HILL DICKINSON

August 2007

Healthcare Update

Welcome

Welcome to the August edition of our Healthcare Update.

Articles in this edition include an in depth analysis of the new Mental Health Act 2007 and the extensive changes that will shortly be introduced to this fast developing area of the law. The Department of Health has also published a revised version of the Estatecode which will be of relevance to those of you who wheel and deal in property.

In the litigation section, as well as focussing upon costs capping, we also feature the first of a number of articles looking at the cases we refer to everyday - starting with the most famous - the Bolam case. How many of us know the facts of the case? Turn to page 15 to see if you are right.

Finally, we wish you all a restful, and hopefully not too wet, Summer break (if you are lucky enough not to have had yours yet...).

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Further FOIA Fun?

The Freedom of Information Act 2000 (FOIA) has now been in force for over two years. Every month further decisions and rulings are published which can provide helpful guidance to NHS bodies when considering FOIA requests. Rhiannon Paddock reviews the important recent decisions.

Deceased person's medical records

In a number of recent decisions, the Information Commissioner ruled that reliance upon the section 41 breach of confidence exemption in respect of a deceased person's medical records was valid.

a) The first decision involved Epsom and St Helier University Hospitals NHS Trust. The Trust had received a request from the mother of a deceased patient for a copy of the deceased's health records. The Trust took the view that the mother was not eligible to access the records in accordance with the Access to Health Records Act 1990. The Trust refused to release the records and relied upon the section 41 exemption by claiming that disclosure of the deceased's medical records would amount to an actionable breach of confidence.

In considering whether the Trust's reliance upon the exemption was valid, the Information Commissioner noted that the Act is designed to be 'applicant blind' and therefore the fact that the applicant in this instance was the deceased's mother was irrelevant. If the information was disclosed to the mother under the Act, it would in principle be available to any member of the public.

The Information Commissioner was satisfied that medical records have the necessary quality of confidence required to sustain an action for breach of confidence and that the duty of confidence attached to medical records can survive the death of the patient. The Information Commissioner formed the view that an action could be brought by a personal representative of the deceased and that whilst an award of damages would be unlikely, given the absence of an obvious financial loss, any action would most likely be in the form of an injunction preventing publication or release of the information.

Accordingly the Information Commissioner ruled that the deceased's medical records were covered by the s41 exemption and thereby exempt from disclosure under the Act. S41 is an absolute exemption and therefore there was no need to consider the public interest test.

b) In a similar case involving County Durham Primary Care Trust, the Information Commissioner upheld the PCT's refusal to supply the deceased's mother with a summary of the medical care provided to her late daughter. In this case the Information Commissioner also noted that the deceased had told her GP that she did not want any details of her medical condition to be disclosed to her parents.

The Information Commissioner recognised that in some circumstances there may be a greater public interest in disclosure of the information which would override the duty of confidence, for example, where there are suspicious circumstances surrounding a death, however, such circumstances would be rare.

Professional -v- private personal information

In considering whether the section 40 personal data exemption applies, the Information Commissioner often distinguishes between professional personal information and private personal information, with information falling in the former category, subject to disclosure.

Calderdale Council received a request for information relating to a trip to Australia and New Zealand, which was undertaken with the aim of recruiting social workers. The request included the names of the officers sent on the recruitment trip. The Council refused to release the officers' names and claimed disclosure would be unfair and therefore in breach of the first data protection principle.

The Information Commissioner decided that the request related to professional personal data, specifically related to the officers' employment and their duties in carrying out that employment, and that accordingly the names of the officers should be disclosed. The Information Commissioner considered that given the nature of the officers' role, the amount of public money spent and the task they undertook, the officers should have expected to be subject to some public scrutiny.

Conversely, in a decision relating to the Information Commissioner's Office, the Information Commissioner upheld a refusal to disclose the residential addresses of all his salaried staff upon the basis that the same was exempt in accordance with both sections 40 and 41.

We will continue to keep you abreast of further relevant decisions and guidance as they develop – watch this space!

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Confidentiality Explained

The duty of confidentiality can be found in the Hippocratic Oath dating back to around 500BC – it didn't commence when the Data Protection Act was passed in 1998!

"All that may come to my knowledge in the exercise of my profession or not in connection with it, or in daily commerce with me, which ought not to be spoken abroad, I will not divulge abroad and will never reveal."

Confidentiality is a fundamental principle of the relationship between a healthcare professional and his or her patients. It will usually be a term of the employment contract for healthcare professionals. The GMC and Nursing and Midwifery Council impose a duty of confidentiality under their professional guidance to members.

A breach of confidentiality can leave you open to disciplinary proceedings by your professional body, an NHS complaint, a breach of employment contract, or an allegation of negligence. A deliberate breach of confidence is unlikely but what about inadvertent breaches? Consider the implications of treating a patient in a busy corridor at A&E, or leaving a patient's medical records open on a computer screen.

In a series of articles, Joanna Crichton will be looking at the various exceptions to the basic rules of confidentiality, starting with police and national security. But first she discusses the general exceptions.

As is often the case, there are several exceptions to the general principle, allowing breach of confidentiality to take place in certain, limited circumstances.

The main exception you will come across is disclosure with the patient's consent. A patient will often consent to disclosure of their medical records, for example, to their employers or in connection with a civil claim. You should consider carefully that the consent has come from the right person where a minor patient is involved.

Consent can often be implied to disclosure within medical teams.

