MEDICO LEGAL

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Welcome to the Medico-Legal Magazine

Welcome to Issue 27 of the Medico-Legal Magazine, produced by SpecialistInfo and publishing partner Iconic Media Solutions Ltd.

This autumn issue of 2024 contains the following articles:

Bethan Parry, Clyde and Co Legal Director summarises a recent obstetrics case report; and

Mr Tahseen Chaudhry, Consultant Peripheral Nerve Surgeon, explains the medico-legal implications of iatrogenic nerve injuries; and

Mr Amar Alwitry, Consultant Ophthalmologist, expert witness and speaker at the ML Conference, invites readers to complete a short survey on informed consent.

Anthony Barton, Medicolegal Consultant and former Assistant Coroner, investigates the negligence litigation system and patient safety; and finally

James Byrne, Barrister, Deka Chambers, asks when is it substantially unjust to deny a dishonest claimant their damages?

In our Expert Witness Directory we showcase more featured experts, who are available for instruction now.

Once again, the magazine will be circulated to up to 40,000 people in the industry, including doctors, insurance companies, law firms and medico-legal agencies. It has a dedicated website www.medicolegalmagazine.co.uk and a page on the Medico-Legal Section of the Specialistinfo.com website, where all the back issues can be viewed. Printed copies can be ordered from Iconic Media.

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

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

Lisa Cheyne

Specialistinfo
Medico-Legal Magazine

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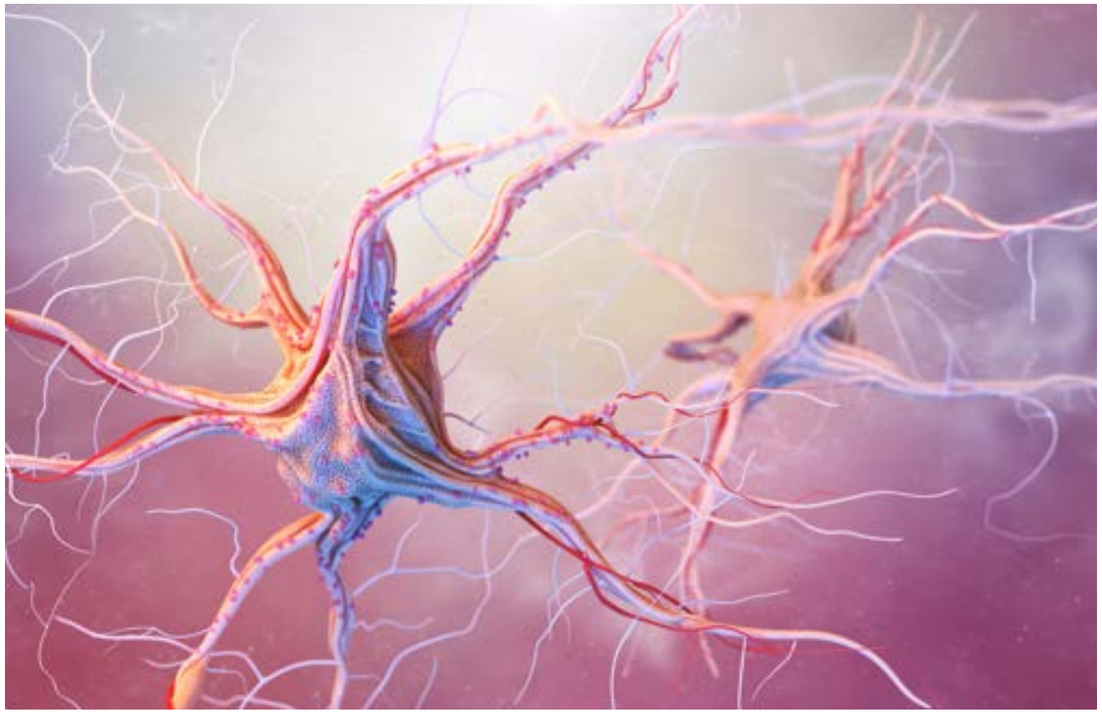

IATROGENIC NERVE INJURIES AND MEDICO-LEGAL IMPLICATIONS

By Mr Tahseen Chaudhry, Consultant Peripheral Nerve Surgeon, University Hospital Birmingham
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Introduction

Iatrogenic injury is one directly caused by medical treatment or investigation. It was George Bonney who famously wrote that "when a patient enters hospital without a nerve lesion and emerges with one, it is seldom possible to resist an allegation of negligence."[1]

The true incidence of iatrogenic nerve injuries is difficult to ascertain. Estimates suggest that up to 25% of all nerve injuries may result from some form of medical intervention.[2] Many of these may be mild and self-limiting but severe injury to a major motor, sensory or mixed nerve trunk can be catastrophic for patients who may experience neuropathic pain, paralysis and sensory loss. Alongside this there is the added psychological distress caused by uncertainty over the diagnosis and a lack of clarity about prognosis.

Most clinicians rarely see nerve injuries, and many will never encounter an iatrogenic injury. Delay to diagnosis is therefore common, and this serves not only to increase the patient's frustration but risks the development of pain syndromes including central sensitisation and type 2 complex regional pain syndrome, which can be notoriously difficult

to treat. A delay to diagnosis may also worsen the outcome for a nerve that is acutely subject to local pressure or ischaemia. Delay may also reduce the chances of successful repair or reconstruction where a nerve injury has caused a time-critical motor deficit.[3,4]

The psychological burden carried by the clinician involved in an iatrogenic nerve injury can be significant, but seldom merits consideration. For peripheral nerve surgeons, an important part of our role is to offer ease of access for colleagues to seek advice, and a prompt clinical review when an iatrogenic nerve injury may be suspected. This also ensures that injuries requiring further intervention are picked up at an early stage.

Classification and Incidence of Nerve Injuries

Peripheral nerve injuries are commonly classified using Seddon's system, which divides them into three categories:[5]

1. **Neurapraxia:** A temporary block in nerve conduction without structural damage. Recovery typically occurs within 2 to 12 weeks. The diagnosis should be approached with caution to avoid delays in treating more severe injuries.
2. **Axonotmesis:** Involves the disruption of the axon and myelin sheath, often due to severe compression or crush injuries. Wallerian degeneration occurs and recovery occurs via axonal regeneration, which proceeds at approximately 1-2 mm per day.
3. **Neurotmesis:** The nerve is completely severed. Recovery requires surgical intervention, such as nerve repair or grafting.
4. **Mixed nerve injuries:** Different fascicles are injured to different degrees and will recover at different rates. A mixed nerve injury can therefore have elements of a conduction block, but a significant part of the nerve may be carrying a more significant injury.

If an iatrogenic nerve injury is identified intra-operatively the patient should be discussed with the local peripheral nerve service. An immediate microsurgical repair of a divided nerve may avoid the need for a more difficult delayed repair that needs an interposition graft. In cases where motor recovery may be uncertain, for example due to long regenerative distances, the patient can be given clarity about the likely recovery process and the need for adjunctive techniques to upgrade motor function such as nerve transfer. If specialist input is not available intra-operatively, the standard advice is to tag the nerve ends to aid identification during re-exploration.[6]

More often, the injury is unrecognised during the procedure but is suspected in the early post-operative period. A significant nerve injury is marked by dense loss of motor and sensory function, loss of autonomic innervation (hyperaemia and dry skin) and severe unrelenting neuropathic pain. The severity and character of the pain is the most distinguishing feature of a high-grade injury.[7,8]

Obtaining a clear diagnosis can be compromised by the use of spinal and regional anaesthesia or where pre-operative documentation of nerve function has been missing or incomplete.

Nerve conduction studies and electromyography are an important part of diagnosing and grading these injuries. However, neurophysiology can be misleading in the first two weeks after nerve injury, as Wallerian degeneration will not yet be established. This can result in a degenerative nerve injury being incorrectly graded as a conduction block, potentially causing a delay to intervention.

