he suggested that a negative discount rate would mean that the approach in Roberts v Johnstone would lead to a nil award. But I am not in a position to find "the fair and proper solution" to the problem as a whole. I am faced simply with the case of this Claimant. In his case maintaining the conventional approach would provide him with the full capital cost of the accommodation, something which clearly would be wrong. I have no evidence which would enable me to consider some other approach. For instance, given the current cost of borrowing, it might have been possible to say that the interest element on an appropriate mortgage (say £600,000 as the cost of a property less the amount of general damages) over a 25 year term would provide a reasonable figure, the cost of annual mortgage interest being the alternative method of assessment suggested in George v *Pinnock. It was rejected in Roberts* v *Johnstone* because the rate of mortgage interest at that time was so high that an award on that basis would result in full recovery of the capital cost of the accommodation. That is no longer the case. However, I have no evidential basis for using such a calculation and none was put forward. In other cases prior to the change in the discount rate it has been suggested that a defendant could take a reversionary interest in the property purchased in which event providing the full capital cost would not involve any windfall benefit; rather it would simply provide the claimant with the accommodation he needs for his lifetime. This solution (so it is said) would remove the imperfection inherent in *Roberts* v *Johnstone. It certainly is superficially attractive. But no such solution was proposed here and again I have no evidence which allows me to adopt it."*

So, it is plain that Davis J was open to an alternative method of calculation, but felt that he did not have the evidential basis to adopt one. He was, of course, also bound by the decision of *Roberts v Johnstone*.

We hope that the appeal to the Court of Appeal can be expedited in so far as it is possible, as there is a great deal of uncertainty presently as to how the courts will deal with net capital losses. This is a barrier to settlement. In our view, there are a number of ways in which the Court of Appeal (in this case or another) might resolve the present conundrum:

1. *Roberts v Johnstone* could be applied strictly and no award made. This would clearly be a major defeat for claimants, some of whom may not have sufficient "fat" in other heads of loss (such as loss of earnings) from which to borrow to buy the property they need.
2. The most generous approach would be simply to award the full net capital sum to the claimant. Many regard this as unlikely. It might be more palatable were a claimant to offer a defendant a charge over the property to ensure no "windfall" to him or his estate.
3. Perhaps the more likely solution will be to identify an alternative, notional method of compensating a claimant. This could be by reference to mortgage rates (although the need to adduce specific evidence as to

this is made plain by the decision in *JR*). It could be by reference to notional rental costs (actually renting is generally wholly unsatisfactory to claimants save as an interim measures).

It seems to us that there are other ways around the present conundrum but these are (currently at least) outside the jurisdiction of the court. A defendant could agree to purchase a property and give the claimant a life interest. This may well be unattractive to both parties and would raise serious practical problems in terms of future moves or adaptations. It has also been suggested that a defendant could give an interest free loan to a claimant, which would enable them to buy a suitable home. However, this may run counter to the terms and articles governing the operation of insurance companies, even if it were regarded as desirable to both parties.

We await the decision of the Court of Appeal in *JR* with interest. Whether any variation to the *Roberts v Johnstone* calculation will survive any future return to a positive discount rate remains to be seen.

ARTICLE BY

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Medical examiners and death certification reform: still in the long grass

It is almost 20 years since Dr Harold Shipman was arrested. Although he was convicted of murder on the basis of 15 test cases, it is likely that he killed at least 200 other patients[1]. He escaped detection for a considerable time, by certifying the deaths of the patients he murdered as being due to 'natural causes'. Certification by a second doctor was then, and remains now, necessary only in cases where the body is to be cremated.

Beginning in 2003 with the Home Office Luce Review and the Third Shipman Inquiry Report, successive investigations have called for urgent reform of the process of death certification and investigation, in order to close this potentially lethal loophole.

The Third Shipman Inquiry Report highlighted the need for a new Coroner Service to: *'...seek to meet the needs and expectations of the bereaved. Its procedures should be designed to detect cases of homicide, medical error and neglect. It should provide a thorough and open investigation of all deaths giving rise to public concern...'*[2].