There are a number of well-known statutory provisions under which it may be acceptable to make a disclosure without the consent of the patient, for example:

- In the Data Protection Act:
    - Crime and Taxation (s29)
    - Special purposes – journalism, artistic and literary (s32)
    - Research, history and statistics (s33)
    - Information made available to the public under enactment (s34)
    - Disclosures required by law (s35 (1))
    - Disclosures made in connection with legal proceedings (s35 (2))
- Road Traffic Act e.g. to the DVLA
- Terrorism Act 2000

The GMC also recognises additional exceptions such as:

- Disclosure in the public interest
- Disclosure to protect the patient or others
- After a patient's death in certain circumstances

Disclosure to the police

The police are not automatically entitled to access patient information such as medical records which come under 'exempt material' for the purposes of the Police and Criminal Evidence Act 1984. However, disclosure to the police may fall within the s29 exception in the Data Protection Act 1998, namely, the prevention or detection of crime or the apprehension of offenders.

This allows disclosure without the patient's consent, as often asking for consent to disclose the records would be a tip-off. You must still weigh the public interest in disclosure against a patient's right to confidentiality. Disclosure is only likely to be justified if it is a serious offence. You should only disclose as much information as necessary.

In practice, the police apply for access to confidential medical records by providing a "Section 29 Form", authorising disclosure without consent under the Data Protection Act 1998.

Security and terrorism

There is a requirement in the Terrorism Act 2000 (introduced by the Anti-Terrorism, Crime and Security Act 2001) for a person to notify the police of any information which they:

"know or believe might be of material assistance in (a) preventing the commission by another person of an act of terrorism or (b) in securing the apprehension, prosecution or conviction of another person, in the UK for an offence involving the commission, preparation or instigation of an Act of terrorism."

Failure to do so is an offence. This statutory duty to disclose relevant information will justify a breach of confidentiality if this information is received in the course of the doctor-patient relationship.

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PCT's "flawed and irrational" decision not to fund Avastin quashed

On Wednesday 18 July 2007, cancer patient Victoria Otley won a High Court ruling that Barking and Dagenham Primary Care Trust made a flawed decision when it refused to fund her Avastin drug treatment.

The facts

Ms Otley, from Dagenham, East London, was diagnosed with bowel cancer and secondary liver cancer in November 2005, two and a half years after she first consulted doctors about her symptoms.

After chemotherapy failed to halt the spread of the disease, Ms Otley was told that without treatment she had a life expectancy of only three to six months. She then learnt about Avastin, a drug that is widely available in Europe. She raised £15,000 to privately fund Avastin and other drugs and her condition improved. Her tumours reduced in size and she did not suffer any side effects.

However, once her funds had run out, the PCT refused to fund the treatment, which costs around £1,200 for each cycle. Amongst the PCT's reasoning was the fact that the drug was not cost effective and evidence of its efficacy was poor. In addition, while the amount claimed by Ms Otley was relatively modest, there was potential for many similar claims to subsequently be made.

Ms Otley claimed that the PCT's refusal contravened the European Convention on Human Rights: "a state is obliged to give life-sustaining treatment when there is a known and real and immediate risk to life, so long as it did not pose a disproportionate burden on the authorities."

The judgment

Mr Justice Mitting held that the PCT's refusal was flawed and irrational. He said the PCT had only concentrated on Ms Otley's short-term prospects. While the PCT's policy on financial resources could not be criticised, Mr Justice Mitting said that Ms Otley's case was exceptional, as Avastin had been shown to be of clinical benefit to her. He stated that the PCT's panel had failed to take due account of her 'slim but important' chance of surviving more than a few months if she was treated with that drug. The Judge said the panel had also failed to take into account the possibility that the tumours might shrink – meaning that life saving surgery may then be possible.

The decision was therefore quashed and the PCT will now pay for five cycles of the treatment before reviewing Ms Otley's condition.

Comment

The judgment has not impacted on NICE guidance which states that Avastin is not cost effective in similar cases to Ms Otley's. However, it remains to be seen whether this case will set a precedent, although it is clear that Ms Otley's case was exceptional in that she could demonstrate that the drug had been clinically effective in her case.

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Consultation Paper issued to update Cremation Regulations

The Ministry of Justice launched a consultation document on 16 July 2007, Cremation Regulations – Consolidation and Modernisation, to update the existing regulations and try to prevent another "Shipman".

The current regulations date back to the 1930s and have been amended six times.

The new proposals will allow the family of a deceased to check the medical certificate to see what information has been recorded regarding the final illness and cause of death, prior to cremation. They can then raise any concerns to the countersigning doctor, who can decide what action to take, such as referral to the Coroner.

Previously, relatives were not given the right to inspect this document, and in the Shipman case the referring doctors were deceived by Dr Shipman's account of the case. In addition, it is proposed that a 'work colleague' will not be able to countersign the medical form, to further protect its independence.

The consultation document also proposes simplifying the procedure in the case of deaths by plague or contagious diseases.

Responses are to be provided to the Ministry of Justice by 22 October 2007.

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Inquest Update

Inquests and the CPS: Case Comment

The facts

The fatal shooting of Jean Charles de Menezes by police marksmen on 22 July 2005 has attracted much media attention. Attention has focussed on allegations of gross negligence manslaughter made against the firearms officers involved and allegations of system failures against the Metropolitan Police.

No criminal charges were brought against any of the individual firearms officers involved. Criminal proceedings are, however, being brought against the Commissioner of Police of the Metropolis under sections 3 and 33 of the Health and Safety at Work etc Act 1974 – essentially the general duties of employers and self-employed to persons other than their employees.

The Inquest was opened and subsequently adjourned at the request of the Crown Prosecution Service (CPS), pending the conclusion of the various criminal investigations arising out of Mr de Menezes' death.