Early Referral to a Peripheral Nerve Surgeon

The BOAST guidelines offer some clarity in the early management of a peripheral nerve injury and outline when to seek the involvement of a peripheral nerve surgeon.[6] Failure to offer early diagnosis, specialist referral and treatment, may expose the patient to further deterioration and may close the window of opportunity for successful intervention.[3]

The guidelines emphasize that early intervention is particularly important in cases of suspected axonotmesis or neurotmesis, where timely surgical exploration and repair can significantly impact recovery. Early referral is also advisable where the complexity of the case adds to uncertainty regarding the diagnosis, or where the primary clinician lacks the necessary experience in assessing nerve injuries. By seeking advice early, the treating clinician can avoid delays in treatment that might otherwise result in poorer outcomes and an increased risk of litigation.[9,6]

Medico-Legal Considerations

Medico-legal claims related to iatrogenic nerve injuries are not uncommon.[9,10]

Iatrogenic nerve injuries may result from distorted anatomy, intra-operative positioning, traction to the limb, prolonged tourniquet usage, or direct trauma to the nerve from misplaced metal work, diathermy or power tools. Minimally invasive surgery or approaches with limited sight of local neurovascular structures may also carry additional risk.[10]

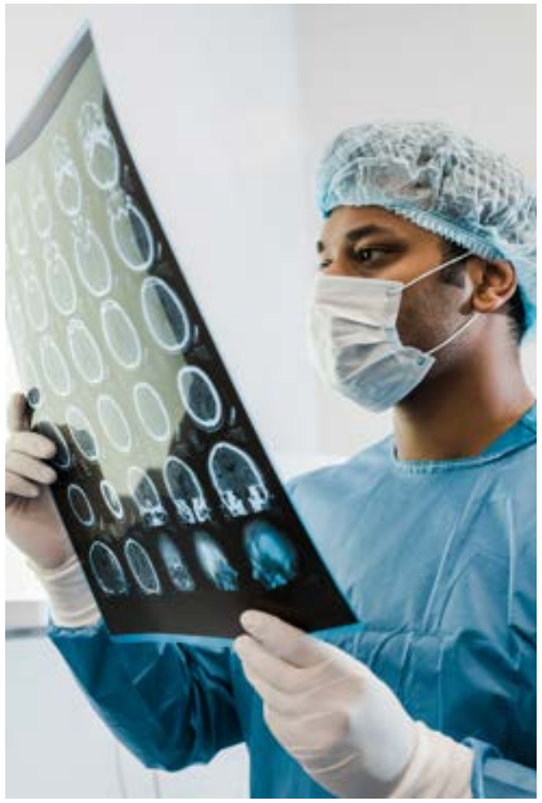
Causes of litigation include inadequate informed consent, delays in diagnosis or treatment, and mismanagement of the injury postoperatively. Poor assessment and poor documentation can be a contributing factor.

The Montgomery ruling[11] has emphasised the importance of obtaining detailed informed consent, particularly for procedures that carry a risk of nerve damage. Surgeons are advised to discuss potential risks with patients thoroughly and document these discussions, and this may serve to mitigate the risk of legal action.[10]

An analysis of litigation claims in trauma and orthopaedic surgery within the NHS from 2008/2009 to 2018/2019 revealed that nerve injuries accounted for 9.2% of claims. However, neurological injuries accounted for 24.5% of damages paid out, highlighting the significant, often lifelong impact of these injuries on patients.[9]

Role of a Peripheral Nerve Surgeon in Medico-Legal Settings

A peripheral nerve surgeon plays a crucial role in the medico-legal evaluation of nerve



injuries in the realms of both negligence and personal injury.

There is frequently a lack of clarity over which nerve trunk has been injured and the depth and grade of injury. A careful review of the notes and an up-to-date assessment of the patient is usually enough to clarify the diagnosis and the extent of recovery, as well as the likely prospects for further spontaneous recovery.

Differentiating neuropathic pain from other types of pain is a particular challenge, particularly in a longstanding injury where nerve pain is established. Pain scoring, for example using the S-LANSS and NPQ systems, alongside careful clinical evaluation can be helpful, but the natural history of the nerve injury, and a thorough clinical evaluation for objective markers of nerve regeneration are also important.

Features of central sensitisation such as allodynia and hyperaesthesia are common findings and may be hallmarks of a wider pain syndrome.[10]

Where there is an ongoing pain driver from an injured peripheral nerve that has failed to respond to adequate therapy and neuropathic pharmacology, a strategy of ultrasound guided nerve blocks may be devised to determine whether surgical treatment of a painful neuroma can offer a reliable route to pain relief.[4]

Results can be unpredictable, however, particularly where there is an established pain syndrome or longstanding neuropathic pain. Where nerves are tethered in scar tissue, a local mechanical stimulus for pain may be a significant factor and needs addressing at the same time.[8]

Surgery may involve techniques such as, nerve wrapping, nerve reconstruction using allograft or autograft, nerve capping, targeted muscle reinnervation (TMR) or regenerative peripheral nerve interfaces (RPNI). When successful, the pain relief afforded can be life changing and have a significant impact on prognosis. Devices such as peripheral nerve stimulators and spinal cord stimulators have found some success in intractable pain but are expensive and require long term follow up and patient engagement.[4,7,8,10]

A peripheral nerve specialist is invaluable in determining whether late-stage or missed diagnoses still offer treatment options that could significantly alter the prognosis. Often there are a number of possible options available. A clear evaluation of each of these ensures that the involved parties have a clear understanding of the injury's implications and the realistic outcomes of potential treatments, thereby helping to shape the course of litigation or settlement discussions.[10]

Conclusion

Iatrogenic nerve injuries, though rare, remain a significant concern, both for their impact on patients and the potential for medico-legal repercussions. The rise in litigation claims over the past decade underscores the need for diligence in surgical practice, informed consent, and early recognition and intervention when injuries occur. Initiatives like GIRFT, and clear guidelines for specialist referral offer hope for reducing the frequency and cost of these claims, but ongoing efforts are needed to ensure that preventable injuries are minimised.

Recent research and technological advances in peripheral nerve surgery have increased the options available for treating nerve injuries, both in the acute setting, and where an injury has been missed or undertreated.

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3) Your duty is to the court, not the paying party. Your report should be balanced and considered, with realistic concessions where necessary. Don't ignore the evidence and avoid extreme opinions.

4) Do you have all the medical records you need to make a fair and balanced assessment of the case? Are they complete and legible? Remember, the devil is in the detail!

5) Do you have the time to dedicate to the report and any subsequent court appearances that may be required around your current clinical commitments?

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Do

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Do defer to other experts as appropriate – e.g., a breach may be a failure to examine, but what would have been found if "X" had been appropriately examined?

Do keep it simple and consistent.

Don't

Don't paraphrase literature, books or guidelines – reference and exhibit them correctly.

Don't re-phrase your opinions if they're clear.

Don't work without all required material. Are there medical records missing? Make sure you have everything you need before starting your report!

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Tristan Holdom,
Head of Personal Injury, Brain & Spinal Cord Injury Specialist, Tollers Solicitors

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Jennifer Tierney
Claimant

"I was given clear instructions how to get to my appointment. So when I arrived I was not stressed. The consultant was brilliant. I was so at ease and I was provided with so much information to help me with my settlement for an insurance claim."

Claire Cambridge
Claimant

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WHEN IS IT SUBSTANTIALLY UNJUST TO DENY A DISHONEST CLAIMANT THEIR DAMAGES?

By James Byrne, Barrister, Deka Chambers, London e: jbyrne@dekachambers.com

James is a highly sought after barrister, with a busy high value practice across a wide field of personal injury and clinical negligence claims.

To date, and perhaps surprisingly, there has been very little attempt by the Courts to grapple with this vexing question when considering whether to impose the consequences of a finding of fundamental dishonesty pursuant to s57 of the Criminal Justice and Courts Act 2015.

