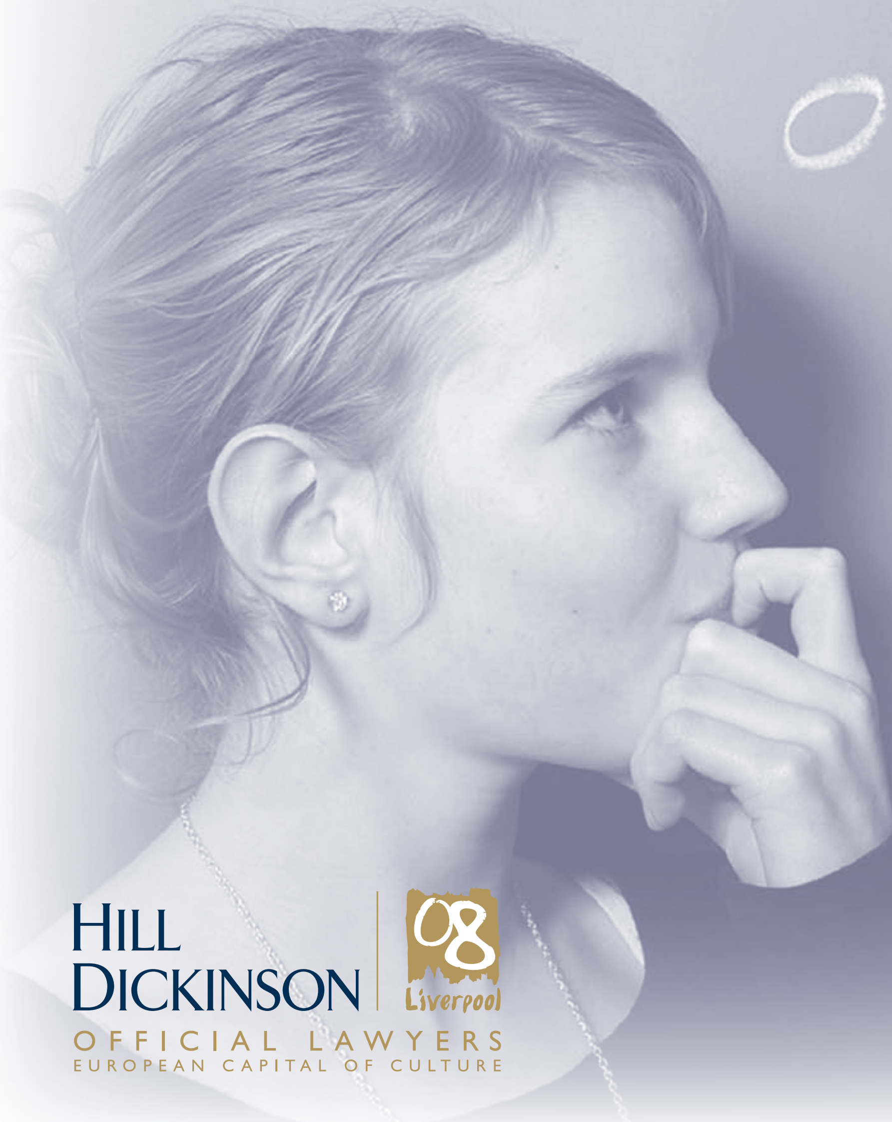
HILL DICKINSON

April 2008

Healthcare Update



Welcome

Welcome to the latest edition of Hill Dickinson LLP's Healthcare Update.

There are a large number of articles spanning both healthcare and litigation issues including the hot topic of procurement, tips on information security in the NHS and the importance of giving apologies after adverse patient incidents. We hope that you find the articles both of practical use and thought-provoking.

The level of damages in clinical negligence claims has spurred Richard Hackett to write an interesting article on page 16. Those of you involved in valuing claims may have asked yourself the question of how much a nose is worth? A French winemaker has this week insured his nose for £3.9m to cover the loss of his nose and sense of smell. No doubt this comes from the French edition of the JSB Guidelines...

You will not need to be reminded that the Corporate Manslaughter and Corporate Homicide Act 2007 comes into force on 6 April 2008. We will be sending out a separate mailing about this and the implications for NHS Trusts very shortly.

As always, we welcome your feedback and comments about articles or practical issues which you would like to see covered in future editions.

STOP PRESS...

Clinical Negligence Training Day

To supplement the current training programme which we are providing throughout the year, we will be holding a one-day seminar in September 2008 dealing with topical issues relevant to Clinical Negligence cases.

To be the first to receive details about this course, please contact: carol.holland@hilldickinson.com.

Contents — Page no.

Healthcare Focus

Procurement - A current hot topic 3
Where can an open window lead you to? 4
Disciplinary process - the effect of delay 4
Call me what you like 5
Freedom of Information Act 2000 Update 6 - 7
Hospital response to fundamental medical care issue 7
Information security in the NHS 8
Unexpected deaths and the Children Act 2004 9 - 10
Right to Life - Article 2 of the Human Rights Act 10

Commercial Property Focus

Register of Surplus Public Sector Land 11

Intellectual Property Focus

IP licensing - Cash behind the sofa? 12

Litigation focus

Quantum update 13
Litigation update 14
When sorry seems to be the hardest word 15
Leslie Ash's £5 million... 16
Statements of Truth - what are you signing? 17
Classic cases revisited - Episode 4 - Psychiatric Injury Claims 18
Limitation - House of Lords decision in A -v-Hoare 19

Hill Dickinson Focus

Hill Dickinson's tips on green travel 20

PROCUREMENT: A CURRENT HOT TOPIC

In this edition, it is particularly timely for us to reflect on a topic of the moment in the field of public procurement, which will now virtually always be a consideration whenever an NHS Trust (or other public body, for that matter) purchases anything of any value from the private sector.

Perhaps the hottest topic of recent months has been whether contracts between NHS bodies and private sector contractors which are signed, and up and running, are actually safe if they have been procured without complying with the EU procurement rules. Until the summer of 2007, it was more or less universally believed that once a contract was signed, it was safe – even if the procurement rules had been breached during the procurement. Then came a European Court of Justice decision, followed closely by a new EU "Remedies Directive" – a piece of legislation setting up a series of rights for private sector contractors wishing to challenge unlawful procurement decisions and reverse illegal tendering processes, both in the latter part of 2007. Between them, these events have now confirmed that contracts which have been awarded without any competition (in circumstances where a competition of some sort is required) could be undone.

This is not surprising, given that these so-called "illegal direct awards" are seen by Europe (from where the procurement rules stem) as the most serious breach of procurement law. As a result of the new legislation the courts will have new powers to tear up contracts which have been signed in these circumstances.

There may sometimes be overriding reasons of general interest why a contract, even if procured illegally, should stand – perhaps a contract for certain indispensable medical services or the supply of equipment which, if overturned, would result in an essential supply being curtailed and potentially place lives at risk. If so, the courts would be able to exercise special powers and allow the contract to stand, but impose an alternative sanction – perhaps a large fine, or a shortened contract period.

Illegally-awarded contracts are potentially at risk of being overturned for up to six months from the date they were awarded, if no contract award notice has been published. Interestingly, the same can happen where, even if there has been a competition, the mandatory standstill requirement has not been followed prior to the award. This is because during that time businesses who would have been interested in bidding for the contract can apply to have the contract ruled ineffective.

Many contracts awarded by NHS Trusts are for clinical or other health-related services – so-called "Part B" services. The procurement rules apply to Part B services only to a limited extent but, as a result of the new Directive, the pre-award standstill requirement will start applying to these services as well. The UK has been given until late 2009 to make this a part of its domestic law. For the moment, the message is that any contract to which the procurement rules apply (including Part B services) need to be subject to at least some degree of competition unless there is plainly only one possible contractor able to meet the requirement.

Christopher Brennan
christopher.brennan@hilldickinson.com

Where can an open window lead you to?

Earlier this year, a Mental Health Trust was prosecuted by the Health and Safety Executive after an elderly patient was injured after falling from a window. The woman, who was an inpatient at a Swindon hospital, fell 5.5 metres, sustaining a broken ankle and a fractured spine. The Trust pleaded guilty to a breach of section 3(1) of the Health and Safety at Work Act 1974 and was fined £20,000 with £12,502 costs.

The Trust had already identified a risk in respect of the particular window and window restrictors had been fitted but they failed to reach the required standard. The hospital cared for patients who were elderly and confused and there was a history of similar accidents. The window restrictors which had been fitted were not found to be sufficiently robust, and allowed the window to open in excess of 100mm, which is the maximum distance specified in the Health and Safety Executive guidance. There was no system of inspection in order to check that the window restrictors were appropriate.

The case of Longfield Residential Home -v- The Coroner for Blackburn in 2004 dealt with an inquest held into the death of a woman who died after falling out of a first floor window of a care home. In that case all of the windows in the care home, apart from one, had window restrictors. The window in the residents' lounge had been opened by a member of staff by raising the lower sash, and then left unattended. The deceased fell out of the window, suffering a broken pelvis and died the next day in hospital.

The narrative verdict stated that her death from pneumonia was accelerated by the effect of the injuries sustained when she fell through an unattended open window, which lacked a window restrictor.