On 26 February 2007, the Coroner again exercised his discretion to adjourn the Inquest under s16(1) of the Coroners Act 1988. That section states that where the CPS inform the Inquest that there is to be a criminal prosecution associated with the death, the Coroner may, in the absence of a valid reason to the contrary, adjourn the Inquest. The family of Mr de Menezes sought to judicially review the Coroner's decision to adjourn the Inquest.

The judgment

The Court held that s16 provided the Coroner with a discretion to adjourn and refused the family's application for Judicial Review.

The Court emphasised that the State's Article 2 obligation (the right to life under the Human Rights Act 1998) to investigate and learn lessons to prevent future deaths arising out of similar circumstances was better fulfilled by having the Inquest following the criminal trial, rather than the other way around. Clearly, the Inquest would be better informed by evidence given at the criminal trial against the Metropolitan Police.

Comment

The rationale behind criminal investigations into deaths taking precedence over the inquest process has logic. However, the length of time that it takes the CPS and police to conclude the criminal process is hugely problematic, especially in the context of the NHS.

In addition to the Inquest being put on hold, the police and CPS are often insistent that NHS Trusts do not undertake the usual processes that would follow a patient death. These include:

- Internal investigations to identify areas of improvement are delayed
- Meetings to provide an explanation to the deceased's family
- Healthcare professionals involved in serious incidents can often remain suspended for years
- Civil claims for compensation arising out of clinical negligence cannot be investigated or settled

The Memorandum of Understanding reached last year between the NHS, Health and Safety Executive and the police should help NHS Trusts to access information throughout the criminal investigation. However, the thorny issue of all other legal processes being put on hold pending the conclusion of the criminal process remains.

The Coroners' Reform Bill

Following on from Emma Di Giacomo's article on the key provisions of the Coroners' Reform Bill in our August Newsletter 2006, we are pleased to advise that at long last, Gordon Brown has included the Bill in his parliamentary timetable for implementation in 2007/8.

We will keep you updated on developments ...

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When is it not good to talk . . .?

Government pressure has recently been focussed on hospitals to relax outright bans on using mobile telephones on their premises. Questions have been asked as to whether such bans are really necessary – the Department of Health has now issued guidance upon this.

Whilst it is acknowledged that mobile telephones are a useful way of ensuring communication, support, comfort and often a necessary link back to a patient's social and working life, there are still some issues with their use in healthcare areas. These include:

- Disruption – Patients may be resting and recuperating and will be disturbed by ringtones, alarms and conversations
- Obstruction – Ringtones, alarms and conversations may obstruct important healthcare discussions e.g. between professionals or with patients
- Confusion – Ringtones and alarms may be confused with the alarms on medical equipment
- Interference – As mobile telephones emit electromagnetic signals, they could interfere with the use of medical devices
- Legality – The use of mobile telephones, particularly as cameras and video recorders, could breach patient confidentiality, disrespect patient dignity and undermine confidence in the healthcare profession

The Department of Health has now issued guidance on best practice in this area: "Using Mobile Phones in NHS Hospitals" (May 2007). It applies to all NHS Trusts and has been copied to Foundation Trusts for information.

Overview of DoH guidance

- Trusts should carry out a thorough risk assessment as to where and when mobile phones should and should not be used.
- Trusts should have a written mobile phone policy under the responsibility of one official, encompassing the use of mobile phones, their cameras, music players and video recorders, which should be made known to all staff. The policy should cover what can be used, where and in what circumstances, as well as outlining why such a policy is necessary. It should also be regularly updated as technology moves on.
- Mobile phones should not be switched on or used in clinical areas (including wards) unless there are good reasons to do so. In particular, mobile phones should not be used within 2 metres of sensitive medical equipment (as defined by the MHRA), or when this would disturb recuperating patients. Staff should have powers to challenge inappropriate use of mobile phones.
- There should be designated areas within hospitals where mobile phone use is acceptable; where there are minimal issues of patient privacy/dignity and interference with medical devices. These should be clearly marked and could be, for example, a hospital café area or the hospital entrance.
- Mobile phones should not be charged using the hospital's power supply.
- Consent to photographs of patients or their confidential information should be sought from that patient.

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The Mental Health Act 2007 – radical change or window dressing?

The new legislation has been a long time coming and takes the form of amendments to the Mental Health Act 1983 ("MHA") and the Mental Capacity Act 2005 ("MCA") rather than wholesale change. Having said that, upon closer inspection the amendments are, in some cases, far-reaching. The Act received Royal Assent on 19 July 2007, although no commencement date has yet been announced. Watch this space for further developments!

The main amendments, as set out below, will have a significant impact on mental health practice, and may bring with them new legal challenges for all organisations who provide mental health care and treatment.

Definition of Mental Disorder

- Stricter rules about detaining those with a learning disability – an individual will only be "sectionable" if their learning disability is associated with abnormally aggressive or seriously irresponsible conduct.
- The Act abolishes the four categories of mental disorder used in the MHA and refers instead simply to "mental disorder", which has broader application. Examples of clinically recognised mental disorders include mental illnesses such as schizophrenia, bipolar disorder, anxiety or depression, as well as personality disorders, eating disorders, autistic spectrum disorders and learning disabilities. Disorders or disabilities of the brain are not regarded as mental disorders unless (and only to the extent that) they give rise to a disability or disorder of the mind as well. This contrasts with the definition of mental incapacity, in the MCA, which refers to an impairment of or disturbance in the functioning of the mind or brain rendering the person "incapable" of making a given decision.
- It is made clear that dependence on alcohol or drugs is not in itself a mental disorder, but if the person is suffering from a mental disorder in addition, whether linked to the use of drugs/alcohol or not, the person can be detained for treatment. Compulsory treatment for drug/alcohol dependence can be given where that is part of the treatment for another mental disorder, in respect of which the person has been detained.
- There was some concern that the proposed replacement of s1(3) of MHA with a clause which just dealt with dependence on alcohol or drugs left the position of those engaging in immoral or illegal conduct e.g. promiscuity as uncertain. In theory, the provisions of the new legislation could be used as a means of discouraging certain types of behaviour viewed as repellent by the majority of society. To counteract this, the House of Lords insisted upon the inclusion of the following principle, in Clause 8, which sets out the fundamental principles of the MHA:

"respect for diversity generally including, in particular, diversity of religion, culture and sexual orientation (within the meaning of section 35 of the Equality Act 2006)".