The best we had were the efforts of Knowles J in London Organising Committee of the Olympic and Para Olympic Games v Sinfield who stated:

"[65]. Given the infinite variety of circumstances which might arise, I prefer not to try and be prescriptive as to what sort of facts might satisfy the test of substantial injustice. However, it seems to me plain that substantial injustice must mean more than the mere fact that the Claimant will lose his damages for those heads of claim that are not tainted with dishonesty. That must be so because of s 57(3). Parliament plainly intended that sub-section to be punitive and to operate as a deterrent. It was enacted so that Claimants who are tempted to dishonestly exaggerate their claims know that if they do, and they are discovered, the default position is that they will lose their entire damages. It seems to me that it would effectively neuter the effect of s 57(3) if dishonest Claimants were able to retain their 'honest' damages by pleading substantial injustice on the basis of the loss of those damages per se. What will generally be required is some substantial injustice arising as a consequence of the loss of those damages."

And Knowles J again in *Woodger v Hallas* [2022] EWHC 1561 (QB), commenting:

"[49]. Counsel on this appeal were unable to refer me to any case which has defined the meaning of 'substantial injustice'. I was not wholly surprised by that. To paraphrase US Supreme Court Justice Potter Stewart in Jacobellis v Ohio 378 US 184, 197 (1964), county court judges will generally, 'know it when they see it'."

Whilst there is a certain attraction to the Lutheran approach of *'know it when you see it'* when considering 'substantial injustice', especially given the wide range of circumstances in which 'injustice' could occur, the lack of a prescriptive test, or a non-exhaustive list of factors, or any real guidance for that matter, is an uncomfortable outlier for practitioners taught to ground advice to statute and precedent. That is especially so because, at least in this practitioner's experience, some lower Courts have to be convinced to move away from the extremist interpretation of Knowles J judgments by refusing to consider at all what the impact of the loss of damages will have on the Claimant.

That was the landscape that faced Ritchie J in *Williams-Henry v Associated British Ports Holdings Ltd* [2024] EWHC 806 (KB), who was invited to grapple with this very issue.

First, as a matter of full disclosure, Ritchie J is of this parish. He was our former Head of Chambers and the author has had the privilege of being led by him on a number of occasions. He is not a man who is afraid to give his opinion or push the established legal frontiers, and though only recently having taken to the bench, he has remained true to his former self.

Second, I would say to anyone who has any pretentions to specialise in catastrophic injury work, particularly concerning brain injuries, that the judgment is essential reading. Ritchie J sets out in devastating detail the importance of careful analysis of the medical records. Give yourself a couple of hours though – it is a long one.

So what was it all about?

There is no doubt that Kirsty Williams-Henry was tragically and seriously injured when she fell off the end of Aberavon Pier in the dark on 21 July 2018. The fall caused her to suffer bilateral cerebral, subdural and sub-arachnoid moderately-severe brain damage amongst other serious injuries. Secondary symptoms included reduced cognition, some hearing loss, fatigue and a slight personality change.

The Defendant admitted primary liability for Ms Williams-Henry's fall, and liability was ultimately agreed with a reduction of one third for contributory negligence.

As found by Ritchie J, and supported by substantial medical notes, Ms Williams-Henry, over the course of 3 years, made a remarkable recovery. She was able to look after herself, live alone, drive, return to work in a demanding role and lead an almost normal life. It was testament to her hard work, that of her family and her NHS neuro-rehabilitation team. Ms Williams-Henry became an advocate for those suffering brain injury and in that respect was and is an impressive person.

This inspirational story was indelibly soured, however, by the conduct of Ms Williams-Henry in litigation (and in her approach to seeking benefits and life insurance) when she pleaded a claim worth £2.5 million for a life irrevocably changed, suffering little by way of recovery and a paucity of enjoyment. In the blunt words of Ritchie J her case was a 'lie', and it was easily unpicked by the Defendant with reference to her own medical and employment records, social media posting and surveillance evidence.

Ritchie J was aghast at how this was ever allowed to happen. Ms Williams-Henry's legal team appointed a brain injury case manager to assist

her in her recovery. In Ritchie J's view he appeared to have either ignored or not properly consider the Claimant's medical records and fatally took her dishonest reported account of suffering at face value. It led to some disastrous decisions including sacking her NHS treating team and embarking on a costly, presumably unwarranted, course of private neuro-rehabilitation. Even worse Ms Williams-Henry unnecessarily decided to give up her successful career working in insurance, in part, so she could get the treatment. The errors in the case manager's conduct were compounded by Ms Williams-Henry's instructed experts, particularly her care expert, who failed to properly raise obvious red flags that Ms Williams-Henry was not as sick as she claimed – *By way of a side note, this is the second judgment where Ritchie J has been highly critical of a party (this time it was the Defendant's care expert) for instructing a 'care expert' with no theoretical or practical experience in managing brain injury cases, so practitioners be warned (see §188 of the judgment).*

By simply tying Ms Williams-Henry to the contemporaneous records of her recovery, Ritchie J found the Claimant had blatantly and persistently lied throughout the litigation for the purpose of unjustly enriching herself at the Defendant's expense. In the circumstances, it was inevitable that she was fundamentally dishonest.

Pursuant to s57(2), Ritchie J was then required to dismiss Ms Williams-Henry's claim unless he found that there was a 'substantial injustice' in doing so.

Applying the 'knows it when you see it' test, I would be surprised if there are many reading this whose first convulsive thought is not that Ms Williams-Henry was the mistress of her own downfall. To those who have that thought I would not suggest that it is not unreasonable, but I would also ask them to consider that when all was said and done, Ms Williams-Henry was seriously injured, she suffered a genuine significant loss as demonstrated by the 'but for the dishonesty' award of c.£600k (on a full liability basis equating to c.£900k), and though not a defence to her actions the impression given by the judgment was that no-one from her family, her case manager or her private treating medical team took her in hand, when she so clearly needed someone to do so.

A further troubling feature was that there was evidence before the Court, which Ritchie J considered and accepted, that since at least July 2023 Ms Williams-Henry had begun to develop genuine depressive psychotic symptoms, no doubt caused at least in part due to the pressure of the litigation and the correctly brought allegations of fundamental dishonesty, and that any fundamental dishonesty finding would lead her to making a genuine attempt to take her own life.

In light of all the above, Ritchie J took the opportunity to express his view on the risk of misinterpreting what Knowles J had stated as to the correct approach to the issue as hand:

"[177] The principle to be applied is that fundamental dishonesty will result in the Claimant losing her genuine damages. This penalty is intended by Parliament. So, the starting point is that a dishonest claimant is not suffering an injustice per se by being deprived of his/her genuine damages. Once fundamental dishonesty has been found by the Judge then the Court must consider whether the dismissal will cause SI. However, trying to identify whether dismissing a claim for damages with a properly assessed genuine quantum of say £600,000 would cause any or even a substantial injustice to a claimant, whilst ignoring the very dismissal which is the only operative cause of any potential injustice, is imposing a blindfold on the Judge which the Act itself does not impose. I do not understand how a Judge will know injustice when she/he sees it, with the blindfold put on. If that is what Knowles J. was saying then I respectfully do not agree with his ruling on the interpretation of SI. The plain words of the Act tie the responsibility to assess any resulting SI to the dismissal of the claim. In my judgment it is the dismissal of the claim for damages that is the trigger for the analysis of whether a substantial injustice will occur if no damages are awarded. One cannot ignore the very thing which S.57(3) takes away when considering the injustice of the taking away. I accept, of course, that the aim of the section is to punish dishonesty by the dismissal of the claim. But this is tempered by Parliament's inclusion of S.57(2). This section gives the Judge discretion which, is to be exercised fairly and only if a threshold with two parts is reached. Part one is a finding of injustice to the Claimant. Part two is a finding that the injustice is substantial."