An accident involving a patient who falls out of a window can have far-reaching implications for NHS Trusts. There may be a prosecution by the Health and Safety Executive, a civil claim and, if the patient dies, a Coroner's Inquest (potentially with a jury if the death is reportable to the HSE). Trusts should ensure that risk assessments are carried out on all windows and that, where appropriate, suitable window restrictors are used. Importantly, the duty of care is continuing and Trusts should ensure that there is a system for regular inspection and maintenance of the window restrictors.

Joanna Crichton
joanna.crichton@hilldickinson.com

Disciplinary process: the effect of delay

Selvarajan –v- General Medical Council [2008]

Between 1994 and 1996, Dr Selvarajan (Dr S), a GP in London, wrote fictitious prescriptions for over 2,500 items of medication; defrauding the NHS of a sum approaching £150,000. Six years after the period of fraud, the information was referred to the GMC and, two years later, the GMC informed Dr S that he would face misconduct charges based on fraud and dishonesty. A further two years later in 2006, the substantive GMC hearing took place. Before the GMC Panel decided on the sanction to impose, Dr S argued that it would be a breach of his human rights to erase his registration, given the delay in concluding the proceedings. The GMC Panel determined that the delay in bringing proceedings against a doctor was irrelevant and erased Dr S's name from the medical register. Dr S appealed.

In February 2008, the High Court considered the appeal and concluded that Dr S's submission in respect of delay was correct as a matter of common sense, past practice and fair trial case law. For the proceedings to take nearly four years from charge to penalty as well as two further years for them to be finally determined in the High Court was unacceptable and unreasonable; the GMC Panel had been incorrect to say that delay was irrelevant. In this case however, the Court determined that the delay did not outweigh the clearly appropriate penalty of erasure.

Application in the NHS

This decision will have an impact on those responsible for regulating primary care performers on PCT Performers Lists and internal employment disciplinary proceedings. The case cements an important concept in law - if the delay in proceeding with a disciplinary matter is deemed unreasonable, it may reduce the severity of the outcome. If a fitness to practise issue arises in respect of a doctor or other primary care performer, the NHS employer or PCT on whose List the practitioner is included must address the issue promptly and, where deemed appropriate, refer the matter to the GMC or other appropriate regulatory body as soon as possible. It is important to have effective systems in place for progressing and monitoring disciplinary cases; those that incur significant delay must be prioritised and concluded within a reasonable time frame, in order to ensure that the desired result is obtained.

Gemma Brannigan
gemma.brannigan@hilldickinson.com

CALL ME WHAT YOU LIKE

Our November newsletter contained an article I had written "Ban that bow tie" which reported on the prospect of the disappearance of the white coat (and even possibly the stethoscope) from the nation's hospitals. Apparently we are the only country in the world to have attempted to ban white coats and protests persist that there is no evidence or logic to support this policy.

Now there are moves to change the names of some of our best known diseases. There exists a debate in medical circles as to whether eponyms should be abandoned.

The Oxford English Dictionary defines an eponym as "a person ... after whom a discovery, invention, institution etc. is named or thought to be named". Examples of well-known medical eponyms are Hodgkin's disease and Tourette's syndrome. These conditions are named after the individuals credited with their discovery and/or first description.

So why would we want to stop using names like these? One common flaw is that eponyms frequently refer to a single individual giving him or her undeserved credit whereas in practice scientific discoveries often reflect a group effort over time. It is also suggested that eponyms lack scientific accuracy because they do not adequately explain and identify the particular signs and symptoms that suggest the presence of the disease or condition.

Of more interest from a medico-legal point of view is the argument that some diseases have different eponyms in different countries. Ankylosing Spondylitis is known as Bechterew's disease in Germany and Marie Strumpell Disease elsewhere in the world. Apparently Quervain's disease can be tendovaginitis of the hand or a rare thyroid disorder.

Clearly this sort of confusion is best avoided especially when one considers the number of overseas doctors now working in NHS practice.

Those that argue that eponyms should be abandoned suggest that a more descriptive classification of individual diseases should be used.

The counter argument to the "descriptive classification" argument is that eponyms are practical and a useful form of medical shorthand. Would you rather refer to violent muscular jerks of the face, shoulders and extremities with spasmodic grunting, explosive noises or coprolalia instead of Tourette's syndrome?

It is also worthy of note that eponyms are widely used in contemporary life (not just medicine). Without eponyms what would we call a cardigan, a sandwich or diesel?

My view is that this debate misses an important point somewhat. The arguments above are of secondary importance to the need for clear communication between practitioners and between practitioners and patients.

Many members of the public will understand that Hodgkin's disease is a form of cancer but not all will. Terminology and communication needs to be patient focused. We deal with too many claims that could have been avoided had communication between patient and clinician been better.

The use of eponyms as well as overly complex descriptive classifications can cause difficulties, as can unwelcome and unexplained abbreviations and medical lingo. We once had to deal with a claim (there would have been a claim in any event) which arose out of circumstances in which a surgical foreign body (a radio opaque surgical swab) had wrongly been left in situ following abdominal surgery. The patient was told that it had been realised that he had a "foreign body in situ" and wrongly assumed that this meant that he had cancer. This caused him significantly more trauma than would have been the case had the true situation been explained to him in a manner that he could understand.

Good communication does not only help in the avoidance of claims and complaints. Good communication aids good healthcare provision and reflects well on all those who provide it. Eponyms or descriptive classifications may be suitable but what is most important is that the patient and everybody involved in the treatment understand the information being communicated to them.

Simeon Bower
simeon.bower@hilldickinson.com

Freedom of Information Act 2000 – Update

Information Commissioner Decision Notice 14 January 2008

In 2006, the Complainant asked Mersey Care NHS Trust ("the Trust") to provide copies of five critical incident reports dated between 2004 and 2005. These five reports related to an internal inquiry carried out by the Trust following a murder involving one of its patients.

The Trust issued a refusal notice on the basis of the following exemptions contained within the Freedom of Information Act 2000:

- Section 36(2)(c) – disclosure of this information held by the Trust would prejudice or be likely to prejudice the effective conduct of public affairs.
- Section 40(3)(a) – this information is personal information which did not relate to the complainant, the disclosure of which would contravene the data protection principles laid down in the Data Protection Act 1998.
- Section 41 – this information was obtained by the Trust from others and to disclose it would give rise to an actionable breach of confidence.

The Complainant requested a review of this refusal, which the Trust duly carried out. In doing so, the Trust upheld its original refusal. The Complainant then contacted the Information Commissioner citing, in particular, the following arguments:

- In relation to section 36, "the balance of public interest and the effective conduct of public affairs lies strongly in favour of informing the public as to whether there are any failings in the Trust's security arrangements, rather than keeping this information secret."
- In relation to section 40, "these are reports on the Trust and whether it adequately protects the security of the public and of patients in its care." The Complainant therefore concluded that the documents could not be 'personal information' although he was willing to accept redacted versions if the Commissioner considered section 40 engaged.

With regard to the section 40 exemption, the Trust responded as follows:

- The Trust was of the opinion that to process the information in question would be unfair to those individuals involved and would be beyond what they believed their involvement would be.
- This would contravene the first data protection principle that data should be processed lawfully and fairly.
- It would also be 'inappropriate' to obtain the consent to disclosure of most of the parties involved and 'highly problematic' in re-establishing contact with many of the contributors.
- Further, providing a redacted version, when taken with some of the other information provided, will lead to the identification of those involved.

The decision

The Commissioner first considered the availability of section 40(2) to this request for information. The decision notes that: "the combined effect of section 40(2) and 40(3)(a) is that information is exempt from disclosure if it constitutes personal data of which the applicant is not the data subject and its disclosure would contravene any of the data protection principles or a section 10 notice under the Data Protection Act 1998 (DPA)."

Was this personal data? - Yes

With regards to the reports in question, the Commissioner accepted that this was personal data. The reports related to identifiable individuals as they can be processed to "learn, record or decide something about the individuals." In addition, the small number of the incidents in question narrowed the range of individuals who could be linked and identifiable within the reports.

Was the first data protection principle breached? – Yes

In essence, the first data protection principle requires personal data to be processed fairly and lawfully. In order to decide whether disclosure of the reports would contravene this principle, the Commissioner considered the following points:

- How the information was obtained. The Commissioner noted that the information generally came from GPs and carers of the patients involved in the critical incidents. It is therefore subject to the doctor-patient confidentiality relationship and is generally not disclosable.
- Expectations of data subjects. The Commissioner acknowledged that in providing the original information on which to base the reports, the contributors and the patients' families would have known that patient confidentiality applied. It was therefore very unlikely that the patients or their families would expect this information to be publicly available.

Continued...

Conclusions

The Commissioner therefore concluded:

1. Disclosing these critical incident reports would breach the fairness element of the first data protection principle.
2. In addition, disclosure would be a breach of confidence and therefore unlawful.

This means that section 40(2) is applicable. There was therefore no need to consider whether the other exceptions cited by the Trust applied.

Redacted copies of the reports

The Complainant had also offered to accept redacted copies of the reports. However, the Commissioner did not believe this to be a viable option. Whilst the information could not be withheld to spare the officials' embarrassment over the incident, in this case, to disclose the reports would entail the disclosure of the history of events. This would necessarily include details of the patients and their medical status, medical treatment and medical opinions on them. Without this information, the reports would be rendered "meaningless."

Comment

This decision reiterates the importance of maintaining patient confidentiality. Clearly, Trusts should investigate and learn from adverse incidents involving patients where appropriate. This decision will assist with this process, as, by providing assurances that exemptions from Freedom of Information Act requests may apply, patient confidentiality can be assured thus encouraging a more open investigation and forthright contributions from those involved. This, of course, does not affect the position where the data subject themselves may apply for access or if parts of the reports could be disclosed without the report becoming 'meaningless.'