"Treatability"

A key issue for libertarian groups, in the reform of the legislation, was to maintain the "treatability" test, within s3 MHA. This required that detention could only be lawful where the compulsory treatment on offer would directly benefit the individual, either by alleviating their mental disorder or preventing its deterioration.

S3 of the MHA has been amended, by the introduction of the "appropriate treatment" test, in place of "treatability". On the face of it, this means that provided the treatment proposed is "appropriate", there is no need for it to improve the patient's condition or prevent deterioration. However, when this is coupled with the revised definition of medical treatment contained in s145 of MHA there is a different story. Medical treatment is now defined as "nursing and also includes psychological intervention, specialist mental health habilitation, rehabilitation and care", with the added rider that it must have the purpose of seeking to alleviate, or prevent worsening of, the disorder or one or more of its symptoms or manifestations.

This latter stipulation effectively revives the "treatability" test. Due to the removal of specific categories of mental disorder, from the definition in s1, the new "treatability" test now applies equally to all mental disorders, whereas it previously only applied to those with certain types of disorder. So, if anything, the "treatability" test is strengthened by the new provisions.

Nearest Relative

In the case of R (on the application of M) -v- Secretary of State for Health [2003] EWHC the existing provisions of the MHA were found to be incompatible with Article 8 of the European Convention on Human Rights (the right to respect for a private and family life). It was argued that the scheme for determining who is the patient's Nearest Relative (NR) (set out in s26 of MHA) is arbitrary and the patient effectively has no choice about who will be their NR, a role which carries with it important powers in relation to the course of the patient's treatment.

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Further, that the patient had no right of legal recourse if they objected to the way the NR exercised their powers and wished to remove them from that role.

To address this incompatibility, earlier drafts of the amending legislation attempted to "democratise" the way in which NRs were appointed so that patients had a say, in collaboration with mental health professionals. The provisions which made it into legislation are somewhat less radical; the method for determining the NR will remain the same, with the exception of new rights of recognition for same sex/civil partners. Having said that, patients will for the first time be able to apply to court to displace the NR, on a number of grounds, including the ground that they are "not a suitable person to act as such".

Changes in personnel

The role of the Responsible Medical Officer (RMO) is replaced by the role of Responsible Clinician (RC). An RC is any practitioner approved for the purpose and need not be restricted to medical practitioners so might include those from other professions e.g. psychology. An RC will be the Approved Clinician (AC) with overall responsibility for the patient's case, and will be taken from a pool of suitably qualified ACs. RCs will take over most of the functions of RMOs although some of RMO's functions will be adopted by ACs. RCs will have new functions in relation to community treatment.

The role of Approved Social Worker (ASW) is replaced with that of Approved Mental Health Professional (AMHP). This means that a wider group of professionals, such as nurses, occupational therapists and chartered psychologists, can be AMHPs, provided they have the right mix of skills and experience and are not a registered medical practitioner, and will be able to make applications under the Act. AMHPs will have new roles in relation to Supervised Community Treatment Orders.

Supervised Community Treatment Orders

These will allow patients to live in the community whilst still subject to compulsory powers under the MHA. Only patients who have been detained in hospital under s3 MHA will be eligible, and there are further criteria to be met, including the approval of an AMHP.

CTOs will be similar to what was known as "supervised discharge" in that conditions will be attached to the order although the criteria for their use are different. In effect, the detention requirement of s3 is suspended. If the conditions of the CTO are breached, the patient may be recalled to hospital by the RC, where a decision can be made as to whether they require further in-patient treatment (the CTO being revoked) or whether the patient can return to the community under the auspices of the CTO.

Deprivation of liberty

The legislation makes important amendments to the MCA. It establishes a new statutory scheme whereby bodies providing care and treatment to incapacitated adults (who have a mental disorder but are not detained under the MHA) must apply for authorisation to deprive those individuals of their liberty, and must be able to show that the treatment in question is in their best interests.

This is the long awaited government response to the "Bournewood gap" – a loophole in the law named after a case which went to the European Court of Human Rights in 2003, touching upon the human rights of a man with severe autism who was receiving long term care in a hospital. The presiding Judges expressed concern that there were no statutory safeguards under English law to protect the human rights of vulnerable adults living in health or social care institutions, who lacked capacity to give consent to the care/treatment regime. The new legislation is aimed at plugging the Bournewood gap! It remains to be seen whether it will have the desired effect.

It is also noteworthy that those who could previously have been detained under the MHA 1983 but whose condition will no longer fall within the definition of mental disorder (some learning disabled individuals) may fall within these provisions of the MCA.

In brief, hospital and care home managers will need to identify which of their patients may be at risk of deprivation of liberty and apply to the appropriate supervisory body for either a standard or urgent authorisation, depending on the timescale. Schedule A1 to the Mental Capacity Act 2005 sets out the details of the authorisation procedure and the qualifying requirements that must be met before an authorisation will be granted. (Please see the article on this topic in the August 2006 newsletter for more detail).