Thereafter, Ritche J set out as a guide a list of factors he believed were relevant to any Court's decision:

"[178] I consider that the correct approach when deciding whether a substantial injustice arises is to balance all of the facts, factors and circumstances of the case to reach a conclusion about SI. The relevant factors in my judgment are all of the circumstances and include:

1. *The amount claimed when compared with the amount awarded. If the dishonest damages claimed were small or moderate compared to the size of the assessed genuine damages which were substantial or very substantial this will weigh more heavily in favour of an SI ruling.*
2. *The scope and depth of that dishonesty found to have been deployed by the claimant. Widespread and gross dishonesty being more weighty against SI than moderate or minor dishonesty.*
3. *The effect of the dishonesty on the construction of the claim by the claimant and the destruction/ defence of the claim by the defendant. This would be measured by considering all matters including the costs consequences of the work done in relation to the dishonesty compared with the work done had there been no dishonesty.*
4. *The scope and level of the claimant's assessed genuine disability caused by the defendant. If the claimant is very seriously brain injured or spinally injured, then depriving the claimant of damages would transfer the cost of care to the NHS, social services and the taxpayer generally and that would be more unjust than if the claimant had, for instance, a mild or moderate whiplash injury. The insurer of the defendant (if there is one) has taken a premium for the cover provided. Why should the taxpayer carry the cost?*
5. *The nature and culpability of the defendant's tort. Brutal long term sexual abuse, intentional assault or drug fuelled, dangerous driving being more culpable than mere momentary inadvertence.*
6. *The Court should consider what the Court would do in relation to costs if the claim is not dismissed. The Judge should ask: will the Court award most of the trial and/or pre-trial costs to the defendant in any event because fundamental dishonesty has been proven? Also, will the claimant have to pay some or all of his/her own lawyers' costs out of damages if the claim is not dismissed? These both aim towards answering the question: "what damages will be left for the claimant after costs awards, costs liabilities and adverse costs insurance premiums are satisfied?" If the genuine damages to be received by the claimant will be substantially reduced or eradicated by the adverse costs awards, then it is less likely that SI will be caused by the dismissal.*
7. *Has the defendant made interim payments, how large are these and will the claimant be able to afford to pay them back?*
8. *Finally, what effect will dismissing the claim have on the claimant's life. Will she lose her house? Will she have to live on benefits, being unable to work?"*

He then applied them to Ms Williams-Henry's case as such:

"[205] For the decision on SI I shall take each relevant factor in turn.

1. *<u>The amount claimed when compared with the amount awarded</u>. The Claimant sought £2.5 million and recovered just under £600,000. The difference is not outside the usual bounds of claims and awards in personal injury claims, however the dishonest parts of the claim inflated the damages sought by over £1 million.*
2. *<u>The scope and depth of the dishonesty found to have been deployed by the Claimant</u>. The scope of the Claimant's untruths was wide. They related to her asserted pain, her ADL, her social life, her physical disabilities and her mental disabilities. The level of dishonesty was high in my judgment and was for financial gain. The Claimant told ancillary untruths to the DWP and the life insurer L&G for financial gain alongside her many*

fundamental untruths to this Court, her treating clinicians and the experts.

3. *The effect of the dishonesty on the construction of the claim by the Claimant and the destruction/ defence of the claim by the Defendant. I consider that the Claimant's dishonesty had a very substantial effect on the trial, on the preparation for the trial and on the evidence relating to the claims for case management, care, therapies, loss of earnings and the figure for pain and suffering and loss of amenity. It also led to many more experts' reports.*
4. *The scope and level of the Claimant's assessed genuine disability caused by the Defendant. The Claimant is moderately severely brain injured but has made a very good physical and cognitive recovery. Depriving the Claimant of damages will not transfer much, if any, cost of care to the NHS, social services and the taxpayer generally. In my judgment she can work and live independently.*
5. *The nature and culpability of the Defendant's tort. The Defendant's tort was at the lower end of the culpability scale. The pier had stood in the state it was in for years with no previous accidents.*
6. *The Court should consider what the Court would do in relation to costs if the claim is not dismissed. If I were to find SI, I would almost certainly award the trial and pre-trial costs to the Defendant in any event because fundamental dishonesty has been proven. These costs may be very substantial considering the size of the Defendant's costs budget. I have, of course, not seen any Part 36 offers, but the fundamental dishonesty will have an overarching effect on the costs orders which usually flow from Part 36 offers. The Claimant would most likely have to pay some of her own lawyers' base costs and success fees out of damages if the claim is not dismissed because of my probable adverse costs orders against her. What damages will be left for the Claimant after adverse costs awards, her own lawyers' costs and insurance premiums are satisfied? Will her adverse costs insurance cover fundamental dishonesty? I doubt it, but have not been shown any policy. In my estimation the genuine damages to be received by the Claimant will be reduced (or potentially eradicated) by the adverse costs orders and the standard terms of her own CFA (which I have not seen but which usually entitle the lawyers to recover their costs on recovery of any sum in damages). It would have assisted the Court if I had been shown the CFA and the adverse costs insurance policy for the SI issue.*
7. *Finally, what effect will dismissing the claim have on the Claimant's life. I am unsure what the effect will be on the Claimant's life. I consider that she is capable of work, physically and mentally, from the perspective of the injuries caused by the Defendant. I take into account the evidence of the Claimant's suicidal ideation. I consider that the Claimant's current unstable state of mental health has been caused by her own dishonesty. The advice she received to take a sabbatical and later, to give up work, was likewise so caused. The Claimant was in work until October 2022. In my judgment her stopping work was not caused by the tort. I am unclear whether the dismissal of the claim will lead to the Claimant being unable to repay her mortgage. She paid part of it off out of the £108,000 she received from an insurance policy after the fall. She should be able to afford the reduced mortgage repayments if she gets back to work. She has minimal savings."*

In reaching his finding that there wasn't substantial injustice leading to the dismissal of the case, Ritchie J also took into account the fact that before trial the Claimant had received £75,000 in interim payments. When dismissing the case then the natural order of things would normally require that these monies were repaid back to the Defendant. The only way that the Claimant would have been able to do this was by selling the one substantial asset she now had, her home.

In what appears to have been an astute tactical decision, the Defendant did not invite Ritchie J to make such an order if he dismissed the case. In fact, the Defendant reminded the court of its power to refuse to make such an order pursuant to CPR Part 25, thus removing probably Ms Williams-Henry's best argument for injustice from the table.

This article was first published on the Deka Chambers website as a "Dekagram" 15th April 2024.

NHS COVER-UP CULTURE: CIVIL LITIGATION HELPS FIND THE TRUTH

By Dr Anthony Barton, Medical Negligence Team, Leeds e: anthony.barton@doctors.net.uk

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Introduction: the problem

Investigating adverse clinical outcomes is vital for patient safety; it serves many functions including opportunity for learning and teaching, raising care standards, safety audit, professional accountability, and preparation for any potential compensation claim.

It ought to be embraced. Sadly, the reality is the opposite: an ostrich approach by the NHS - an institutional lack of openness and transparency. The health service cannot be trusted to investigate itself. Reputation is supreme, trumping patient safety, to sustain the delusion that the NHS is the envy of the world. It is more important than its patients.

Wes Streeting, the Health Secretary, called it "cultural rot" in the national press. The Parliamentary Ombudsman's 2023 report "Broken Trust" listed NHS failings, including "failure to be honest" and "poor-quality investigations". It is a matter of official record. Far from being a cause for concern, the culture of cover up has become normalised.

There are extensive local and national mechanisms for investigating adverse outcomes; their efficacy is inconsistent and unreliable. Duty of candour letters have largely become a box ticking exercise.

So how to investigate adverse clinical outcomes?

Civil litigation

Clinical negligence litigation provides a partial solution: but even a partial solution is better than none. It is concerned with breach of duty causing injury. However, it provides independent, rigorous, judicially regulated investigation according to accepted medical professional norms. The injured patient initiates the action, is a party in an adversarial process and has an active role in proposing the issues, framing the questions: the evidence, the witnesses, the scope, and the direction of the claim.

Clinical negligence litigation is a commercial activity driven by claimant lawyers. Like all businesses, it is about money and how it moves. Access to justice is funded largely by conditional fees, free at the point of need, and available to all. It is a tribute to the enterprise of claimant lawyers, and a triumph of privatisation. Legal aid funds just 0.5 per cent of claims against the NHS.

There are many millions of healthcare encounters, resulting in an unknown but likely significant proportion of adverse outcomes.