Jenna Tsai
jenna.tsai@hilldickinson.com

Health Services Quiz 2008

Our annual client quiz was held on Thursday 6 March 2008 at the Pan American Bar at the Albert Dock, Liverpool. We would like to say a big thank you to everyone who attended for making it such an enjoyable (and competitive!) evening for all.

Special thanks must go to the two Mikes; Mike McKenna who did a smashing job as our quizmaster (we hope you agree!) and to Mike Smith, the pianist and saxophonist who gave us all the opportunity to sing along during the music round!

This year the winners were "Midwives plus 3", a team from the Liverpool Women's Hospital NHS Foundation Trust who scored 78 points! The team from Halton & St Helens Primary Care Trust/Partner and Lift came a close second with 74 points.

We felt that this year could not go by without acknowledging that Liverpool is the European Capital of Culture 2008, so the lucky winners not only received a bottle of champagne but also tickets to the Capital of Culture's Street Festival due to take place in the summer. (Hopefully the mention of the prizes may encourage those of you who could not attend to join us next time!!!).

Each participant received a Capital of Culture Yearbook, which should provide great memories for many years to come of this important year for Liverpool. We hope that those of you who attended will also take away some great memories of a fun and sociable evening!

We look forward to seeing you next year.

Hospital response to fundamental medical care issue

The debate on medical ethics has been highlighted by the recent publicity surrounding the indication that doctors were to seek legal approval to perform a hysterectomy on a severely disabled teenager, Katie Thorpe, aged 15. This was in response to her mother's fear that the girl, who has cerebral palsy, would be unable to cope with the onset of adulthood. The surgery was intended to improve her quality of life as opposed to being strictly medically necessary. Less radical proposals for treatment, inclusive of the contraceptive pill or injections to prevent menstruation, were argued by the child's mother to hold the potential for health problems. A request was also to be made for the removal of the girl's appendix, to prevent the risk of appendicitis.

Due to the fact Katie cannot walk or talk, it was argued she would be unable to indicate the onset of early symptoms. Legal guidance was to be sought due to the teenager's inability to provide valid consent. Despite the child's mother providing parental consent, surgeons wished to obtain a legal opinion in light of the concern regarding whether surgery could be considered to be in her best interests.

Whilst the scenario represents a British first, it follows the recent publicity regarding the Seattle "Ashley X" treatment decision, in which a child with severe developmental disabilities due to static encephallapathy of unknown etiology underwent treatment including growth attenuation via hormonal treatments, hysterectomy, bilateral mastectomy and appendectomy. Subsequent investigation of the American case by the Washington Protection and Advocacy System (WPAS), a private group with Federal investigative authority, ruled that patient rights had been violated by performing a hysterectomy without a Court Order, although no further action in light of the error was indicated.

Having considered the case for several months, the hospital has declined to undertake the procedure without evidence of medical need. However without Court guidance on this issue, it may well arise again.

Catherine Clegg
catherine.clegg@hilldickinson.com

Information Security in the NHS

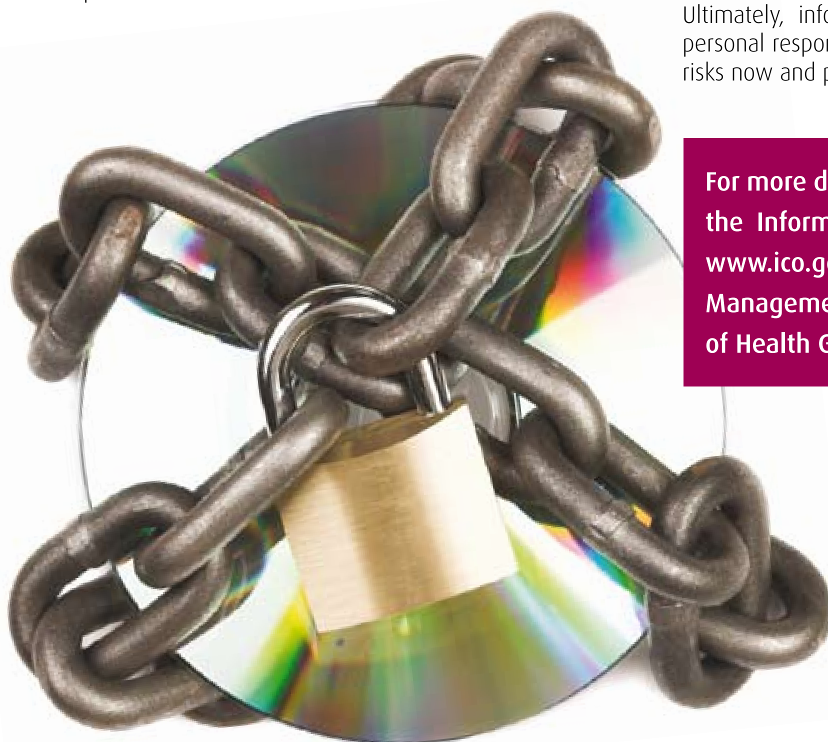
In November 2007 the Prime Minister apologised in the House of Commons for the "inconvenience and worries" caused by the loss of 25 million child benefit records. Following the news story, confessions of further similar breaches were made to the Information Commissioner;

- **More than 15,000 Standard Life customers were put at risk of fraud after a courier lost a computer disk containing their names, national insurance numbers, dates of birth and pension data.**
- **A laptop computer holding sensitive information was stolen from the boot of a car belonging to an HMRC worker, putting hundreds of people at risk.**

On an individual level, in May 2006 Dr Kader, a police surgeon, admitted placing a number of plastic carrier bags into a public rubbish bin in Bradford; these bags contained at least 600 forms giving the names and details of detained persons and alleged victims of crime, blood results and highly sensitive records including details of victims of sexual offences. The GMC Panel imposed conditions on his registration for a period of 18 months, after which time he was erased from the register for failing to comply.

As a result of the scandals, all professionals and organisations (particularly government departments!) need to ensure that their knowledge and practices in terms of information security are up to date and effective; monitoring bodies such as the Healthcare Commission, Health Service Ombudsman, the Prison Service Ombudsman and the Information Commissioner will only become more sensitive to potential breaches in the coming year.

What follows is a brief list of tips which can be implemented on a personal or wider basis and should help avoid some of the potential risks:



People

- Have someone in charge of information security in your Trust, i.e. writing procedures, auditing compliance, investigating security incidents
- Train your staff:
  - so they know what is expected of them
  - to be wary of people who may try and trick them into giving out personal details (including the family of patients)
  - that they can be prosecuted if they deliberately give out personal details without permission
  - to use strong passwords, such as a long word with a combination of upper and lower case letters, numbers and the keyboard characters like the asterisk

Physical Security

- Ensure you have an up to date policy on posting data
- Don't download more data to any disc than is necessary
- Don't send a whole database of personal information on disc by normal post, ever
- Shred all your confidential paper waste
- Check the physical security of your premises
- Lock up paper based personal information at night
- Lock up laptops and computer media like discs\memory sticks at night

Technology

- Only allow staff access to the information they need to do their job and don't let them share passwords
- Encrypt any personal information held electronically if it will cause damage or distress if it is lost or stolen
- Don't dispose of old computers until all the personal information on them has been securely removed (by using technology or destroying the hard disk)
- Install a firewall and virus checking on your computers
- Consider installing anti-spyware

Ultimately, information security must be a combination of personal responsibility and Trust policy and audit. Assess the risks now and prevent a security breach in your Trust.

For more detailed guidance and suggestions, see the Information Commissioner's Office website www.ico.gov.uk and Information Security Management: NHS Code of Practice (Department of Health Guidance, April 2007)

Gemma Brannigan
gemma.brannigan@hilldickinson.com

UNEXPECTED DEATHS & THE CHILDREN ACT 2004

The Children Act 2004 implements the recommendations of the Kennedy Report and makes substantial changes to the way in which unexpected child deaths should be managed and investigated. These changes come into force in April 2008 and will have a significant impact on NHS Trust staff involved in such cases.

BACKGROUND

In 2000 Victoria Climbié died as a result of horrendous abuse and neglect. That same year at least 5000 other children died in the UK, including over 400 as a result of injury and poisoning and over 200 infants dying suddenly and unexpectedly.

In 2003 Sally Clarke and Angela Canning were acquitted by the Court of Appeal, after serving 4 years and 2 years respectively of life sentences for murdering their babies. Both convictions were overturned as being unsafe, on the basis of evidence/information that was actually available 6 weeks after the deaths.

The aim of the new legislation and guidance is to ensure that such child deaths are appropriately investigated and reviewed, so that wherever possible a reduction in these numbers can be achieved. The changes also aim to assist in preventing errors that have been made by agencies responsible for the investigation and review process in the past, of either failing to recognise abuse/neglect of children, or alternatively wrongly accusing families bereaved by the tragedy of natural child death.

What is a "Sudden Unexpected Death of a Child"?

The definition of an unexpected death of a child, under the Children Act is "the death of a child that was not anticipated as a significant possibility 24 hours before the death" or "where there was a similarly unexpected collapse leading to, or precipitating the events which lead to the death". In either of these situations the new procedure should be followed immediately after the death.

Who will be affected by these changes?