Foundation Trusts

S23 (6) of MHA had placed restrictions on the way in which Foundation Trusts (FT) could exercise the power to discharge detained patients. Unlike any other NHS body, FTs were prohibited from delegating the power of discharge from the board to members of sub-committees. A discharge therefore required the approval of three or more non-executive directors of the board, who were duly authorised to fulfil this role. Clearly, this was an onerous procedural requirement which could have considerable resource implications for the Trust. Not surprisingly, it was a real issue of concern for those of our NHS clients who were applying for FT status.

Thankfully, s45 of the new legislation amends s23(6) of MHA, to bring the position of FTs in line with other NHS bodies; the power of discharge can now be delegated to "persons authorised by the board" to carry out that function, provided they are neither executive directors nor employees of the Trust, although remember this has not yet been brought into force.

The Foundation Trust provisions came into force on 24 July 2007.

The recurring theme to these amendments seems to be twofold; a more robust system of safeguards to protect patient rights/dignity and a greater degree of flexibility in the way mental health professionals can respond to the clinical, legal and ethical issues that underpin modern practice.

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We can assist you with implementing the changes in a variety of ways, including the provision of training and review of Trust policies and procedures. For further information please contact a member of the Mental Health Team:

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Mental Health: Case Comment

R (on the application of MM) -v- Secretary of State for the Home Department (2007)

The facts

The appellant (MM) appealed against Mr Justice Mitting's decision to uphold the legality of two orders issued by the Home Secretary directing MM's recall to hospital in accordance with s42 of the Mental Health Act 1983 ("the Act").

MM, who suffered from paranoid schizophrenia, had a long-standing history of hospital admissions and drug abuse. In 1996, he was convicted of unlawful wounding, after attacking a man he believed to be having an affair with his girlfriend with a hammer, and was consequently made the subject of a hospital order pursuant to s37 of the Act, with a restriction order under s41. Since June 1997 there had been a history of conditional discharges followed by recalls by the Home Secretary.

The first recall subject to challenge had been based upon MM's use of illicit drugs and his refusal to undergo a drugs test, which was a condition of his conditional discharge. Following a further conditional discharge and recall (which was not challenged), MM was once again conditionally discharged. The conditions included requiring MM to abstain from illicit drugs and submitting to random drug testing. Subsequently MM tested positive for illicit drugs and, despite a warning letter issued by the Home Office, he tested positive again one week later. Consequently MM was once again recalled by the Home Secretary, despite not displaying any psychotic symptoms; that decision was also subject to challenge.

The issues

It was accepted by both parties that a breach of a patient's conditions of discharge does not provide a freestanding ground for recall.

MM submitted that the Home Secretary was only empowered to order his recall if and when medical evidence demonstrated that he was now in a mental state which necessitated his readmission to hospital for treatment under the conditions set out in s37 of the Act or that he would, if he took drugs, inevitably suffer a deterioration such that he would be in that condition in the imminent future.

MM further submitted that continued drug taking created a risk that his mental condition would deteriorate, but it was no more than a risk, and recall could not be warranted until psychotic symptoms had either recurred or become an immediate inevitability.

The decision

Both the Judge at first instance and the Court of Appeal rejected MM's test as too stringent. The Court of Appeal stated:

"Taken to its logical conclusion, the submission would mean that if a doctor were to advise the Mental Health Unit that in his view there was a serious risk that a patient, who suffered from mental illness and was taking illicit drugs, could at any moment become homicidal, but that there was no certainty of this happening and were no immediate symptoms of psychosis, the patient could not be recalled. This would not make sense."

It was decided that there is no reason in law why it could not be appropriate for a person in MM's position to be detained for treatment before reaching the stage when psychotic symptoms either had recurred or were certain to be on the point of recurring. However the Court of Appeal recognised that determining the point at which the risks are such as to make a detention for treatment appropriate may involve a difficult judgment on the facts of a particular case.

The Court of Appeal noted that for the Home Secretary to recall a patient, who is subject to a conditional discharge, he has to believe on reasonable grounds that something has happened, or information has emerged, which is of sufficient significance to justify recalling the patient. It was not disputed that the Home Secretary must have up-to-date medical evidence about the patient's mental health and the Court of Appeal recognised that in practice the Home Secretary would not (save in the most exceptional circumstances) recall a patient without first seeking the Responsible Medical Officer's (RMO) clinical opinion as to whether it is appropriate to detain the patient for treatment; however, the Court of Appeal declined to lay down a formulaic 'test'.

In dismissing the appeal, the Court of Appeal upheld the original decision that both recalls had been reasonable and lawful in the circumstances.

Comment

This judgment recognises the careful balance between the need for evidence and justification to support a recall against the ability to safeguard and protect patients and the wider public, without the need to wait for a critical event to occur.

Community practitioners play a vital role in supporting and monitoring patients subject to conditional discharge. Where a patient is failing to engage and/or is in breach of conditions, practitioners should refer their concerns to and/or seek further advice from the Mental Health Unit at the Ministry of Justice. In light of this judgment, it is clear that both the Mental Health Unit and the Courts expect RMOs to give their clinical opinion as to whether or not recall for treatment is appropriate. However, it should be remembered that the final decision to recall rests with the Secretary of State.

Please note that in May 2007, responsibility for patients subject to conditional discharge was transferred from the Home Office to the Ministry of Justice.

Hill Dickinson acted on behalf of an Interested Party in these proceedings, namely the specialist Mental Health Trust responsible for providing s117 services to MM during his periods of conditional discharge. As no allegations were made against the Trust, it did not take an active role in the proceedings.

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New Code of Practice for Commercial Leases

Rebecca Wakefield explores the new Code of Practice for commercial leases and considers the impact this will have on NHS organisations seeking to grant new leases on commercial terms.