Claims must represent a minute proportion of clinical encounters. According to NHS Resolution Annual report and accounts 2023/24, last year there were over 13,000 cases against the health service. Claimant sources estimate roughly 300,000 inquiries.

Damages were paid in about 7,000 cases. Claimant costs are usually only paid in successful claims, which means that fees generated by roughly 7,000 successful cases funded the assessment of 300,000 inquiries. This represents a free clinical scrutiny service for the taxpayer.

Trials are expensive; last year there were 29. It demonstrates the efficiency of the litigation process. But while litigation is efficient, there is a weakness that originates in its funding.

There is a striking asymmetry in how lawyers are paid. Claimant funding is privatised, mostly conducted on a no win, no fee basis - it is payment by result that compels competence and economic prudence. There is also the marketing cost of claims acquisition.

Defendant lawyers are state funded. They are paid regardless of the outcome. It sustains reward for failure, and provides perverse incentive for "deny, delay, defend" behaviour. There are no claim acquisition costs.

Expert witnesses are rightly paid regardless of outcome, and regardless of which party they act for.

Clinical negligence cost the health service more than £2.8 billion last year; £2.1 billion was damages payment to claimants. But is this a price worth paying?

Alternatives to litigation

There is widespread concern that the negligence litigation system is economically unsustainable, prompting proposed alternatives to fault-based litigation. The past 50 years have seen periodic calls for a no-fault compensation. All have failed. It does not accord with political or economic reality. Any no-fault system will lower the threshold for claims, thereby increasing the number, but retain the requirement to prove causation. What machinery will manage a no-fault system?

There have been calls for increased use of mediation to resolve clinical negligence disputes. However, it is a non-evaluative consensual process. It is difficult to see its role in investigating adverse clinical outcomes.

The NHS Redress Act 2006 is enabling legislation. It proposed a voluntary alternative to litigation but retaining fault-based liability. It envisaged an integrated remedy based on qualifying liability in tort that would provide a redress package including an offer of compensation, explanation, apology, a report of action to prevent similar occurrences, and appropriate treatment. Legal rights would remain intact but would be waived if an offer was accepted. The statute proposed the NHS investigating itself and effectively adjudicating on its own liability: a clear conflict of interest, lacking the independence, authority, and deterministic finality of a judicial process. There are no plans to implement the Act - it rightly belongs in the dustbin of history.

Coroner's inquest

The need for a coroner's inquest is imposed by law and arises in certain categories of death. In the clinical context it concerned with unnatural death or where the cause of death is unknown. The central question for the inquest is: how did the patient die? The inquest is fact-finding. It is not a trial to determine legal liability; there are no parties. The coroner decides the evidence, the witnesses, and the scope of the investigation. Bereaved relatives have little say. Challenging coronial decisions is costly and cumbersome. Public dissatisfaction seems widespread and largely unaddressed - amply demonstrated by the written evidence submitted to the recent inquiry on coroners by the influential House of Commons Justice Committee.

The NHS spends large amounts on legal representation at inquests. However, findings of fact are not binding. Legal rights are neither asserted nor defended, so the purpose must be to protect reputation, a fight over the facts: better that an inquest conclusion is unclear than damaging to NHS reputation.

Too often there are no independent clinical expert witnesses. Instead, the court relies on the testimony of doctors acting both as witnesses of fact and as expert witnesses — a potential conflict of interest. Where is the essential rigorous independent clinical scrutiny?

Too often an inquest involving patient death is about the NHS investigating itself, but with the cloak of respectability of a judicial process. The court should not do the NHS's washing.

The Ministry of Justice has proclaimed that the bereaved should be "at the heart" of the inquest process. Fine words: too often the opposite is true.

Criminal litigation

This can involve gross negligence manslaughter and murder. The state is the prosecuting and investigating agency. Such cases are high profile but very rare. Clinical details are examined in minute detail; the standard of proof is high. Criminal liability is mentioned for completeness; it is unlikely to provide any useful remedy for most cases of adverse clinical outcome.

Conclusion

Instead of seeking alternatives to fault-based liability or litigation more effort should be applied to making the litigation work better. This likely involves reviewing the economic drivers.

Justice is open, and subject to public scrutiny. Expert witnesses perform a vital role in the administration of justice.

So long as the health service places its reputation above patients, there is a need for civil litigation.

KNOW YOUR LIMITS – THE PITFALLS OF EXPERTS WHO STRAY BEYOND THEIR RELEVANT EXPERTISE

By Bethan Parry, Legal Director, Clyde and Co, Manchester e: bethan.parry@clydeco.com

The importance of knowing your expert and the limits of their expertise should not be underestimated. One very recent case serves to highlight the very severe consequences for parties who seek to rely on a breach of duty opinion from an expert who does not have adequate experience in performing the allegedly negligent procedure.

Background

The claim related to an allegedly negligent surgical termination of pregnancy via a Dilatation and Evacuation ("D&E") procedure whilst the Claimant was in her second trimester of pregnancy (specifically, at 17+2 weeks gestation).

The Claimant alleged that she subsequently suffered from intrauterine adhesions and a period of infertility of around 18 months, as well as a psychiatric injury.

In respect of breach of duty, the Claimant alleged there had been a lack of care/substandard technique in the performance of the D&E procedure. Her specific allegations were that the Defendant had breached his duty of care by:

1. Using an insufficient degree of cervical dilation for termination at 17+2 weeks gestation;
2. Carrying out the procedure too rapidly, implying a lack of care; and
3. Using undue and/or inappropriate force.

In his Defence, the Defendant robustly denied breach of duty further to the supportive expert evidence of a Clinical Consultant Obstetrician and Gynaecologist, who was highly experienced in performing terminations of pregnancy during the second trimester.

During a pre-Defence conference, the Defendant's expert highlighted that there were in fact very few gynaecological surgeons in the UK who had second trimester termination of pregnancy experience, due to the high level of specialist training and experience required to perform the procedure.

The Defendant's expert (and the Defendant himself) were part of that small pool.

Following the Costs and Case Management Conference (CCMC), it became clear that the Claimant's condition & prognosis expert (a Consultant Gynaecologist practising in Reproductive Medicine) was also the expert they had relied upon in relation to breach of duty. Therefore, it was unclear whether the expert was also part of that pool.

The role of experts in clinical negligence claims

CPR 35.3(1) makes it clear that it is the duty of experts to help the Court on matters that are *within their expertise*.

When considering the question of breach of duty, the experts in this case needed to consider whether the standard of care provided by the Defendant (specifically, in performing the second trimester termination of pregnancy) fell below the standard of care expected of a consultant gynaecologist acting with ordinary care in accordance with a responsible and reasonable body of medical opinion at the index time (the *Bolam/Bolitho* test).

Clearly, to legitimately and authoritatively answer that question, it was essential that the experts themselves had the requisite experience in performing second trimester terminations of pregnancies via D&E.

A tactical approach

The issue was first raised in open correspondence following the CCMC, when the Defendant's solicitors queried whether the Claimant's expert had carried out these types of procedures before. At this time, the Claimant responded to say: "*We have spoken to [the Claimant's expert] and she has confirmed she has the relative experience to comment on liability in this matter*".

However, following exchange of liability evidence, the Defendant's solicitors served robust Part 35 questions which probed the Claimant's expert further into her experience and, ultimately, her ability to reliably address breach of duty in the claim.

In her responses, the expert confirmed that she did not perform second trimester surgical terminations and that these are not carried out at her hospital Trust. In addition, she confirmed that she had not carried out any surgical terminations at the index time she was asked to comment upon.

Upon receipt of the responses, it was promptly highlighted in open correspondence that the Claimant's case on liability was entirely misconceived, being as it was, based on evidence from an expert lacking the appropriate expertise. A 'drop hands' offer was put forward and later accepted by the Claimant.

Comment

This claim serves as an important reminder to all practitioners that clinical negligence cases will absolutely stand or fall on the quality of expert evidence, and it is therefore crucial that an expert's own clinical experience (and their practise at the index time) is suitably interrogated, to ensure that they can legitimately comment on the issues of breach of duty. As highlighted in this case, the fact that the Claimant had sought to deploy an expert who was inexperienced in the specific procedure which they were criticising was fatal to the Claimant's case.