In its introduction the Luce Review observed: *'...During the last three-quarters of a century, the Government has twice commissioned reviews of these subjects, in 1936 and 1965. Very little happened in response to their reports. The services are showing the consequences of this neglect. We, and those whom we have consulted, hope that the inaction will not continue...'* [3]

A key feature of the new death certification and investigation regime envisaged in 2003 was a statutory medical examiner. This would be a doctor working alongside each coroner. He or she would be responsible for auditing the death certification performed by doctors in the area, dealing with many of the natural cause deaths reported to the coroner, helping the coroner with the medical aspects of their investigations, and acting as a bridge between the coroner service and the worlds of public health, healthcare, and public safety.

They would not be pathologists, but would be registered medical practitioners of at least five years' standing. It was envisaged that they would mostly be recruited on a part-time basis, performing medical examiner duties along with other clinical work as GP's or hospital doctors.

The medical examiner would also be the second of two doctors certifying all deaths not reported to the coroner, not just cremation cases. He or she would confirm that the certificate was in order, be available for consultation with the family if they wished, and give authority for the burial or cremation of the body.

In 2006 the Government published a draft Bill: 'Coroner Reform: Improving death investigation in England and Wales'[4]. In the introduction Lord Falconer observed: '... we will also be providing coroners with significant new medical expertise to help inform their decision making. There will be a new Chief Medical Adviser to the coroner service to whom the Chief Coroner can look for advice on strategic medical issues, and each coroner will be funded to buy in medical support, in consultation with the local authority, which is best suited to meet local needs. In these ways we will address weaknesses that have become increasingly evident over the last 20 years...'.

In 2007 the Department of Health published: 'A Consultation on Improving the Process of Death Certification'.

The Coroners and Justice Act 2009 received Royal Assent in 2009. The 2009 Act, as amended by the Health & Social Care Act 2012, provided for local authorities (in England) and local health boards (in Wales) to appoint persons as medical examiners in order to fulfil the role envisaged by the Luce Review. It also provided for regulations to be made for medical examiners to act as the second death

1 *First Shipman Inquiry Report (July 2002), Chapter 14, 'The Numbers'. Available from:* ***http://webarchive.nationalarchives.gov.uk/20090808154959/http://www.the-shipman-inquiry.org.uk/reports.asp***

2 *Third Shipman Inquiry Report (July 2003), 'Death Certification & the Investigation of Deaths by Coroners', Chapter 19, 'Proposals for Change'. Available from:* ***http://webarchive.nationalarchives.gov.uk/20090808154959/http://www.the-shipman-inquiry.org.uk/tr_page.asp?id=56***

3 *'Death Certification and Investigation in England, Wales and Northern Ireland: The Report of a Fundamental Review'. Available from:* ***http://webarchive.nationalarchives.gov.uk/20131205100653/http:/www.archive2.official-documents.co.uk/document/cm58/5831/5831.pdf***

4 *Available from:* ***http://webarchive.nationalarchives.gov.uk/+/http:/www.justice.gov.uk/docs/coroners_draft.pdf***

certifier, and for the appointment of a National Medical Examiner.

However, the medical examiner provisions never came into force. Instead, from 2008, seven medical examiner pilot schemes funded by the DOH in Sheffield, Gloucester, Powys, Leicester, north London, Brighton and Hove, and Mid Essex, were tasked with scrutinising over 23,000 deaths. These pilot schemes were reported to show numerous clear benefits[5]:

- Improved accuracy of death certification. The certification of death is often delegated to junior doctors and is not always accurate. When death certificates were checked by a medical examiner, the underlying cause of death was recorded differently in 22% of cases.
- Helping to avoid unnecessary distress for families, by listening to their concerns and providing reassurance. Bereavement support groups involved in the pilots were universally supportive.
- Providing reassurance to families about the terms used on the death certificate, as families often found the medical terminology difficult to understand.
- Identifying trends in unexpected causes of death, for example clusters of fatal post-operative infections.
- Ensuring that the right deaths were referred to a coroner for investigation, and avoiding unnecessary post mortem examinations. When the certifying doctor was unsure of the need for coronial referral, a discussion with the medical examiner usually clarified the position.
- Establishing close working relations between medical examiners and the local coroner's office. Coroners welcomed the improved quality of medical information they received.
- Immediate referral of avoidable deaths to the coroner. This resulted in faster coronial investigations and reduced the distress for relatives.
- Helping to foster candour in the NHS. Health professionals who raised concerns felt supported and protected by the authority and independence of the medical examiner.
- Discussing and defusing potential complaints, through better explanation of the cause of death. In one pilot, there was a substantial fall in complaint and litigation costs.