The Code for Leasing Business Premises ("the Code") has been created by the Royal Institute of Chartered Surveyors in conjunction with other property industry stakeholders, such as the Department for Communities and Local Government and the Law Society, and was unveiled on 28 March 2007. The Code is an example of best practice, rather than a piece of legislation, making compliance voluntary. However, the Government has indicated that it will be watching its implementation closely with the veiled threat of legislation if the industry does not adopt its terms. Moreover, the new 2007 Estatecode makes reference to the Code of Practice and encourages the use of it by all NHS organisations (subject to appropriate legal advice).

The objective of the Code is to redress the balance between landlords and tenants given that prospective tenants will, more often than not, be at a disadvantage in terms of bargaining strength. The Code requires landlords to be much more transparent in their approach to lease negotiations.

At present, there is some debate that, as the Code is prejudicial to landlords, any industry professional would need the landlord's explicit instructions before it could utilise the Code or even draw its existence to a prospective tenant's attention.

The nuts and bolts

The Code is made up of three parts:

a. The Landlord Code is a mere two pages long in recognition of the fact that the landlord is more likely to be in receipt of professional advice at the outset and is in the stronger bargaining position.
b. The Occupier's Guide runs into six pages and contains 37 tips for prospective tenants to consider when negotiating the Heads of Terms and the lease terms.
c. The Model Heads of Terms provide a comprehensive checklist for the parties to consider and agree before solicitors are instructed to draft the lease.

All are available to download from http://www.leasingbusinesspremises.co.uk/

The Code also provides guidance to be considered when negotiating the lease, drafting the lease and conduct during the term of the lease.

Negotiating the lease

Landlords are encouraged to make clear offers in writing, to promote flexibility (for example, by offering different rents for different terms) and to provide comprehensive service charge information.

Tenants are advised to obtain plans showing the premises, to request an estimate of the service charge and to ask the landlord to confirm that the new lease will comply with the Code.

Landlords are expected to highlight where their proposed terms do not comply with the Code and to offer a reason why there is non-compliance.

2. The Lease terms

The Code seeks to limit some of the more restrictive practices exercised by landlords keen to protect the value of the lease. For instance:

- by limiting the pre-conditions to be satisfied before a break clause can be validly exercised;
- by limiting the requirement for an authorised guarantee agreement on assignment of the lease.

One of the biggest changes from current practice is in the rent review provisions which provide that either the landlord or the tenant should be able to initiate the rent review process and that the landlord should not be entitled to interest on back rent if it does not initiate the rent review on the review date.

As to the assignment of the lease, the Code states that the landlord should not specify any circumstances which must exist before he will grant consent. This is at odds with the provisions of the Landlord and Tenant Act 1927, which says that where circumstances have been specified and are not satisfied, the landlord would not be acting unreasonably in withholding consent.

Rent in sub-leases should be the market rent at the time of sub-lease, so in theory the rent could be less than that of the head lease. If the sub-tenant is not to enjoy security of tenure, then the sub-lease should not be on the same terms as the head lease. The common clause that sub-tenants should comply with the terms of the head lease would therefore fall foul of this provision.

The Code only contains provisions for the insurance terms where it is the landlord who is to insure. The Code advises prospective tenants to request a copy of the insurance policy, to check with other insurers that it offers good value for money and to ensure that the lease requires the kandlord to use the insurance money to rebuild or reinstate the premises.

During the term

It is fair to say that the Code does not contribute much to this area as any decent landlord will already satisfy the Code's guidance. The recommendations include dealing with tenants and any guarantors in an open and constructive way and allowing the tenant time to rectify any breach before taking action.

Implications for NHS Organisations

The Code provides clear guidance for estates managers and should provide a handy ready reference guide to all. There is no real reason why the NHS cannot comply with the Code, save for the insurance provisions which do not fit with the terms of the NHS Risk Pooling Scheme. This, of course, would not apply to Foundation Trusts who may exercise their right to obtain insurance on the commercial market.

However, it should be noted that the Code is not weighted in a landlord's favour and NHS organisations seeking to grant leases on commercial terms should consider whether its application will materially detract from the requirement that the NHS obtains best value.

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Estatecode 2007 - new name, new policies, new beginning?

In May 2007, the Department of Health published a revised version of the Estatecode or "Health Building Notes". As with the previous Estatecode the Health Building Notes ("the Notes") give "best practice" guidance on the design and planning of new healthcare buildings and the adaptation/ extension and management of existing facilities. Guidance is also provided to support the briefing and design processes of individual development projects in the NHS, including those under LIFT or PFI Schemes.

It is intended that the Notes will assist NHS personnel in providing greater flexibility in a climate where delivery is constantly changing and the boundaries between primary, secondary and tertiary care have become blurred. The Notes have been organised into a suite of 17 core subjects. The subjects include the Core Element Notes which largely summarise the content of the old Estatecode with further specific notes relating to, for instance, mental health, in-patient care, diagnostics and community care.

For the purposes of this article we will concentrate on the Core Elements specifically aimed at the following organisations:

- NHS Trusts (including Acute, Mental Health and Ambulance Trusts)
- NHS Foundation Trusts
- Primary Care Trusts
- Care Trusts
- Strategic Health Authorities
- The Department of Health

The good news is that the Notes are much easier to read, less prescriptive and more transparent with regard to the Department of Health's aims and objectives than the previous Estatecode. In this article, you will be provided with an overview of the Core Elements Notes with a more in-depth analysis to follow in subsequent articles.