Throughout the claim, the member was represented by Bethan Parry, Legal Director at Clyde and Co, under instruction from Allison Munro, Claims Manager and Solicitor from Medical Protection Society.

After the case, Allison Munro stated:

"This case highlights how critical it is to secure appropriately qualified and experienced experts from the outset. The time taken to make the necessary enquiries is an important investment and, as in this instance, can prove essential in achieving a favourable outcome. Our member was understandably relieved and delighted by the discontinuance, thanking MPS and Clyde & Co for '*exceeding excellence*'."

OPINION VARIANCE SURVEY - ETHICAL DILEMMAS RELATED TO MEDICAL LAW

By Amar Alwitry, Consultant Ophthalmologist e: alwitrymedlegal@btinternet.com

Amar Alwitry has a Masters in Medical Law and regularly takes on clinical negligence medico-legal work. He is a Speciality Advisor to the CQC and PSIRF Medical Ambassador to Spire Hospitals. He is also author of "Complaints, Litigation and Clinical Errors" published by Taylor and Francis, a book for all medical and allied professionals.

I recently had the privilege of presenting at the Medicolegal Conference 2024 on the issue of Consent. The talk was interactive and involved questions posed to the audience regarding consent conundrums. Bearing in mind I had a very select audience of learned experts I expected there to be general consensus in the responses to my questions. However, I was amazed to see a lot of variance in the answers with often a 50:50 split in viewpoints. It occurred to me if we were "experts" and we disagreed and had a big variance of opinion how can we properly fulfil our role to the Court to assist in the maintenance of justice?

Prompted by the talk I am writing this article to introduce a new series of opinion variance surveys presenting to the readership questions regarding their thoughts on some ethical dilemmas related to medical law.

Below are this edition's questions, which I would be grateful if you could answer by scanning the QR code.

1- An ophthalmologist is planning cataract surgery for a patient. As part of the consent process, he explains to the patient the risk of infection. He explains to the patient that there is a risk of infection, but he has never had one in his entire career. The pre-printed consent form states a risk of 1:1000 of endophthalmitis (intraocular infection).

The patient subsequently develops an infection and loses their vision in that eye.

The patient subsequently litigated over the issue of consent. It is alleged that the surgeon gave the patient inappropriate assurance regarding the risk of endophthalmitis.

Defence argument: "It is important that patients are given accurate information about the risks of surgery. It is therefore entirely appropriate for the surgeon to present to his patients his audited complication rates. Usually, general complication rates are a reasonable starting point however the surgeon owes a duty to his patient to reflect true real world complication rates in his hands. He was the only one who was going to perform the operation and therefore the consent process was acceptable."

Claimant argument: "It was entirely inappropriate to use personalised complication rates for the consent process. Established complication rates were more appropriate and had the Claimant been made aware of the true risks of surgery she would have declined surgery."

Q1 – Is it appropriate to use personal audited and verified complication rates for the purposes of consent when that surgeon will be operating?

Y/N

2- A patient has bilateral carpal tunnel syndrome and is due to have a carpal tunnel decompression to their right hand. They are appropriately consented and all the risks and benefits of the procedure are explained. The procedure is successful. The patient returns for their left hand surgery. The operating surgeon states "the procedure will be exactly the same this time as last time. If you are happy to proceed then please sign the same consent form you signed previously."

Q2 – Is this adequate consent?

Y/N

3- Data suggests that trainees undertaking procedure x have a higher complication rate than consultants undertaking the same procedure. A patient attends for procedure x and a trainee will be undertaking it.

Q3a – Is the trainee operating a material risk of procedure x?

Y/N

Q3b – Should this material risk be disclosed and discussed with the patient?

Y/N

4- A patient attends for an endoscopy. They state categorically that they do not wish to know about any of the potential complications and that they trust the hospital and the doctor doing it.

Q4 – Should we respect the patients wishes?

Y/N

5- A patient attends for a cataract operation. They are consented for the risk of some visual loss (1:100), risk of losing the eye (1:10000), infection (1 in 800), blindness (1:1000). They develop a complication following surgery called cystoid macular oedema. This occurs due to inflammation causing swelling of the retina at the back of the eye. It usually resolves with medical therapy (eye drops and potentially intraocular or periocular injections). In the patient's case the vision does not resolve and they were left with vision significantly worse than pre-operatively. The patient litigates.

Claimants argument: "The Claimant was not informed appropriately of the risks of cystoid macular oedema (swelling at the back of the eye). It was not mentioned on the consent form and it was not discussed with the Claimant at any time. Had the Claimant been made aware of the risk of swelling and the fact that it sometimes does not resolve she would have not proceeded with surgery."

Defendants argument: "We accept that the specific complication of cystoid macular oedema was not documented and not discussed with the Claimant however the risk of visual loss was clearly discussed and explained to the Claimant. The exact mechanism of the visual loss is not relevant and the duty of care of the clinician is to ensure that a patient knows the material risks of potential adverse outcomes and not exactly the mechanism of those outcomes."

Cystoid macular oedema occurs in between 0.1–2.35% of cataract cases.

Q5a – Is cystoid macular oedema a material risk of cataract surgery?

Y/N

Q5b – Should the Claimant have been made aware of the risk of cystoid macular oedema?

Y/N

Q5c – Does the Claimant have a valid case that the consent was inadequate?

Y/N

The anonymised responses will be collated and presented in the next edition with a discussion of the findings.

I am very grateful in advance for your time and assistance in answering the questions.

Scan QR code to Participate in Survey

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EXPERT WITNESS DIRECTORY

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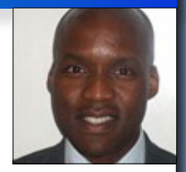

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Mr Chukwuemeka was the Royal College of Surgeons' Regional Specialty Advisor and served on the Medical Technologies Committee at NICE. He serves on the NHSE - Clinical Reference Group for Cardiac Services, NHSE - London Clinical Senate Council and the Medicines and Healthcare products Regulatory Agency (MHRA).

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He specialises in the analysis of gait related musculo-skeletal problems relating to foot and leg malfunction, dividing his time between his private practice and expert witness work. He focuses on Personal Injury cases where approximately 75% of his work is for the claimant, and 25% for the defendant.

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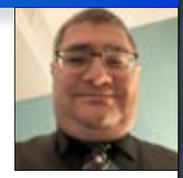

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- Whiplash
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- Ankle, knee and hip fractures, lower limb injuries
- Soft tissue injuries

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- Primary and revision hip and knee replacements
- Pelvic and acetabular fractures
- Long bone and periarticular trauma

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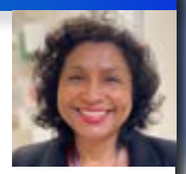

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Her medico-legal practice includes medical negligence, second opinions, decisions on escalation and resuscitation, ethical situations, inappropriate/harmful testing and treatments, and breeches in communication. She is able to provide comprehensive case reviews and expert opinion on the quality of the care provided at the different stages of care.

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Mr Sarwat Sadek has been practising as an ENT Consultant for nearly 40 years and is currently Consultant Otolaryngologist and Head & Neck Surgeon at Musgrove Park Hospital and the Nuffield Hospital, Taunton.

Areas of interest:

- Noise induced hearing loss
- Occupational rhinitis
- Facial & neck trauma
- Traumatic loss of sense of smell and taste
- Deafness, tinnitus and vertigo as a result of road traffic accidents

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Mr Kumar, is a Consultant Orthopaedic Surgeon, specialising in trauma and upper limb conditions, with a focus on medicolegal practice since 2011. He serves on the trauma rota at the Royal Lancaster Infirmary. He holds an LLM in Medical Law & Ethics and is on the Medicolegal Committee of the British Orthopaedic Association. He performs assessment of doctors for the General Medical Council and examines for the Royal College of Surgeons. With regulatory experience, he has advised the CQC. He provides concise medical reports for clinical negligence and personal injury cases, with clinics in Manchester, Lytham, Bolton and Lancaster.