Subsequently the Francis Inquiry report[6], published in 2013, also made a number of recommendations about death certification and inquests relating to medical examiners and hospital deaths:

- Independent medical examiners should be independent of the organisation whose patients' deaths are being scrutinised.
- Sufficient numbers of independent medical examiners need to be appointed and resourced to ensure that they can give proper attention to the workload.
- Death certification national guidance should set out standard methodologies for approaching the certification of the cause of death to ensure, so far as possible, that similar approaches are universal.
- It should be a routine part of an independent medical examiner's role to seek out and consider any serious untoward incidents or adverse incident reports relating to the deceased, to ensure that all circumstances are taken into account, whether or not referred to in the medical records.
- So far as is practicable, the responsibility for certifying the cause of death should be undertaken and fulfilled by the consultant, or another senior and fully qualified clinician in charge of a patient's case or treatment.
- Appropriate and sensitive contact with bereaved families. Both the bereaved family and the certifying doctor should be asked whether they have any concerns about the death or the circumstances surrounding it, and guidance should be given to hospital staff encouraging them to raise any concerns they may have with the independent medical examiner.

Similar conclusions were reached in the Inquiry Report into the care provided by the maternity and neonatal services at the University Hospitals of Morecambe Bay NHS Foundation Trust, published in 2015[7]: *'...Legislative preparations have already been made to implement a system based on medical examiners, as effectively used*

5 *'Reforming death certification: Introducing scrutiny by Medical Examiners. Lessons from the pilots of the reforms set out in the Coroners and Justice Act 2009. Available from:* ***https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/521226/Death_certificate_reforms_pilots_-_report_A.pdf***

6 *Francis R. 'Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry'. 'Executive Summary – Table of Recommendations'. Available from:* ***http://webarchive.nationalarchives.gov.uk/20150407084003/http://www.midstaffspublicinquiry.com/sites/default/files/report/Executive%20summary.pdf***

7 *Kirkup B. 'Report of the Morecambe Bay Investigation' (2015), chapter 8, 'Recommendations'. Available from:* ***http://www.gov.uk/government/uploads/system/uploads/attachment_data/file/408480/47487_MBI_Accessible_v0.1.pdf***

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in other countries, and pilot schemes have apparently proved effective. We cannot understand why this has not already been implemented in full, and recommend that steps are taken to do so without delay. Given that the systematic review of deaths by medical examiners should be in place, as above, we recommend that this system be extended to stillbirths as well as neonatal deaths, thereby ensuring that appropriate recommendations are made to coroners concerning the occasional need for inquests in individual cases, including deaths following neonatal transfer...'.

Notwithstanding the accumulated evidence that reform was required urgently, and that there were substantial potential benefits, it was not until March 2016 that the DOH published a fresh consultation: *'Introduction of Medical Examiners and Reforms to Death Certification in England and Wales: Consultation on Policy and Draft Regulations'*[8].

This latest in a long line of consultations, inquiries and reviews, set a timetable for independent medical examiners to start work across England & Wales by April 2018. Now, less than one year before that unambitious target was due to be met, the starting date has been put back again until April 2019: *'...to allow for more time for preparation to ensure that the benefits of the new system were realised...'*[9].

No doubt frustrated by the glacial progress in implementing reforms he had first proposed in 2002, when interviewed by the BBC in early 2015, former Home Office Review Chairman Tom Luce remarked[10]: *'...Seven million deaths have been dealt with through a system known for at least a dozen years to be unsafe, and it is scarcely believable that this is to continue...'*.

It now seems that in 2019, we will look back once more with incredulity, and ask why nine million deaths were dealt with through a system known for at least 16 years to be unsafe.

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8 Available from: ***https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/517184/DCR_Consultion_Document.pdf***

9 ***http://www.health-and-care-update.co.uk/2017/04/medical-examiners-scheme-delayed-until-april-2019.html***

10 ***http://www.bbc.co.uk/news/uk-30909270***

Inquest touching on the death of BT

Background

BT was found deceased by her partner and carer, S, on the morning of 5th June 2016.