The policy context

This is expressed in similar terms to the predecessor Estatecode in that there is a requirement upon an NHS organisation to ensure that:

- The land and property is used effectively to support Government plans and clinical needs;
- Appropriate levels of affordable healthcare facilities are in the right location, fit for purpose and capable of supporting the provision of quality health care;
- The environmental impact of NHS organisations is addressed with regard to both existing and new builds/ refurbishments; and
- All statutory requirements, national and international directives are observed.

That said, the Notes are not simply a regurgitation of the old guidance. Specific reference is made to current policy drivers affecting the NHS which include patient choice, moving health care from acute to community settings and joint provision with social, education and leisure departments of Local Authorities.

It is also noted that these policy drivers will greatly challenge the traditional estate ownership models and estate managers will be required to demonstrate a greater level of flexibility and, within reason, imagination in the way that they structure and plan their estate strategy.

Guidance and powers

NHS Trusts, NHS Foundation Trusts and PCTs may own or lease land in their own right and name. These rights do not, however, apply across the board and for this reason specific reference is made in the building Notes to the various forms of NHS organisation and their ability to deal in land and property transactions.

Primary Care Trusts

At schedule 3 of paragraph 15 of the National Health Service Act 2006 it is specifically provided that:

"(1) the Primary Care Trust may do anything which appears to it to be necessary or expedient for the purpose of, or in connection with its functions.

(2) in particular, it may;

a) acquire and dispose of property ...."

What is "necessary or expedient" is open to interpretation although the Notes confirm that decisions need to be reasonable and should involve consideration of the relevant functions of the PCT. While PCTs have no power to borrow and, consequently, no power to mortgage or charge, PCTs do have income generation powers. By schedule 4 paragraph 20 (1) of the National Health Service Act 2006, PCTs are permitted to acquire land or property by agreement and manage and deal with land and property in order to make money available for improving health care services. Income generation must not interfere with the duties and performance of the PCT and it should be noted that where an individual scheme results in an annual turnover of £50,000 or more, a "memorandum trading account" must be maintained. The retention of trading accounts for smaller schemes while recommended, are not compulsory.

NHS Trusts

NHS Trusts are also permitted to deal in land (as provided for in schedule 4, paragraph 14 of the 2006 Act) in much the same way as PCTs in that the power is linked to the NHS Trust's functions. An NHS Trust's principle function is expressed as providing goods and services for the purpose of healthcare provision. In addition, NHS Trusts have similar income generation powers to those prescribed for PCTs (as discussed above).

NHS Foundation Trusts

It is clearly stated within the Notes that it is anticipated all NHS Trusts (including Acute and Mental Health Trusts) will at some time in the future assume Foundation Trust status. The Notes refer to the regulation of Monitor but remind Foundation Trusts that they should be familiar with the Notes and utilise the guidance as "best practice".

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Established under Chapter 5 of the National Health Service Act 2006, Foundation Trusts are effectively free from central Government control and possess three key characteristics that distinguish them from NHS Trusts:

1. Freedom to decide locally how to meet their obligations.
2. Accountability to local people, who can become Members and Governors.
3. They are authorised and monitored by Monitor.

A Foundation Trust has powers to deal in land and property and will be governed by its "terms of authorisation" where assets are classified as "protected" or "unprotected". Protected assets are defined as those which are required for the purpose of providing either mandatory goods and services or mandatory education and training. Non protected assets are those which are not required for mandatory goods and services and may be disposed of by a Foundation Trust without the approval of Monitor. The definition of "disposal" includes a part sale of assets or granting an interest in them, although it should be noted that Foundation Trusts are not permitted to create floating charges on their property (s45(6) of the National Health Service Act 2006).

Strategic Health Authorities

Strategic Health Authorities do not have an express power to acquire and dispose of land but rather enjoy the delegated powers of the Secretary of State who may acquire and dispose of land for the purpose of carrying out its functions. The functions of the Strategic Health Authority are exercised for the benefit of the geographical area under their control and while using delegated powers they are able to carry out property transactions in their own name. In practice these rights are extremely limited and tend to relate to the provision of offices in appropriate geographical locations.

Special Health Authorities

Special Health Authorities are one of the three types of arms at length body which provide a service to the public. There is no common set of powers for Special Health Authorities and the ability to carry out land and property transactions is provided by delegated authority under statute or specific direction issued by the Department of Health.

Decision making

All NHS organisations are responsible for making what they believe to be the best decisions concerning land and property for their particular organisation and the NHS as a whole. Decision making processes should be "clear, documented and of a high standard in order to satisfy probity, governance and auditing purposes". Organisations are only permitted to act within their delegated limits and, where dealings may require an organisation to deal above its limits, the business case should be submitted to the Strategic Health Authority and approval received before proceeding. Delegated limits for NHS Trusts, PCTs and Strategic Health Authorities are set by the Secretary of State in consultation with the Treasury.

Comment

It should be borne in mind at all times when undertaking a property transaction that NHS organisations are required to obtain appropriate legal and professional advice (from those with knowledge of NHS policy and procedures) for all land and property transactions.

Nonetheless, the intention of the Notes is to allow NHS organisations, and their personnel, to deal with legal and professional advisors in the capacity of an "informed client". The rule of thumb should, however, always be that if you do not have specific expertise in an area then preliminary advice should always be taken from an appropriate advisor.

Specific issues relating to acquisitions, disposals, estate strategy and leases will be discussed in subsequent articles, but in the meantime if you think that you or your organisation would benefit from a meeting with members of our specialist NHS Property Team then why not attend one of our NHS Property Workshops? This is a free service offered to all of our NHS clients providing informed and practical advice on how to comply with the Estatecode when entering into property transactions. Aimed at groups of 6 to 8 individuals and with an opportunity for open discussion and questions throughout, the workshop provides a valuable insight into the workings of a commercial property transaction.