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Dr Neil Mo is a consultant rheumatologist and clinical lead in Swansea Bay University Health Board. He was previously a consultant in Charing Cross and Hammersmith Hospitals. He has received training in report writing and courtroom skills, and has produced over 300 medicolegal reports. He provides comprehensive, authoritative and well balanced reports with a quick turnaround time.

He has expertise in all areas of adult rheumatology, and maintains his clinical and medicolegal knowledge to deliver an up to date expert opinion. He is experienced with risk management within the NHS and has undergone training with NHS resolution.

EMAIL ME

EXPERT WITNESS DIRECTORY

MEDICO -LEGAL NEWS:

By Lisa Cheyne,
Medico-Legal Manager,
SpecialistInfo

A round-up of news in the industry of the third quarter of 2024

NEWS

Anaesthesia and Physician Associate Lawsuit against the GMC

The Anaesthesia and Physician Associate Order is due to come into force in December 2024. However, there is a growing concern from the medical profession about the role of these healthcare professionals after they have completed only 2 years of training. Many members of the BMA and Medical Royal Colleges feel that Parliament was misled when the order was debated, and that the new Government must pause the legislation to allow the Health and Social Care Committee to assess their concerns about patient safety.

A campaign group called Anaesthetists United has proposed a claim for judicial review challenging the GMC's failure to introduce the safe and lawful practise measures and its failure to regulate on a properly informed basis as unlawful. The legal case against the GMC was joined in September by two families who have suffered bereavements following care delivered by Physician Associates.

Read more:
https://anaesthetistsunited.com/our-legal-arguments/

Junior Doctors accept Government Pay Deal

Junior doctors voted to accept a pay deal of around 22% over two years, the BMA announced on 17 September, stating:

"The BMA's junior doctors committee (JDC) in England has accepted the government's pay offer, with 66 per cent of junior doctors voting in favour of the deal."

The average of 4% over their existing pay award for 2023-24, will be backdated to April 2023.

The statement added: "Outside the pay negotiations, the government has agreed that from September 18 'junior doctors' across the UK will be known as 'resident doctors' to better reflect their expertise.

"This follows a motion to the BMA's annual policy making conference in 2023 when doctors voted in favour of a name change."

Wes Streeting, the health secretary, said he is pleased the BMA has accepted the government's pay deal and said that the situation "should never have been allowed to get this bad".

Read more: https://www.gov.uk/government/news/junior-doctors-accept-government-pay-deal
https://www.bma.org.uk/our-campaigns/

Yaser Jabbar Paediatric Surgery Scandal at GOSH

Mr Yaser Jabbar, paediatric orthopaedic surgeon, is at the centre of an inquiry by Great Ormond Street (GOSH), looking at the care of hundreds of children since 2017. At least one patient has had a leg amputated, others have been left in chronic pain and with deformed limbs.

Senior leaders were told as early as 2020 about concern over Jabbar's practice, but nothing was done until 2022.

He performed operations without the full consent of patients at GOSH and privately at the Portland Hospital.

Jabbar is facing an investigation by the GMC, although he has voluntarily given up his licence to practise in the UK. He left GOSH at the end of September 2023 and was listed as working in Dubai, where he was operating on children at the Clemenceau Medical Center and for orthopaedic specialist firm Orthocure.

It seems likely that multiple claims will be brought against his employers.

Read more: https://www.bbc.co.uk/news/articles/c3035e26gl0o

Partisan Experts in Wilson v Ministry of Justice [2024] EWHC 2389 (KB)

The judgment of HHJ Melissa Clarke (sitting as a judge of the High Court) in *Wilson v Ministry of Justice [2024] EWHC 2389 (KB)* found that several of the multiple experts were not fulfilling their roles as independent advisers to the court.

Mr Wilson was a guest of Her Majesty when he was stabbed in the prison kitchens by another inmate. He suffered multiple life-threatening and life-changing injuries and was hospitalized for several weeks. The defendant admitted negligence in allowing a convicted murderer access to kitchen knives. At the trial on damages there were seven different disciplines of expert: spinal injury, psychiatry, pain medicine, physiotherapy, care/OT and accommodation, together

with a single joint expert in urology. The claimant was awarded damages of over £5 million.

The Judge criticized Mr Naveen Kumar, Spinal Surgeon and expert for the defendant: "I found Mr Kumar to be a partisan witness who, unusually, agreed quite early on in his cross-examination with the contention that he had lost all independence and objectivity in this case. He initially agreed that part of his evidence (that he did not find Mr Wilson to have any balance or weakness issues) was wrong, and it was put to him that it showed he had a lack of objectivity and was advocating for the Defendant. Mr Kumar replied "I agree. I have said he had impaired balance previously".

She also found wanting the evidence of the pain medicine expert for the Defendant, Dr Edwards, who "significantly altered his stance in cross-examination to reach a position much closer to that" of the Claimant's expert. The Defendant's physiotherapy expert, Mrs Keech, "departed from her fair and independent approach, to one which veers into a partisan approach" having seen the surveillance evidence, "cherry-picking what she mentioned and what she failed to mention in order to paint a positive and improved picture of Mr Wilson, which was not one that could fairly be drawn from the video surveillance" evidence. And finally, the Defendant's accommodation expert, Mr Burton, emerged from cross-examination "with his credibility and independence significantly damaged". Having initially, like Mrs Keech, approached the case independently and fairly, upon seeing the surveillance videos Mr Burton then allowed his evidence "to be corrupted".

The Judge, unsurprisingly, preferred the evidence of the claimant's experts in all these areas, after the experts for the defendant endured cross-examination and ultimately public humiliation.

The responsibility for any expert is to assist the court and not the party who instructs them.

Read more: https://www.bailii.org/ew/cases/EWHC/KB/2024/2389.html

September was Aortic Disease Awareness month and September 17th was World Patient Safety Day

Missed aortic disease in Emergency Departments, including dissection and ruptured abdominal aortic aneurysm, is one of the most common causes of death related to misdiagnosis (NHS Resolution report).

Aortic dissection can be a challenging diagnosis to make, and may present with collapse, chest or back pain or with neurological symptoms and signs. The Royal College of Emergency Medicine (RCEM) produced a 'THINK AORTA' poster campaign. The RCEM chest pain standard requires senior review before discharge of patients over 30 years of age with this presentation.

The charity Aortic Dissection Awareness states that "Our mission is to save lives by improving diagnosis of Aortic Dissection and ensuring that every family affected by this disease has access to the best available information, care and support."

The registered charity is led by patients, for patients and was named the UK's Best Specialist Patient Support Charity in the 2023 Non-Profit Organization Awards. Membership of the charity is free to anyone affected by or interested in aortic dissection.

Success is measured by the increasing number of aortic dissection survivors and by the changes we see happening in the aortic dissection healthcare landscape, such as:

Publication of the first-ever national guidance on diagnosing acute Aortic Dissection by RCEM and the Royal College of Radiologists, working with our THINK AORTA campaign.

Agreeing a national set of national Aortic Dissection research priorities with the Department of Health, which have resulted in an additional £4 million (and counting) funding for Aortic Dissection research since 2020.

Publication of the new NHS England Acute Aortic Dissection toolkit, to help regional Aortic centres to improve their services and patient pathways in order to end the 'postcode lottery' of regional variation in care and outcomes.

A reported 68% increase in emergency Aortic surgery cases in the UK between 2014-2021, as a result of awareness initiatives such as our charity, our annual AD Awareness Day and our life-saving THINK AORTA campaign.

The charity held its annual UK patient conference at the Royal College of Surgeons, Edinburgh this September along with the sister Irish patient conference in Dublin's Guinness Enterprise Centre.

Awareness is reaching all corners of the world with the "THINK AORTA" campaign posters being taken up by more countries, who have translated the message into many more languages including Brazil (Portuguese), Cananda (French) and many Arab speaking regions.