Under the Act and related guidance, it is the relevant Local Authority that takes the lead in coordinating a rapid response team investigation following such a death, over-viewing all child deaths in the area via the local Safeguarding Children Panel and ensuring adequate ongoing support to the family. However a range of other individuals/agencies are also involved in this new process including paramedics/ambulance crews, emergency department staff, paediatricians, GPs, midwives, police officers, coroners, pathologists, specialist health visitors and social workers.

All these individuals need to have a broad understanding of the new procedure and in particular know what immediate steps they should take when a sudden unexpected child death occurs. The Act also introduces a further statutory obligation for those agencies involved to share information.

New requirements of the Act

The Act places a duty on each Local Authority to set up a Local Safeguarding Children Board. It also places a duty on all agencies including NHS Trusts, to make arrangements to promote and safeguard the welfare of children in its area, under s11.

The new "rapid response" process that should be followed when a sudden unexpected death of a child occurs, includes within it:

- A rapid response by a group of key professionals who come together for the purpose of enquiring into and evaluating each unexpected death of a child.
- A thorough, systematic yet sensitive investigation to help to clarify where possible, the cause of death and any contributory factors (in conjunction with the coroner).
- Identifying any contributory factors such as factors intrinsic to the child, around parental capacity or care, in the wider family and environmental circumstances, including services provided/needed.
- To provide ongoing support to the family.
- An overview of all child deaths in the area, undertaken by a panel, the Local Safeguarding Children Board.

The family must be at the centre of this process, fully informed at all times, and treated with care and respect. Throughout the process, joint agency working draws on the skills and particular responsibilities of each professional group.

How will this affect NHS staff?

Throughout this process, key medical personnel are involved including in the following ways:

- Paramedics/ambulance staff should transfer the child's body from the scene to the hospital emergency department, at a hospital with a paediatric unit. Information they have obtained in the course of attending upon the child could also prove crucial in the investigation.
- At the hospital the parents should where possible be met by a specialist support nurse.

Continued...

- The responsible Consultant should then inform the police child investigation team of the death, fax/telephone all agencies (including the coroner and Local safeguarding Children Board) to tell them of the death and so start the multi-agency rapid response. The Consultant Paediatrician will also be part of the rapid response team.
- The Consultant Paediatrician should take a detailed narrative account of events from the parent(s)/carer(s), looking at the circumstances of the death, the child's medical history & the family and household history.
- The senior clinician should gently and sensitively inform the parents of what is happening, give the parents time to be with child and to hold him/her if they wish, explain the need to talk further with parents and the role of the police/ coroner in the process.
- A joint home visit should take place by the paediatrician and police officer, when a further history will be taken from the parent(s)/carer(s).
- The child's GP and paediatrician will meet with the rapid response team (also including a social worker and police, usually within 24 hours of the death) and later again with the local multidisciplinary case discussion meeting to review the information available and if possible agree a cause of death.
- The GP should provide support to the family and in particular the child's mother.
- A key worker should be appointed (often this will be a midwife) to maintain close contact with the family, particularly the mother and support her/them through the investigation.
- The coroner may order that a post mortem examination should take place, following the evidence-based protocol. It is important that a specialist paediatric pathologist carries out such autopsies.

Comment

Most NHS Trusts will already have effective agreed systems and procedures in place that should be followed by their staff in cases where an unexpected child death occurs. The Children Act 2004 places additional statutory requirements on NHS bodies to protect and safeguard child welfare, and to work jointly with other agencies with this in mind. Whilst the lead agency with regard to the steps to be taken following an unexpected child death is the local authority, guidance also sets out key roles for a variety of NHS staff. NHS Trusts should ensure that key personnel such as those identified above are aware of and trained in this new procedure. At all times joint working with other agencies should be promoted and as ever, documentation will be crucial.

Rebecca Fitzpatrick
rebecca.fitzpatrick@hilldickinson.com

Right to life – When is Article 2 of the Human Rights Act engaged?

In the recent decision of <u>Savage -v- South Essex Partnership NHS Foundation Trust</u>, the Court of Appeal considered the test for a breach of Article 2 Human Rights Act 1998 (HRA).

THE FACTS

Anna Savage's mother committed suicide after absconding from the hospital where she had been detained under s3 of the Mental Health Act 1983 (MHA). Ms Savage brought a claim for damages for breach of the HRA, in particular Article 2, the right to life, and also Article 8, the right to private and family life.

It was alleged that the Trust had failed to comply with their obligation under Article 2 HRA to safeguard Mrs Savage's life in that they had failed to take reasonable measures to prevent the risk of suicide and, in particular, they had failed to properly assess the risk of her absconding.

As a preliminary issue, the Court was asked to rule the correct legal test that should be applied in order to establish that a breach of Article 2 HRA had occurred.

DECISION

The Court of Appeal found that, in the circumstances of the case, the Claimant did not have to show that the Trust had been grossly negligent in order to establish that a breach of Article 2 HRA had taken place; simple negligence would suffice. All that was required was for the Claimant to show that the Trust knew or ought to have known of the existence of a real and immediate risk to the life of Mrs Savage and had failed to take measures to avoid that risk.

IMPLICATIONS

Mrs Savage was detained in hospital under s3 MHA. The judgment specifically considers whether a patient who is detained under the MHA is more akin to a prisoner, or a voluntary patient in a hospital. The Judges considered that a patient detained under the MHA is more akin to a person detained in prison. The European Court of Human Rights (ECtHR) has previously stated that prisoners are in a particularly vulnerable position. The Court of Appeal found that this vulnerability also extends to patients detailed under the MHA, who are under the control of the State in a way in which ordinary patients are not.

The judgment therefore distinguishes between people detained either in prison or under the MHA, and patients who are not detained, being cared for hospital. In the case of the former, a claimant need only establish simple negligence in order to engage Article 2. The effect of this will be that it will be easier for a claimant to obtain damages for breach of Article 2. Ms Savage only sought damages for breach of the HRA, and did not make a claim in negligence, or under the Fatal Accidents Act. Potentially, the case means that there are more people able to bring a claim arising out of the death of a patient – this is the first case where the HRA has been used to claim damages for the death of a person in detention, by someone other than a spouse. In addition, those claimants who pursue a negligence claim or a Fatal Accidents Act claim may seek additional damages for breach of the HRA.

This case may also have an impact on Inquests as a jury Inquest will be required where a breach of Article 2 HRA can be established. However, the decision only relates to patients detained under the MHA or in prison. In those cases it is generally established that Article 2 is engaged and a jury is required, in any event.

The judgment draws a distinction between detained and voluntary patients. The decision does not change the law for voluntary patients whether receiving treatment for mental or physical illnesses. In those cases the principle is still that a claimant must be able to show that gross negligence has occurred in order to engage Article 2, as was established in Byrzykowski -v- Poland. Simple negligence, such as an error of judgment on behalf of a health professional or negligent co-ordination amongst health professionals, is not sufficient. A claimant in a damages claim or a family arguing for a jury at an Inquest would still have to demonstrate gross negligence before Article 2 was engaged.

Joanna Crichton
joanna.crichton@hilldickinson.com

REGISTER OF SURPLUS PUBLIC SECTOR LAND

Rebecca Long-Bailey examines the highly regulated area of public land disposal.

In July 2007, the Secretary of State directed that all service bodies must note upon the Register of Public Sector Land, all vacant land, buildings or property which are deemed surplus to requirements. The register was set up to provide a central database detailing all surplus public sector land. Its primary objective was to improve public service delivery in making all public bodies aware of proposed public sector land sales so that the land could be transferred within the public sector prior to placing it on the open market.

The existing Estatecode rules relating to priority purchasers who will use a surplus property for the benefit of the NHS do, however, continue to apply and this class of purchaser should always be given a right of first refusal if applicable. There are also a number of land interests excluded from the register which are leases of less than 99 years, dwellings subject to right to buy provisions, staff accommodation being transferred to an RSL (registered social landlord) and property that is proposed to be sold to a charity that provides services to the NHS.

The register is monitored and maintained by English Partnerships on behalf of the Department for Communities and Local Government and the process for noting surplus land on the register can be found in the Government Accounting Rules and also the Department of Health website.

Briefly the process is as follows:

- The disposing body provides details of the property to English Partnerships. A 40 working day notice period begins and English Partnerships notifies all government agencies of the property within 48 hours.

- Interested parties obtain relevant details from the register and advise the disposing body of their interest.

- Interested parties provide to the disposing body a 'priority assessment report' which details how the property could meet their business objectives and also formally confirm the desire to acquire.

- The disposing body may accept or reject the proposal. If accepting, a 28-day period for agreement of terms begins proceeding to completion. If the proposal is rejected then the disposing body may proceed to sell the property on the open market. Please note however that NHS bodies are required to fully document their reasons for refusal.

So what are the benefits of using the register?

It is argued by many that the register is a shining example of how public bodies are working in conjunction with each other to make more effective and better use of collective assets. The Government has asked English Partnerships to take a lead role in ensuring that the public sector makes best use of the current land supply with a specific emphasis on regeneration and much needed social housing.

Indeed the social demographics of our country are inadvertently changing with life expectancy rising, increased medical conditions relating to lifestyle rather than transferable disease, increased need for social housing and support services and so with this change also comes the need for change of premises/ location, new developments and regeneration.

What can be better than to re-utilise redundant public sector land for a different public authority use that is required in the locality and thus save on expensive marketing costs that could be channelled into much needed areas elsewhere?