She had an extremely complicated medical history that included diabetes, obstructive sleep apnoea, schizoaffective disorder and dissociative disorder, epilepsy, migraines and asthma.

One of the many medications BT was taking up until her death was the drug dosulepin which she had been prescribed since 2003. Dosulepin was the subject of a safety alert in 2007 published by the Medicines and Healthcare Products Regulatory Agency (MHRA) cautioning against its prescription due to a number of fatalities being associated with it. Although it is a very effective drug for depressive illnesses it can be extremely toxic if taken outside the therapeutic dose.

On the night of 4th June 2016 her carer, S, gave BT her medication as usual before they both went to bed.

The post-mortem report stated that the main cause of death was dosulepin intoxication. This was due to the high concentration of the drug in her post-mortem femoral blood (the normal therapeutic level being 1.5mg/L).

S was adamant that BT had not taken any excessive quantities of the drug on the night she died.

Inquest – 20th March 2017

The inquest was heard at Warrington Coroner's Court by Dr Janet Napier.

S gave evidence first and described the care that her partner received for many years and the multiple physical and psychiatric issues she had. In addition, she described the medication regime. She was certain that the usual dosage of dosulepin was given on the night BT died and, crucially, that after BT's death, the amount of the drug that should have remained was still in the cupboard where it had been left (therefore BT could not have gotten up in the night and ingested more).

Upon invitation, at the end of S's evidence, the Coroner stated that her evidence as to the administering of dosulepin and the surrounding circumstances was accepted as fact for the purposes of the inquest.

An array of medical practitioners were to give evidence including the psychiatrist responsible for prescribing the dosulepin Dr Christopher Findlay, her GP Dr Vivien Williams, a neurologist Dr Anita Krisnan, the post-mortem writer Dr Mohammad Al-Jafari and a toxicologist Dr Colin Seneviratne.

Dr Findlay gave evidence and was questioned about the prescribing of the drug including the fact that BT had been a long-term patient who had taken the drug prior to the guidance against such prescriptions and that BT had a very difficult set of symptoms and illnesses.

After the other medical practitioners the toxicologist, Dr Seneviratne, gave evidence and the following issues were explored with him: 1) whether changes in her drug metabolism (possibly because of having a fatty liver and severe obesity) could have affected the rate in which BT processed the drug leading to death; and 2) the extent to which polypharmacy (the combination of medications she was taking) could have contributed to her death. He answered in the affirmative for both these propositions.

In response to this line of questioning the previous medical witnesses were re-called and somewhat unusually sat opposite Dr Seneviratne. They then proceeded to ask him multiple questions some of which appeared to explore the theory that BT excessively ingested the drug shortly prior to her death.

This line of questioning was interrupted numerous times including with the observation that S, who had given very specific evidence on this subject, was believed for the purposes of the inquest and therefore excessive ingestion was the *only* possible cause that had effectively been ruled out.

Dr Seneviratne confirmed that due to the fact the blood sample had been taken post-mortem it was not necessarily demonstrative of the quantity of the drug taken and the only reliable sample would have been an "in life" one.

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The bizarre form of questioning (multiple witnesses questioning a toxicologist) continued with multiple interruptions and steers from myself as the advocate for the family. Dr Seneviratne eventually pointed out that, in his opinion, the only reliable method of further narrowing down the potential causes of the intoxication was to instruct a clinical pharmacologist.

Submissions were then made for an adjournment of the inquest for this to be done which the Coroner refused.

Due to the evidence that was given, Dr Al-Jafari stated that given the many health difficulties BT experienced pinpointing a cause of death may now be difficult and he was questioned as to the veracity of his original post-mortem report.

Given all these circumstances the application to adjourn for the instruction of a clinical pharmacologist was renewed on the basis that given excessive ingestion could not be made out on the facts the causes of the intoxication needed to explored further especially given the potential dangers of dosulepin. This was again refused.

The Coroner asked questions about BT's heart failure but all that was established factually that this occurred as part of the process of dying.