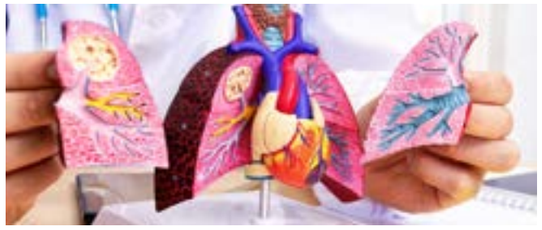
Chair of the Aortic Dissection Awareness Charity, Gareth Owens, said:

"The international theme and Faculty for Aortic Dissection Awareness Day UK this year demonstrates clearly how THINK AORTA has become a truly global Aortic disease awareness campaign. THINK AORTA leaders from North and South America, Europe & Asia joined us in Edinburgh, while in Africa, the THINK AORTA Egypt team held their launch event with 200 patients, relatives and clinicians the same day. The recent translation of our resources into Arabic for Egypt has extended the reach of the campaign to the whole Arab world. The life-saving THINK AORTA poster is now available in the native language of 50% of the world's population. This has all happened faster than we expected, thanks to the support of our THINK AORTA partner organizations and the worldwide medical community."

Read more: Aorticdissectionawareness.org

Thinkaorta.net

https://scts.org/news/307/think_aorta_campaign
https://resolution.nhs.uk/wp-content/uploads/2022/03/1-NHS-Resolution-ED-report-High-value-and-fatalities.pdf



The European Society of Cardiology (ESC) Updated and published their *Guidelines for the management of peripheral arterial and aortic diseases 2024*

The new guidelines were published 30 August 2024 and presented at the ESC Congress in early September.

"The 2024 ESC Guidelines for peripheral arterial and aortic diseases (PAAD) represent the first instance where recommendations for these two conditions have been merged, updating and consolidating the 2017 guidelines for peripheral arterial diseases and the 2014 guidelines for aortic diseases. The focus is primarily on atherosclerotic arterial diseases, though non-atherosclerotic genetic conditions are also considered. These guidelines provide a comprehensive framework for healthcare professionals, covering the entire PAAD patient journey — from diagnosis and risk stratification at initial presentation to long-term management post-hospitalisation. Emphasising patient-centred care, the guidelines also stress the importance of preventive strategies, lifestyle modifications, and physical activity recommendations to prevent disease progression and complications. While not exhaustive, they offer practical recommendations on diagnosis, surveillance, and treatment, with new and revised recommendations highlighted at the beginning of the document. Healthcare providers are encouraged to consider non-atherosclerotic conditions and consult specific documents as needed. The objective is to equip healthcare professionals with the best available evidence to manage patients of all ages with PAAD effectively."

Read more: https://www.escardio.org/Guidelines/Clinical-Practice-Guidelines/Peripheral-Arterial-and-Aortic-Diseases

Men on Epilepsy Drug, Sodium Valproate, Advised to use Contraception

The Medicines and Healthcare products Regulatory Agency (MHRA) now say men, as well as women, under the age of 55 should not take sodium valproate, unless all other treatment options had been rejected, because of "a potential small increased risk" of neurodevelopmental disorders in their future children.

The dangers of exposure in the womb are well-known, according to the MHRA these include intellectual disorders, communication disorders, autism, ADHD, specific learning disorders, motor disorders, tic disorders and other neurodevelopmental disorders.

An estimated 20,000 children in the UK have had life-changing injuries from exposure to the drug before birth. However, there are still an estimated 65,000 boys and men under 55 taking sodium valproate.

The new guidance follows a similar warning from the European Medicines Agency, after data from Scandinavian national registries suggested 5% of children born to men taking the drug were harmed.

Read more: https://assets.publishing.service.gov.uk/media/65660310312f400013e5d508/Valproate-report-review-and-expert-advice.pdf

Lord Darzi Published his Independent Investigation of the NHS in England this September

Lord Darzi, surgeon and Labour former minister, addressed his report to the Secretary of State for Health & Social Care and his overall conclusion was that:

"The NHS is in critical condition, but its vital signs are strong"

He went on to say:

"It continues to struggle with the aftershocks of the pandemic.

Its managerial capacity and capability have been degraded by disastrous management reforms, and the trust and goodwill of many frontline staff has been lost. The service has been chronically weakened by a lack of capital investment which has lagged other similar countries by tens of billions of pounds. All of this has occurred while the demands placed upon the health service have grown as the nation's health has deteriorated."

His report includes a section devoted to clinical negligence and the worrying rise in claims, particularly in obstetrics.

"'Complaints have nearly doubled in a little over a decade, according to data shared with the investigation by the parliamentary and health service ombudsman. As the highest level to which complaints about the NHS can be directed, they received 14,615 formal complaints in 2011-12, rising to 28,780 complaints by 2023/24."

He clarified that:

"Nothing that I have found draws into question the principles of a health service that is taxpayer funded, free at the point of use, and based on need not ability to pay. With the prominent exception of the United States, every advanced country has universal health coverage—and the rest of the world are striving towards it. But other health system models—those where user charges, social or private insurance play a bigger role—are more expensive. It is not a question, therefore, of whether we can afford the NHS. Rather, **we cannot afford not to have the NHS**, so it is imperative that we turn the situation around.

"Many of the solutions can be found in parts of the NHS today. The vast array of good practice that already exists in the health service should be the starting point for the plan to reform it. The NHS is a wonderful and precious institution. And no matter the challenges it faces, I am convinced it can return to peak performance once again."

Read more: https://assets.publishing.service.gov.uk/media/66e1b49e3b0c9e88544a0049/Lord-Darzi-Independent-Investigation-of-the-National-Health-Service-in-England.pdf

Civil Procedure Rule Updates from 1 October 2024 and Extension of Fixed Recoverable Costs in Low Value Clinical Negligence Claims

On 1 October 2024, the latest amendments to the Civil Procedure Rules will come into force. The full text of the Civil Procedure (Amendment No. 3) Rules and Practice Directions 2024 are in the links below.

For Expert Witnesses, the main change is the amendment to the overriding objective (Part 1), in addition there are amendments to Parts 3, 28 and 44, to promote the use of alternative dispute resolution. This amendment follows a consultation by the Civil Procedure Rule Committee to implement the Court of Appeal's Decision in *Churchill v. Merthyr Tydfil CBC [2023] EWCA Civ 1416*.

Dealing with a case justly and at proportionate cost will include "promoting or using alternative dispute resolution", and active case management will include ordering (in addition to the existing encouraging) the parties to use, and facilitating the use of, alternative dispute resolution.

All clinical negligence claims with a value agreed between £1,501 and £25,000 will be subject to fixed costs unless they qualify for a 'specified exclusion'. These include claims involving: a litigant in person, stillbirth or neonatal death, and more than three medical experts.

Whilst the Lower Damages Clinical Negligence Claim FRC (LDFRC) Scheme proposes to fix Claimant legal representative costs, the position in terms of expert fees remains unclear.

It will be interesting to see how this will operate in practice, given that expert fees usually take up a significant portion of the costs in bringing a clinical negligence claim [see PD 45 – Tables of Fixed Costs (2024)]. Significantly, overvalued claims which settle within the £1,501 to £25,000 range will still be subject to the LDFRC Scheme costs, *whether or not* they followed the LVCD Protocol.

Read more: https://www.legislation.gov.uk/uksi/2024/839/made

https://www.justice.gov.uk/documents/171st-practice-direction-update.pdf

https://www.legalfutures.co.uk/associate-news/fixed-recoverable-costs-in-low-value-clinical-negligence-claims

If you are interested in training to be an accredited civil mediator, please see the Mediation course dates on the SpecialistInfo booking site: https://www.specialistinfo.com/mediation-course

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- Have their Medico-Legal CV listed on SpecialistInfo

Both grades are expected to adhere to specified standards of good practice covering compliance, availability and service by conforming to a Code of Good Practice.

Non-Members appearing on the SpecialistInfo directory are Consultants and GPs who have indicated their willingness to undertake Medico-Legal work but have not yet qualified for FEW membership.

If you are a medical expert interested in joining our panel or you are a company looking for a quality expert, please contact Lisa Cheyne lisa@specialistinfo.com 01423 787 984