Rebecca Long-Bailey
rebecca.longbailey@hilldickinson.com

IP Licensing: Cash behind the sofa?

Anyone who has successfully licensed intellectual property (IP) will tell that it's far easier to talk about it than to make money doing it. NHS Trusts, however, are uniquely well placed to benefit. Following on from our previous articles about the various kinds of IP, we now discuss, briefly, four elemental requirements for making money out of IP by licensing it and how, in respect of each of those requirements, the NHS is well-placed.

You need IP to license

Hardly an astonishing observation. Yet many people fall at this first hurdle; not because they don't have any IP but because they don't know that they have any IP. NHS trusts employ large numbers of highly-trained specialists. Every day at work, each and every one of them confronts practical difficulties associated with deploying their skills to the best advantage. It would be surprising, to say the least, if one or two of them didn't have the odd idea about how to improve things. Just because they don't feel that they have the time to share their ideas with others doesn't mean they don't have any ideas. The chances are that your trust has plenty of IP; you just haven't managed to capture it.

You need someone to license it to

Another non-revelation. But, for the majority of would-be licensors looking to make some money from their IP, finding the right business to approach and then getting their attention proves to be an insurmountable obstacle. Here is where NHS Trusts find themselves in pole position. Your Trust will spend large sums of money purchasing healthcare equipment and services from outside suppliers. Those suppliers could be a ready-made constituency of potential licensees. As for getting their attention, if one of your biggest customers asked some of your senior managers to a meeting to discuss a business opportunity, would you refuse?

You need the expertise to capture your IP

'Capturing' IP sounds like a phrase from a game of buzz-word bingo. In fact it's describing exactly the process involved. Inventors, particularly those that haven't been involved in protecting IP before, are notoriously reluctant to offer up their ideas. In the vast majority of cases this is for perfectly innocent and understandable reasons: fear of appearing boastful by doing so; fear of the ridicule they feel their idea may attract; and general shyness. So persuading people to open up and give you their ideas isn't as straightforward as it sounds on paper. An experienced 'facilitator' is a great advantage. Employers have their role to play, as well, in providing the 'space' for employees to attend an IP Capture event and, where appropriate, incentives.

You need the skills and expertise to protect and license IP

It is easy to wave a hand over the process of obtaining patent protection as though it were trivial. It isn't. Proof of that lies in the fact that, nationwide, there are probably no more than a handful of law firms that have the expertise in-house to do it. And a deep understanding of the business of obtaining patents can prove to be a significant advantage when it comes to licensing them.

If you would like to know more about IP Capture and Licensing, then contact Bruce Jones.

Bruce Jones
bruce.jones@hilldickinson.com

QUANTUM UPDATE

There have been quite a large number of settlements in the recent months and the following cases will hopefully be of assistance when valuing general damages in claims:

Fuk Wan Hau -v- (1) Shushing Jim, (2) Steven Jim – December 2007 – broken leg and other injuries

A 47 year old man was assaulted by two people. He sustained multiple injuries including lacerations, bruising and a broken leg. Some 16 months after the incident he had returned to working part time and eventually increased his hours to full time. He was awarded £15,000 in respect of general damages. It was not appropriate to make a separate award for aggravated damages (High Court).

A (suing by her Litigation Friend H) -v- Powys local Health Board – December 2007 – dyskinetic cerebral palsy

The Claimant suffered birth injuries resulting in dyskinetic cerebral palsy. She was aged 16 at the time of settlement. The award for general damages for dyskinetic cerebral palsy was increased to reflect her life expectancy of 70 years and the intellectual insight she had into her condition and its consequences. She was awarded £225,000 for pain, suffering and loss of amenity (High Court).

Akhtar -v- McGeever – December 2007 – neck and lower back injuries

A 51 year old woman sustained neck and lower back injuries in a road traffic accident. She exacerbated pre-existing symptoms in both areas and suffered from sleep disturbance and general discomfort. She recovered to pre-accident levels approximately 12 months after the accident. She received £2,000 general damages (County Court).

A -v- Krstic – November 2007 – extraction of four teeth

An 8 year old girl (aged 6 at the date of the incident) had four front upper milk teeth wrongly extracted. She suffered physical discomfort and sensitivity as well as impaired appearance and speech. She received £3,500 (out of Court settlement, approved by Court).

AB (by her Litigation Friend, the Official Solicitor) -v- South East Coast Strategic Health Authority – November 2007 – total blindness

The Claimant developed bilateral retinopathy following a failure to properly monitor her arterial oxygen levels following her premature birth in 1986. She was aged 21 at the time of settlement and suffered, for functional purposes, total blindness together with serious mental health problems, diabetes and obesity. She received £225,000 for pain, suffering and loss of amenity (out of Court settlement).

Chapman –v- Epsom and St Helier University Hospitals NHS Trust – November 2007 – rectal wound

A 63 year old man received £7,000 general damages after medical staff re-opened a previous wound in his rectum. The wound healed after approximately 5 months but during the period of recovery he suffered from anxiety, lack of sleep and was unable to socialise (out of Court settlement).

Joy -v- Medway NHS Trust – November 2007 – additional surgical procedure to remove piece of drain tube

A 36 year old woman had a piece of drain tube left in her abdomen following a hysterectomy. She suffered anxiety and underwent a further surgical procedure to have the drain removed. She received £5,500 general damages (out of Court settlement).

Owen -v- Velindre NHS Trust – November 2007 – hysterectomy, loss of fertility, neuropathic bladder

A 30 year old woman's (22 at date of accident) smear test was incorrectly reported as being negative. She subsequently underwent a hysterectomy which caused her to suffer from loss of fertility and a neuropathic bladder. She received £80,000 General Damages (out of Court settlement).

T (A Child) -v- Cornish – November 2007 – back injury

A 3 year old girl was awarded £1,000 for soft tissue injuries to her back sustained in a road traffic accident. She suffered from disturbed sleep and travel anxiety but made a full recovery within 6 months (County Court).

John Clossick (by his wife and litigation friend) -v- Keith Walton Brickwork Ltd – November 2007 – serious head injuries

A 43 year old man sustained serious head injuries at work in July 2003. He suffered a significant decline in his intellectual capacity, his life expectancy was reduced, he required constant care and would not be able to return to work. He received £150,000 general damages (out of Court settlement, approved by Court).

Chamberlain -v- (1) Kwrambra, (2) Motor Insurers Bureau – November 2007 – knee and chest injuries

A 49 year old man received £2,250 general damages for knee and chest injuries sustained in a road traffic accident. He recovered within 18 months (County Court).

Horsfall -v- Daniel Thwaites plc – October 2007 – wrist injury

A 56 year old man received £7,850 general damages for a fractured wrist sustained in an industrial accident. He was expected to continue to suffer from aching in cold and damp weather and from discomfort when lifting heavy items. He was absent from work for 10 weeks (out of Court settlement).

Nevins (A Patient) -v- (1) Nicholson, (2) CIS Insurance Society Ltd – October 2007 – serious brain damage

A 23 year old man suffered a range of serious injuries in a road traffic accident. He suffered brain damage and displayed severe cognitive and behavioural deficits. He suffered from epilepsy and some incontinence. He required constant care and supervision and would never be capable of working. He received £220,000 general damages (out of Court settlement, approved by Court).

TJ -v- Heatherwood & Wexham Park Hospitals NHS Trust – October 2007 – brain injury at birth

A boy (aged 13 at settlement) sustained asphyxial brain injury at birth. He suffered significant microcephaly, cognitive impairment and epilepsy together with right-sided hemiplegia and almost complete loss of useful vision in his right eye. He suffered cognitive and memory impairment and consequent developmental retardation. He also suffered epilepsy. He received £125,000 general damages (out of Court settlement, approved by Court).

Continued...

Gabriel -v- Loxham Access – October 2007 – back injury and PTSD

An 11 year old boy (aged 8 at time of accident) suffered a soft tissue back injury in a road traffic accident. He suffered from associated travel anxiety and symptoms of post-traumatic stress disorder. The physical injuries recovered within one week and he made a full recovery from the psychological symptoms within 18 months. He received £3,000 general damages (out of Court settlement, approved by Court).

Geraghty -v- Davis – October 2007 – hysterectomy

A 60 year old woman was wrongly prescribed medication. She suffered thickening of her endometrium and had to undergo hysterectomy and removal of both fallopian tubes and ovaries. She received £26,000 general damages (out of Court settlement).

Anthony Steel
anthony.steel@hilldickinson.com

LITIGATION UPDATE

There are a number of interesting cases in this issue's litigation update:

Eileen Corr (Administratrix of the Estate of Thomas Corr, deceased) -v- IBC Vehicles Ltd – February 2008 – loss attributable to death by suicide recoverable

Mr Corr suffered from a major accident at work for which his employers were to blame. As a consequence he became clinically depressed and killed himself. His widow claimed for compensation from the employer and the employer argued that Mr Corr's suicide fell outside the duty of care owed by them. The House of Lords stated that compensation could be claimed by the widow as the depression caused by the accident was foreseeable and the employer was negligent in not dealing with the depression. The claim was not barred by principles of causation, remoteness or foreseeability.

Welsh Ambulance Services NHS Trust & Another -v- Jennifer Mary Williams – February 2008 – financial benefit brought by children irrelevant to assessment of financial dependency

Following the death of a successful family businessman his wife and children qualified as dependants under the Fatal Accidents Act 1976. The financial benefit that two of the children brought to the family subsequent to the father's death was irrelevant to the assessment of the dependency under the Act (Court of Appeal).