By the end of the inquest the focus of the practitioners, with the exception of the toxicologist, were moving away from intoxication being the primary cause of death (with no factual change other than S' evidence having been accepted as to BT not excessively ingesting the drug) and with no further medical evidence than was before Dr Al-Jafari when he wrote the post-mortem report.

One potential difficulty was that, once excessive ingestion was discounted, the only other potential causes as to any intoxication (if this was to remain the primary cause of death) seemed to be whether BT began metabolising the drug differently due to her weight and liver problems or the effect of polypharmacy. Further exploration of either of these areas necessarily would have called into question the drug regime BT was under (in her particular circumstances).

Result

The cause of death was found to be:

1A Cardi-respiratory failure

1B LVH, severe fatty liver, epilepsy, dosulepin intoxication.

"It is not known why the level of dosulepin was so increased (the level found post-mortem in BT's blood). There is no evidence of self-harm. There is no clinical evidence of liver failure. It is possible that it was secondary to fatty liver ad also possible that multiple medications had an effect on the level of dosulepin".

Conclusions

The way the questioning became a 'round forum' discussion is just one of the ways in which the Coroners' Court can throw out surprises.

The only way of dealing with it was to accept the Coroner can formulate the court in any way she chooses but ensure that whatever occurs you, as the advocate, still take the same active part as before.

The form of the 'discussion' (the questions by some of the practitioners) helped demonstrate what their thinking was and why which, unusually, opened up further lines of enquiry of them by me.

Although the result of the inquest possibly left questions unanswered as to any effect of the use of dosulepin in these particular circumstances the family's main concern was that BT's death was not recorded as excessive ingestion of the drug shortly prior to death (i.e. suicide) as they were certain, from the circumstances, that this could not have happened.

This case also demonstrates how difficult finding a cause of death can be for someone with multiple health difficulties who is taking a variety of medications.

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News and reviews

Book review: *Medical Treatment: Decisions and the Law*

Medical Treatment: Decisions and the Law is edited by Christopher Johnston QC, this is the third edition which looks at "The Mental Capacity Act in Action". The book is published by Bloomsbury and follows previous editions in that it sets out the law in this complicated and fast moving area in a user friendly way. Changes to the law in this field are occurring so rapidly that Serjeants' Inn is updating the book regularly through its UK Medical Decision Law Blog. The blog is an excellent way of keeping pace with developments; updates include The Law Commissions published report on Mental Capacity and Deprivation of Liberty and draft bill. The blog neatly summarises the Law Commissions conclusions and advises on what happens next.

This book is a practical legal guide in three parts. Part one deals with the general principles and procedures underlying patient autonomy, and those without capacity. Explanations are clear and are provided within the context of Montgomery consent and the case law evolving from this landmark decision. It also looks at consent within the context of advanced decisions, deciding for others - adults and children. This part of the book provides guidance on practice and procedure and looks at some of the factors that can help to determine whether court proceedings are an appropriate or necessary course of action. It also looks at deprivation of liberty and restraint.

Part two looks at specialist areas of practise such as, sterilisation, abortion, assisted reproduction, religious objection to treatment and end of life decisions – to name but a few of the topics covered under this section. Part three sets out the key precedents, forms and materials relating to each chapter.

Unlike many books on this topic, this is a structured and well written book that goes to the heart of the Mental Capacity Act 2005. Not only does it make the application of the law in this area feel more manageable but its straightforward style makes it a book you actually want to pick up and read, we can't recommend it highly enough!

Serjeants' Inn Chambers

New directory of service providers

AvMA has published a directory of service providers who provide services specifically for clinical negligence solicitors. It is an essential easy reference point for any services that a clinical negligence solicitor or their client needs. You can download a copy of the directory here: http://i.emlfiles4.com/cmpdoc/6/0/6/0/3/1/files/34464_lawyers-service-directory-acnc17.pdf. A new edition of the directory is being published to coincide with AvMA's Annual Clinical Negligence Conference (Leeds, 23rd-24th June) and will be emailed direct to your inbox as well as being available on the AvMA Lawyers Service members website: https://www.avma.org.uk/resources-for-professionals/members-area/. Please mention AvMA's directory when contacting service providers. Also please let us know if there is a category or a service provider you think should be included. Contact: vicki@avma.org.uk for more information or a booking form which is available for download here: http://i.emlfiles4.com/cmpdoc/6/0/6/0/3/1/files/34463_lawyers-service-directory-entry-form---pro-rata.pdf.

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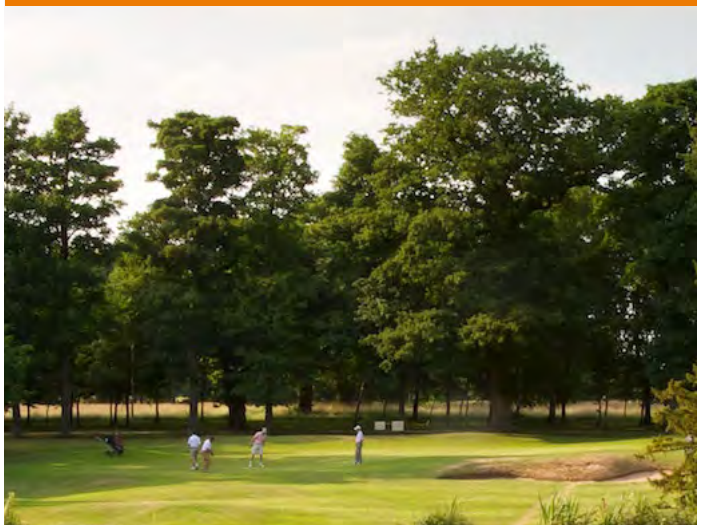
AvMA 35th Anniversary Charity Golf Day

22 June 2017, Rudding Park, Harrogate



The thirteenth AvMA Charity Golf Day will take place on Thursday 22 June 2017 at the stunning Rudding Park in Harrogate and this year it will be a special event marking AvMA's 35th Anniversary. The Welcome Event for the Annual Clinical Negligence Conference will take place later that evening in Leeds (30 minutes' drive away) so the Golf Day offers the perfect start to the essential event for clinical negligence specialists.

We will be playing Stableford Rules in teams of four and you are invited to either enter your own team or we will be happy to form a team for you with other individuals. The cost is only £98 + VAT per golfer, which includes breakfast rolls on arrival, 18 holes of golf and a buffet and prize-giving at the end of the day. All profits go directly to AvMA's charitable work.

If you have not already booked your place at the Golf Day or Annual Clinical Negligence Conference, you still have time to do so!

Annual Clinical Negligence Conference 2017

23-24 June 2017, Royal Armouries Museum, Leeds

The Annual Clinical Negligence Conference (ACNC) is the event that brings the clinical negligence community together to learn and discuss the latest developments, policies and strategies in clinical negligence and medical law.

As ever, it will be an event not to be missed, with the usual high standard of plenary presentations and focused breakout sessions that you would expect from this event, ensuring that you stay up to date with all the key issues and providing 10 hours CPD (SRA, Bar Council and APIL). The programme this year will have an orthopaedics theme, whilst also covering many other key medico-legal topics at such an important time for clinical negligence practitioners.

#ACNC 2017 offers you:

- Spotlight on orthopaedics
- Many other key medico-legal topics
- Plenary presentations from leading experts
- Highly focused breakout sessions
- Latest developments on the issues that matter

Take advantage of the concession rates available for:

- Multiple bookings
- Junior solicitors and barristers
- Paralegals
- Trainee legal executives

As well as providing you with a top quality, thought provoking, learning and networking experience, the success of the conference helps AvMA to maintain its position as an essential force in promoting justice.

Medical Negligence & Access to Justice in Ireland Today

12 October 2017, College of Anaesthetists of Ireland, Dublin

We are delighted to return to Dublin for an essential one day conference covering the major issues currently affecting medical negligence litigation in Ireland. At such an important time for those working in the field of medical negligence law in Ireland, this is an event you cannot afford to miss. The programme will be available and booking will open in July.

Court of Protection Conference

9 November 2017, Manchester Conference Centre

Since its inception in 2007, the Court of Protection has made crucial decisions to try to protect the wellbeing of vulnerable individuals. In a rapidly-evolving legal environment, AvMA's inaugural Court of Protection conference will examine the current state of litigation and the challenges and responsibilities facing those who work in this important area. The programme will be available and booking will open in August.