Latona Allison -v- London Underground Ltd – February 2008 – duty to investigate inherent risks rather than no-fault liability

The duty imposed by the Provision and Use of Work Equipment Regulations 1998 Regulation 9 was not absolute and did not impose no-fault liability. The test for the adequacy of training for the purposes of health and safety was what training was needed in light of what the employer ought to have known about the risks arising from the activities of his business. The Regulations imposed a duty on the employer to investigate the risks inherent in his operations, taking professional advice where necessary (Court of Appeal).

European Surgeries Ltd -v- Cambridgeshire Primary Care Trust & Secretary of State for Health (interested party) – November 2007 – PCT entitled to refuse to pay for private treatment

A Primary Care Trust was entitled to refuse to reimburse the tariff or equivalent NHS cost of an out-patient procedure carried out on a United Kingdom patient by a private medical service provider where the patient did not himself request payment. Any right to claim the tariff cost of the operation lay with the patient and not with the medical service provider (High Court).

Bashir & Others -v- Ahmed & Others – November 2007 – claims struck out for misleading the Court

The County Court struck out as contrary to CPR 1.3 the personal injury claims of four Claimants, including two genuine Claimants. All four had deliberately and fraudulently misled the Court about their involvement as passengers in a road traffic accident.

Lloyd -v- Ministry of Justice – October 2007 – failure to warn of history of violence

A prison officer was forced to leave the prison service due to an injury following an attack on him by a prisoner. The prison officer would have taken further precautions if he had been alerted about the prisoner's history of violence and assaults on prison officers. The Ministry of Justice was negligent in failing to inform him accordingly and thereby failed to provide him with a safe system of work.

Thompstone -v- Tameside & Glossop Acute Services NHS Trust (and other related cases) – January 2008 – Periodical Payment Orders

This series of cases involved severely injured Claimants who were seeking future losses, particularly costs of future care. The Court of Appeal held that the use of the Annual Survey of Hours and Earnings (ASHE) 6115 index was appropriate for Periodical Payment Orders for care and case management as opposed to the Retail Price Index.

The Court also held that it was an objective test for the Judge to decide what form of Order best meets the Claimant's needs and that only in rare cases would it be appropriate for a Defendant to adduce expert evidence to demonstrate the Claimant's form of award would not best meet his/her needs. Similarly it would rarely be appropriate for a Defendant to argue its proposal would meet the Claimant's needs better than the Claimant's own proposal. It is possible that the decision will be appealed to the House of Lords.

For further details about any of these cases, please contact Anthony Steel.

Anthony Steel
anthony.steel@hilldickinson.com

When sorry seems to be the hardest word...

BACKGROUND

Complaints do not always arise out of a desire to obtain financial compensation.

Perhaps, given common perceptions about the growing "litigation culture", that comment will be met with a degree of incredulity.

However there is no doubt that it is true. In 2001 the National Audit Office, concerned about the escalating cost of settling claims, undertook a detailed examination of clinical negligence litigation. They found that solutions, including the provision of detailed technical explanations, assurances about how recurrences would be prevented and apologies, had been sufficient to meet the requirement of some complainants.

It stands to reason therefore that of the complaints that turn into claims, some do so simply because a patient was not given a suitable explanation or apology. It should be remembered that even claims lacking legal merit have a cost to the NHS in terms of resources. Quite aside from the fact that it is ethically appropriate that apologies are provided, it is clear that there can be a mutual benefit.

It is also fundamental to the standing of the profession and the development of good clinician/patient relationships that all patients have a belief that they will be treated with respect and that they will be told honestly and openly whenever something has gone wrong.

Policy

The GMC is clear on this issue. The 2006 Guidance states that if a patient has suffered harm or distress or has complained about the care they have received, they are entitled to a "prompt, open, constructive and honest" response, including an apology (if appropriate) and a full explanation.

The National Health Service Litigation Authority is similarly clear, and has been for some time. In 1997, 2002 and 2007 the Chief Executive, Mr Walker, forwarded circulars on apologies and explanations to the Chief Executives and Finance Directors of all NHS bodies. The guidance says that it is, "natural and desirable for those involved in treatment which produces an adverse result, for whatever reason, to sympathise with the patient or the patient's relatives and to express sorrow or regret at the outcome".

However, despite the consistent messages there seems to remain a considerable reluctance to engage with this policy on the ground.

Concerns

Everyone's car insurance policy says that they should avoid accepting responsibility after a crash!

It is likely that the most significant reason for any reluctance to apologise following an adverse medical incident will be the fear that this will be seen as an admission of legal liability and seized upon by a cunning lawyer to fuel a claim. There may also be concerns about the potential impact of any apology upon insurance cover.

However, those concerns whilst well-founded do not stand up to analysis. It is perfectly possible to empathise with a patient, express regret at an adverse outcome and provide an explanation without for a moment saying that there are any issues of "fault" or "blame".

As the NHSLA circular explains such expressions of regret would not normally constitute an admission of liability and, furthermore, they would never seek to dispute any payment, under any scheme, solely on the grounds of such an expression.

It is important that the profession overcomes its ongoing concerns in this area.

Law

It is worth noting that, even if a situation arose whereby an apology following an adverse incident was considered to amount to an admission of liability, that is not the end of things.

The Court of Appeal decision in the case of Walley -v- Stoke on Trent City Council [2006] deals with the withdrawal of pre-action admissions.

Briefly, the Local Authority retained loss adjusters to deal with the Claimant's claim arising out of his knee injury. Following an investigation, the loss adjuster confirmed that, "liability would not be in issue". (The loss adjuster was later fired for incompetence). Court proceedings followed and the Local Authority filed a defence to breach of duty, which the Claimant sought to strike out on the basis of the earlier admission. The Court determined that the pre-action admission was evidential only and, since a full explanation had been provided and the Claimant was not prejudiced, the Local Authority was entitled to withdraw it.

Procedural rules relating to admissions are contained in Part 14 of the Civil Procedure Rules, which was recently updated.

Key practice points

- The provision of apologies and explanations has an important role to play in improving clinician patient relationships and is likely to avoid some claims being brought at all, even following adverse incidents;
- The GMC and the NHSLA fully support and encourage this practice;
- It is possible to express regret, empathise with patients and explain how problems have occurred without suggesting anyone is to "blame";
- Even if an apology is wrongly construed as amounting to an admission of liability, that so called "admission" can be withdrawn and will not make a future claim indefensible.

Further developments in this area are likely in the near future and the policy will no doubt be a cause of ongoing discussion.

David Locke
david.locke@hilldickinson.com

Leslie Ash's £5 million – an illustration of an alarming upward trend in the value of clinical negligence claims

According to a reliable source of information, the reaction of many clinical negligence claimants to the news media reports of Leslie Ash's settlement has been to ask their solicitors why, if the law is meant to treat everyone equally, an ordinary claimant is expected to settle for (say) £50,000 for injuries resulting in suffering and disability equal to those for which Leslie Ash was paid £5 million.

Of course, the answer to the question is that the greater part of Leslie Ash's £5 million represented compensation for the earnings she lost in consequence of her injury.

There are several aspects of the Leslie Ash case that are nevertheless very disturbing. To many ordinary people, it must seem unsatisfactory to say the least for such a massive amount to be removed from hard-pressed NHS resources in order to maintain one person's relatively privileged lifestyle.

A 'falling out of bed' injury

In outline, the circumstances giving rise to the claim were as follows: Leslie Ash was admitted to Chelsea and Westminster Hospital in April 2004 with broken ribs and a punctured lung having fallen off the bed during sexual activity with her husband, Lee Chapman, the former footballer. During the hospital admission, she developed a boil on her back. Unfortunately, it became infected (though not with MRSA). Although nursing staff were made aware of it, there was a failure to seek medical attention for it. The patient was discharged home without treatment for the infected boil. Within a short time, it gave rise to systemic illness. She was re-admitted and required surgical removal of the infected abscess. She was left with permanent nerve damage, partial paralysis, and damage to her career as an actress.

Increasing high value claims

Leslie Ash's lawyers have trumpeted their success in obtaining the highest ever UK compensation award for contracting a hospital infection.

This is particularly disturbing because the news reports of the Leslie Ash settlement came just a few weeks following the unreported judgment in A –v- Powys Local Health Board. In the latter case, a cerebral palsy Claimant was awarded damages of £10.7 million. This is apparently the largest ever personal injury award of damages following a contested quantum trial.

Needless to say, £10.7 million is an enormous amount to provide for the needs of just one person. Even so, it is dwarfed by the staggering 9-figure sum claimed in Horton –v- Evans, a clinical negligence claim brought against non-NHS Defendants by an American 'super-woman' who had combined a legal career with various entrepreneurial activities. The case came to trial in 2007, but good sense prevailed and damages were assessed at just £1.4 million.

The relentless increase in the value of clinical negligence claims is also apparent from data published by the NHS Litigation Authority. Under the CNST and ELS schemes, payments in respect of claims totalled £579 million in 2006/07 as compared to £423 million in 2003/04.