Target audience: Court of Protection specialists, including CoP lawyers and clinical negligence lawyers with an involvement with the CoP, professional deputies, private client experts, trustees, case managers, charities, local authorities.

AvMA Specialist Clinical Negligence Panel Meeting

1 December 2017, 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. This year's meeting will take place on the afternoon of Friday 1st December - registration and a networking lunch will commence at 12.30, with the meeting starting at 13.30 and closing at approximately 17.00, prior to AvMA's 35th Anniversary Gala Celebration at the same venue that evening. The programme will be available and booking will open in September.

35 YEARS avma action against medical accidents

AvMA 35th Anniversary Gala Celebration

1 December 2017 (evening), Grand Connaught Rooms, London

Booking now open!

Join us to celebrate AvMA's 35th anniversary and to mark the progress that has been made in patient safety and justice since AvMA was formed in 1982.

The evening will be one of celebration, with a drinks reception followed by a fantastic three course meal with wine, live entertainment, dancing and some special surprises!

It will be the perfect event to entertain clients / contacts or reward staff, on an evening that will bring together the key people from the patient safety and medico-legal worlds. AvMA's Specialist Clinical Negligence Panel Meeting will take place that afternoon at the same venue - the Grand Connaught Rooms - a short walk from Covent Garden and Holborn underground stations.

Make sure you're there on AvMA's big night! It promises to be the most memorable of occasions and we look forward to seeing you there.

Details of further events for Winter 2017 and early 2018 available soon.

Tel: **0203 096 1140**
Email: conferences@avma.org.uk
Web: www.avma.org.uk/events

AvMA medico-legal webinars

Working on a client file and looking for more information to assist you with your case? AvMA medico-legal webinars give you immediate access to medico-legal talks on subjects ranging from interpreting blood test results to medico- legal issues in surgery.

Featuring some of the UK's leading authorities on medico-legal issues, AvMA's webinars bring you all the benefits of a specialist targeted seminar, all without having to leave your office. Covering over 20 of the most popular subjects, AvMA webinars are a vital addition to any clinical negligence solicitor's library.

The webinars can be watched at a time convenient to you. On average they last approximately 60 minutes and can be accessed on any device with an internet connection. You can watch the video as many times as you want, download the slides and extras materials to aid your learning.

Webinar subscription package

Access all title for your clinical negligence team from **£1,200** + VAT

AvMA Lawyers' Service members **£1,200** + VAT

Standard Rate **£1,900** + VAT

To book your webinar, go to www.avma.org.uk/learning

For more information contact Paula Santos
paulas@avma.org.uk
0203 096 1140

Current webinar titles include:

- Anaesthesia - Medico-Legal Issues in Peri-Operative Care
- Blood Pressure - Implications and Outcomes
- Cerebral Palsy - Understanding Your Client's Needs
- Hand and Wrist Surgery
- Hospital Acquired Infections - the Current State of Play
- How to Became a Panel Member
- How to Interpret Blood Test Results
- Joint Replacement of the Hip and Knee
- Knee Surgery
- Loss of Chance in Clinical Negligence
- Marketing for Lawyers
- Medico-Legal Issues Arising from Bariatric Surgery
- Medico-Legal Issues Arising from Facial Cosmetic Surgery
- Medico-Legal Issues in Acute Medicine
- Medico-Legal Issues in Ambulance and Paramedic Care
- Medico-Legal Issues in Cauda Equina Management
- Medico-Legal Issues in Diabetes
- Medico-Legal Issues in Foot and Ankle Surgery
- Medico-Legal Issues in Laser Eye Surgery
- Medico-Legal Issues in Maxillofacial Injuries
- Medico-Legal Issues in Meningitis and Septicaemia
- Medico-Legal Issues in Obstetric Emergencies
- Medico-Legal Issues in Orthopaedics: a Paediatric Focus
- Medico-Legal Issues in Pain Management
- Oncology and GP Referral
- Orthopaedic Radiology
- Radiology in Spine Injury
- Spinal Surgery
- Understanding Biochemistry Test Results
- Upper Limb Surgery Focusing on Shoulder Surgery

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