Comment

I hope that eventually society will see its way to exerting a more effective form of control over high value damages than the common law. For that to happen, however, it may require a disastrously huge damages payment to show the need for change. This is not beyond the realms of possibility. Imagine if the patient had been a seriously high earner, as opposed to Leslie Ash who would probably not have been described as an 'A-list celebrity' in 2004 if she ever was. This is the really, really disturbing aspect of the Leslie Ash case. What if it had been Tiger Woods? He reportedly earns £90 million per annum. Supposing the career of a mega-star was ruined, damages might conceivably be measured in billions, not millions. There is no statutory maximum.

I do not know whether the risk highlighted above is capable of being managed except to ensure that, if an ambulance brings a Mr Andrew Murray or a Ms Scarlett Johansson into your hospital, the most skilled members of staff are called in immediately and everything known to medical science is done (and done correctly!) to restore this patient to the very best of health.

Richard Hackett
richard.hackett@hilldickinson.com

Statements of Truth - What are you signing?

There are a wide variety of documents which we send to the Trusts that require a Statement of Truth to be signed. But what are you signing? And what are the legal implications of signing such documents? This article shall look at the Statement of Truth and the disclosure statement.

The Statement of Truth

The Statement of Truth must appear on specific documents including Statements of Case (including the Defence), Witness Statements, Lists of Documents and Counter-Schedules of Loss. It confirms the maker's belief in the truth of the facts contained in such a document prepared for the purposes of the legal claim. The Statement of Truth appears in the following form:

"[I believe]/[the [Claimant/Defendant] believes] that the facts stated in this [name of document being verified] are true"

If one of the above-named documents does not bear a signed Statement of Truth, it cannot be relied upon as evidence and it may be struck out by the Court on the application of the other party.

Whenever anyone signs a document containing a Statement of Truth, that person takes personal responsibility for the truthfulness of all the information in that document. It should be signed by somebody holding a senior position and different Trusts have in place different arrangements for this.

The disclosure statement

A party to proceedings must serve a List of Documents. This list should contain details of all documents which are or have been within the control of that party. Standard disclosure requires a party to disclose only the documents which:

- Adversely affect his own case;
- Adversely affect another party's case;
- Support another party's case.

The List of Documents bears a Disclosure Statement, which concludes with the following phrase:

"I certify that I understand the duty of disclosure and to the best of my knowledge I have carried out that duty. I certify that the list above is a complete list of all documents which are or have been in my control and which I am obliged under the said order to disclose."

If a document upon which a party relies is not within this list, that party may not be permitted to rely on it.

The duty to inform the opposing party of the existence of such documents continues until proceedings are concluded. If a document to which the duty applies comes to the attention of the disclosing party, he must immediately notify the other party of its existence. It is important to ensure that a reasonable search for all relevant documents has taken place and the List contains all of the documents that you have sent to your solicitors.

Why is it important?

If anything in a signed document containing a Statement of Truth is untrue, the person who signed is at risk of proceedings for contempt of Court (imprisonment or a fine) if the document was signed without an honest belief of its truth. It is also open to the Court to strike out a Statement of Case not supported by a Statement of Truth or make an adverse costs order. If you do not think you are the appropriate person to sign the Statement of Truth or you are uncertain as to the accuracy of the contents of a Defence then please contact the solicitor dealing with the claim. You are entitled to rely upon the advice being given to you by your solicitors who will have drafted the document.

Katie Donne
katie.donne@hilldickinson.com

Classic Cases Revisited - Episode 4

Alcock and "secondary victim" claims for psychiatric injury

Alcock & others -v- Wright (Sued as Chief Constable of the South Yorkshire Police)
House of Lords, 28 November 1991

Who can recover damages for psychiatric injury after witnessing a traumatic event and what do they need to prove? It is safe to say that the law is a regular source of criticism, but to date there has been little sign of legislation and so parties are reliant upon a number of key decisions.

It is acknowledged that merely viewing an event which has arisen due to someone else's negligence is insufficient grounds for a successful claim, even where the experience has caused psychiatric injury.

In the context of the healthcare sector, claims may be brought by family members who have observed an adverse outcome for the patient, where the shock causes them psychiatric injury.

The claimant will have suffered no physical injury him/herself, but will claim damages for the consequences of pure psychiatric illness caused by viewing the physical suffering of another. This is why they are known as "secondary victim" (rather than primary victim) claims. The damages sought can include an award for general damages for the psychiatric condition, costs of counselling and loss of earnings, if the condition precludes them from working.

But the line of case law, of which Alcock is the most frequently referenced, sets out very strict circumstances in which such a claim can succeed.

The facts

This litigation arose out of the tragedy at Hillsborough Football Stadium in April 1989, in which 96 Liverpool FC supporters sadly lost their lives and hundreds more were injured. On behalf of the Police, the Chief Constable of South Yorkshire admitted liability in respect of the deaths and physical injuries.

Alcock involved a total of 16 claims brought by people who were not present in the area where the disaster occurred, although four of them were elsewhere in the ground. All were connected in some way with people involved, either as a family member or, in one case, as the fiancée of a victim. Each claimed that they had suffered psychiatric injury as a result of nervous shock following their experiences. Ten of the claims went to the House of Lords.

The Alcock "control mechanisms"

In his judgment Lord Ackner set out a number of propositions which set claims for nervous shock apart from other claims in terms of foreseeability. In summary:

1. Even where the risk of psychiatric illness is foreseeable, there are no damages unless the psychiatric injury is caused by shock. He refers to an example from an earlier case which suggested that a parent who suffers psychiatric illness as a result of the wayward conduct of a brain damaged child has no claim. In that scenario, there would be no "shock".
2. Even where nervous shock and the subsequent psychiatric injury were foreseeable, damages are not generally recoverable for merely being informed of, or reading, or hearing about an accident. The incident itself must generally either be seen or heard.
3. Mere mental suffering, even if foreseeable, where there has been no physical injury (i.e. a recognised psychiatric disorder) is not enough for a damages claim. The Fatal Accidents Act 1976 provides separately for compensation for bereavement for certain classes of persons.
4. There is no authority that someone is liable for shock-induced psychiatric injury to another following their own self-inflicted death or injury. For example, he remarked that a negligent window cleaner who falls onto railings would not be liable to a bystander who witnessed the incident.
5. He states that " 'shock' ... involves the sudden appreciation by sight or sound of a horrifying event, which violently agitates the mind". He says this does not include psychiatric illness caused by the accumulation over a period of time of more gradual assaults on the nervous system.

In addition, he endorsed the view of Lord Wilberforce in the earlier case of McLoughlin -v- O'Brien (1983), which noted three ways in which the duty of care is qualified in these claims, namely:

- A limit on the class of persons whose claims should be recognised. There must be a close tie of love and affection – the closer the relationship, the stronger the claim.
- A requirement for sufficient proximity to the incident, in both time and space - this can include the immediate aftermath as well as the incident itself.
- A limit on the means by which the shock is caused – in this case, seeing the incident on television was considered insufficient.

Nervous shock in clinical negligence claims

We are assisted by two Court of Appeal decisions:

Sion -v- Hampstead Health Authority (1994)

This claim was brought by the father of a young man who had been injured in a motorbike accident. As a result of the hospital's admitted negligence, the son did not recover and died 14 days after admission. His father, who had stayed by his bedside during this time, suffered a psychiatric injury and claimed damages. He was unsuccessful, however, as he was unable to establish that the injury was caused by "a sudden and unexpected" shock. The Court held that an accumulation of more gradual assaults on the nervous system over a period of time was not sufficient.

North Glamorgan NHS Trust -v- Walters (2002)

In this case a mother who witnessed the deterioration and death of her ten month old son was successful in her claim. Crucially, the parties' medical experts agreed that her injury was caused by the shock of what she had witnessed. The Court of Appeal agreed that the deterioration, which started when the baby had a fit which his mother woke to witness, until he died 36 hours later in her arms could be considered as "one drawn out experience" such that the "event" could be said to have covered the whole period. The Court made it clear, however, that this was not an extension of the law as stated in Alcock.

Conclusions?

Whilst Walters demonstrates that there may be situations in which a claim for nervous shock will succeed in a clinical negligence claim, the strict criteria set down in Alcock remain appropriate and the burden will be on the claimant from the outset to establish that those criteria are met. Put simply, proving a recognised psychiatric injury on its own is not sufficient and the claimant must prove that this resulted form a "shocking event" rather than understandable grief or sorrow.

Jonathan Heap
Jonathan.heap@hilldickinson.com

House of Lords reconsiders the proper approach to limitation – **but how does this impact upon clinical negligence claims?**

A -v- Hoare; C -v- Middlesbrough Council; X & Y -v- London Borough of Wandsworth; H -v- Suffolk County Council and Young -v- Catholic Care (Diocese of Leeds) and the Home Office (House of Lords, 2008)

Background to the decision

Each of the six Claimants alleged that they had been victims of sexual abuse during their childhood. The first claim in particular attracted significant media attention as the "Lotto rapist" case.

The first five appeals turned on the issue as to the applicable limitation period. S11 of the Limitation Act 1980 concerns claims for damages for negligence, nuisance or breach of statutory duty and provides a three-year limitation period, with discretion to extend it, in certain circumstances, under s33. However, the earlier House of Lords decision in Stubbings -v- Webb (1993), held that s11 did not apply to acts of deliberate assault. Consequently, the Court was bound to a six-year period, with no discretion, pursuant to s2 of the Act and each of the claims had failed.

The House of Lords found that Stubbings was wrongly decided and held that s11 should apply to such cases, hence the s33 discretion would be available.

The Young claim, however, pleaded systemic negligence on the part of the employers of the alleged abuser in order to avoid s11. The appeal concerned the issue as to the appropriate date of knowledge under s14 of the Act. The events in question were alleged to have taken place between 1974 and 1977, but proceedings were not issued until April 2003.

At first instance it was held that the Claimant did not have "knowledge" for the purposes of the Act until police investigations were commenced in 2000/2001, i.e. within three years of proceedings being issued. The claim was therefore allowed to proceed. The Judge applied the test formulated in KR -v- Bryn Alyn Community (Holdings) Ltd (In Liquidation) (2003) as to when the Claimant would "reasonably turn his mind to litigation".

The Court of Appeal reversed that decision on the basis that the date of knowledge was in excess of three years before proceedings were issued.

Date of knowledge – an objective test

The key issue for the House of Lords was whether the Claimant's date of knowledge should be judged subjectively or objectively.

Lord Hoffman said that the test is "an entirely impersonal standard: not whether the Claimant himself would have considered the injury sufficiently serious to justify proceedings but whether he would "reasonably" have done so. You ask what the Claimant knew about the injury he had suffered, you add any knowledge about the injury which may be imputed to him under s14 (3) and you then ask whether a reasonable person with that knowledge would have considered the injury sufficiently serious to justify his instituting proceedings..."

He added that "s14 makes time run from when the Claimant has knowledge of certain facts, not from when he could have been expected to take certain steps".

Instead, it was held that issues such as the Claimant's mental state in consequence of the injury should be taken into account when considering the exercise of discretion under s33.

In suggesting a stricter approach to the date of knowledge question, the House advocated a more liberal approach to s33 in such cases. The claim was remitted to the Trial Judge for the s33 issue to be reconsidered.

But does this affect clinical negligence claims?

The decision is helpful in that it sets out clearly the objective nature of the "date of knowledge" test in personal injury claims and will hopefully make the Court's task easier when considering limitation.

It may assume more relevance in cases where it is argued that the psychological impact of treatment should fix the claimant with a later date of knowledge. Such an argument is perhaps now less likely to succeed. However, it will be a factor the Court will need to consider when deciding whether to exercise its discretion under s33. It may be that the Court will take a more liberal approach to such cases in the future if it is felt that a fair trial is still possible, especially if the records are still available and witnesses can be contacted.

The decision does not suggest that claimants will have either an easier or a more difficult time in overcoming limitation, but what it does is emphasize the importance of ensuring that all appropriate issues are addressed when the Court is asked to exercise its discretion.

The First Defendant in the Young claim was represented by Jason Spencer and Kathy Perrin of Hill Dickinson LLP

Jonathan Heap
jonathan.heap@hilldickinson.com

In this, the penultimate in our series of green articles, we will be looking at ways of being more environmentally friendly when travelling or "green" travel. This can be done on an individual basis or with assistance from an employer.

According to the Islington Council website, "green" travel is any form of transport that causes less damage to the environment and the community than driving.

The main forms of "green" travel are walking, cycling or using public transport. Shortening and combining car trips, maintaining your car or driving a car that runs on cleaner fuel than conventional petrol or diesel are also "green" alternatives.

Whilst it is accepted that the day-to-day practicalities mean that it is not always possible to consider the environment when travelling more often than not, people use their cars even on extremely short journeys without giving it a second thought, which is often unnecessary.

Did you know?

- Riding a bicycle uses less energy than a car uses to power its headlights.
- Every minute spent walking can extend your life on average by 2 minutes.
- Car drivers breathe up to three times as much traffic fumes due to their low seat position.

It's an employer's responsibility too!

In these times, there is also a duty on employers to become greener, including promoting and assisting employees to consider greener forms of transportation. To assist employers in setting up green travel plans, the HM Revenue & Customs have developed a fact sheet which explains how the tax and national insurance systems encourage employers to set up travel plans for their employees. The Travel Plan is a package of practical measures to reduce car use for journeys to and from work and for business travel.

When an employer helps employees to get to and from work, such as by providing petrol or season tickets, these benefits are normally taxable. There is no Tax or National Insurance to pay if an employer offers:

- Free or subsidised work buses.
- Subsidies to public bus services.
- Cycles & safety equipment made available for employees.
- Work place parking for cycles and motorcycles.

Of course, whilst it is up to the employer to set up a green approach to travel and take on board the Travel Plan package, if an employee or individual feels that they may benefit or use one of the options set out above, then there is no harm in approaching the employer directly. If the employer is not already party to the Travel Plan package, it may encourage them to adopt it.

Making a start

If green travel is something that you want to adopt into your own life but do not know where to start, car sharing can be a practical option. Personal car travel produces 13% of the UK's total greenhouse gas emissions and it contributes to local air pollution and congestion.

As well as saving you money, car sharing will reduce congestion and cut carbon dioxide emissions. There are websites where you can enter your journey details and connect with other people travelling along the same local routes. For further information, you can register on the Travel Choice website which is: www.travelchoice.org/directory.asp.

If this is not a viable option and you cannot live without your car, think about driving a car with a smaller engine or lower carbon dioxide emissions. This will not only lessen your impact on the environment but also save you money. Buying a greener car does not mean you have to compromise. Most fuel-efficient cars use less fuel so they produce fewer emissions. When looking at the fuel efficiency of a car, remember different versions of the same car model or type of car can vary significantly in fuel efficiency so buy a more fuel-efficient version of the type of car or model you want. The general rule is, smaller cars and cars with smaller engines are more fuel-efficient!

The way you drive your car will also affect how much fuel you use and the amount of emissions your car produces. Therefore, the next time you get into your car, think about the following:

- Switch off your engine if you know you will not be moving for a while.
- Stick to the speed limit – at 70 mph you could use up to 30% more fuel than at 50 mph.
- Remove any unnecessary weight and roof racks. They increase the weight and air resistance and will increase the amount of fuel you use.
- Air conditioning and other onboard electrical devices like mobile phone chargers or MP3 players increase fuel consumption. These should only be used when necessary.

Although there is more pressure on both individuals and employers to consider greener travel, we know that this article is not going to encourage everyone to make changes to the way they travel. That said, if it is something that you have been considering, this may give you the impetus to make a start. For others, hopefully the information and tips included in this article will give some food for thought and may make you think twice before next getting in your car!

Monia Sood
monia.sood@hilldickinson.com

About Hill Dickinson

Hill Dickinson offers a comprehensive range of legal services from offices in Liverpool, Manchester, London and Chester, and its associated firm Hill Dickinson International has offices in London and Greece. Collectively the firms have 152 partners and a complement of more than 1000 staff.

Hill Dickinson is a major force in insurance and is well respected in the company and commercial arena. The firm's marine expertise is internationally renowned and it has one of the largest marine practices in the UK following a merger with Hill Taylor Dickinson on 1 November 2006. The firm has an award winning property practice and is widely regarded as a leader in the fields of commercial litigation, employment, intellectual property, NHS clinical/health related litigation and private client.

For further details please contact:

Allan Mowat
Head of Health Services and
Head of Healthcare Team
0151 600 8298
allan.mowat@hilldickinson.com

Richard Watson
Head of NHSLA Team
0151 600 8331
richard.watson@hilldickinson.com

The editorial team:

Andrew Craggs
Partner
0151 600 8334
andrew.craggs@hilldickinson.com

Joanna Trewin
Associate
0151 600 8292
joanna.trewin@hilldickinson.com

Hill Dickinson LLP:

Liverpool Office
No. 1 St. Paul's Square
Liverpool
L3 9SJ

T: +44 (0)151 600 8000
F: +44 (0)151 600 8001
DX 14129 Liverpool

Manchester Office
50 Fountain Street
Manchester
M2 2AS

T: +44 (0)161 817 7200
F: +44 (0)161 817 7201
DX 14487 Manchester 2

London Office
Irongate House
Duke's Place
London EC3A 7HX

T: +44 (0)20 7283 9033
F: +44 (0)20 7283 1144
DX 550 City of London

Chester Office
34 Cuppin Street
Chester
CH1 2BN

T: +44 (0)1244 896600
F: +44 (0)1244 896601
DX 19991 Chester

Hill Dickinson International:

Greek Office
2 Defteras Merarchias St.
Piraeus, 185 35
Greece

T: +30 210 428 4770
F: +30 210 428 4777

London Office
Irongate House
Duke's Place
London EC3A 7HX

T: +44 (0)20 7283 9033
F: +44 (0)20 7283 1144
DX 550 City of London

The information and any commentary contained in this newsletter are for general purposes only and do not constitute legal or any other type of professional advice. We do not accept and, to the extent permitted by law, exclude liability to any person for any loss which may arise from relying upon or otherwise using the information contained in this newsletter. Whilst every effort has been taken when producing this newsletter, no liability is accepted for any error or omission. If you have a particular query or issue, we would strongly advise you to contact a member of the health team, who will be happy to provide specific advice, rather than relying on the information or comments in this newsletter.

www.hilldickinson.com

HILL DICKINSON

08 Liverpool

OFFICIAL LAWYERS
EUROPEAN CAPITAL OF CULTURE
Hill Dickinson LLP is a limited liability partnership

As Official Lawyers and first Official Partner to Liverpool 2008: European Capital of Culture, the firm is providing sponsorship and backing for the programme of events including the provision of legal services on issues such as corporate structures, contracts, sponsorship, broadcasting, events and intellectual property rights.