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Trademarks and passing-off - Episode 3

Further to the article in the last edition on designs and design right, we will now look at the law surrounding trade marks.

What is a trade mark?

The law of trade marks is governed by the Trade Marks Act 1994. Trade marks protect words, signs or symbols which distinguish one business from its competitors. The mark will indicate the source of the goods and services and may indicate a certain level of quality; customers will often purchase goods and services based on the reputation that the mark carries.

Trade marks can be registered or unregistered. You can register words, logos, letters, numbers and shapes. In some cases, you can even register colours, sounds or smells.

In order to be registered, a trade mark must fit certain criteria:

1. Distinctive

Made-up words or words that are distinctive or not commonly used for related products and logos may be registered. However, in some cases, simple initials or combinations of colours can be registered.

For example, in the health service "Medical Services" could not be registered, whereas "Natmeds" or "Plum Services" could.

2. Descriptive

Marks that merely describe goods or services cannot be registered. However, by adding a brand name, or arranging the words in an unusual order, the mark may be registered.

For example, "Cough-Drink" or "Heat-Pad" could not be registered, whereas "WellCo Cough-drink" or "Abdo-Heat" could.

3. Deceptive or against public policy

Anything rude or offensive is unlikely to be registered. Similarly, anything which claims to be something it is not, or otherwise is purely laudatory, cannot be registered. "Sugarfree Dream" could not be registered for a chocolate bar that contains sugar.

Why register a trade mark?

The owner of a registered trade mark is the only person who can use that mark. The owner can sue anybody who uses the registered trade mark without permission, where such use conflicts with the rights the owner has in the mark.

Unlike some instances of copyright infringement, it is not necessary to prove that the person knew about the mark in order to take legal action against them. It is also not necessary to show that damage has been suffered to enjoy the remedies offered by the Trade Marks Act 1994.

Registered trade marks are like any other property, in that they can be sold or licensed to make money. If anyone wants to use your trade mark on their product or services, you can charge them to do so.

Infringement of a registered trade mark is also a criminal offence, both under the Trade Marks Act 1994 and the Trade Descriptions Act 1968.

A trade mark registration lasts from the date of application for a period of 10 years and can be renewed in perpetuity.

When can you claim infringement?

If someone uses a mark that is confusingly similar or identical to your mark, on similar goods or services you can sue for infringement.

In some cases, if the trade mark is a household name, this may prevent anyone using a similar mark for any products whatsoever. For example, a company making medical equipment may not be allowed to use the names "Sony" or "Coca Cola", as these marks are so well known, they transcend any particular class of goods or services.

How to register your trade mark

Applications to register trade marks are made at the UK Intellectual Property Office. Once the form is received, the applicant is notified and the mark is examined by a specialist team. If the mark is accepted, it is published in the Trade Mark Journal, and provided no one objects to your mark, in due course you receive a certificate confirming your registration.

Passing-off

The law of passing-off protects unregistered trade marks in which the owner has built up goodwill.

Passing-off is a false representation or misrepresentation as to the business or geographical origin or business connection of a product or service.

The essence of passing-off is taking unfair advantage of the goodwill acquired by another party for your own benefit. In order to prove passing-off, a party must show:

1. Goodwill in the trade mark relating to the product or service – this can be evidenced by market share, money spent on advertising and the general reputation of the mark;
2. Misrepresentation – as to the origin, business connection or geographical origin; and
3. Likelihood of damage to the claimant – by way of loss of sales or reputation.

Note the differences between the requirements and evidence required to support a successful action for infringement of registered trade marks are much simpler than for passing-off (infringement of an unregistered trade mark).

Remedies

Remedies for trade mark infringement and passing-off include injunctions, delivery up of offending products and claims for damages or account of profits. What is appropriate in each case differs depending on the facts of the case and the circumstances of the parties.

If you have any queries about trade mark law, or any other IP issue, or if you would like to receive copies of Hill Dickinson's Intellectual Property and Information Technology newsletter, please contact Shelley Thomas or Philip Woods at our Manchester office on 0161 817 7200, or shelley.thomas@hilldickinson.com and philip.woods@hilldickinson.com.

Costs Capping in Litigation Cases

The costs being claimed by claimants' solicitors in pursuing clinical negligence cases is a hot topic, and one method of controlling these costs is to seek an order from the Court that the costs in respect of pursuing the claim in question must not exceed a certain amount. These are known as Costs Capping Orders. This article seeks to explain the principles behind costs capping, and the circumstances in which these Orders can be sought, by reference to the key cases.

Some general principles, emerging from previous caselaw, are:

- The Civil Procedure Rules give the Court ample powers to make a Costs Capping Order at any stage of the proceedings.
- Such Orders are essentially case management decisions, depending heavily on the Judge's perception of the needs of the case.
- In order to succeed, the applicant has to show that: "there is a real and substantial risk that without such an Order, costs will be disproportionately or unreasonably incurred and that this risk may not be managed by conventional case management and a detailed assessment of costs after a trial". This can sometimes be a difficult hurdle to overcome.
- Clinical negligence cases can involve more complicated issues of liability than personal injury cases arising out of road traffic accidents, and thus higher costs are often incurred in relatively low value clinical negligence cases. This means that a straightforward test of proportionality may not be applied and Courts will not attempt to set a specified ratio of costs to damages for any particular type or class of case.

The judgment in the personal injury case of Brenda Willis -v- Neil Alick Nicholson was handed down by the Court of Appeal in March 2007.

First Instance decision

In September 2002, Mrs Willis knocked Mr Nicholson off his motorbike whilst driving her car. He suffered catastrophic injuries with damages worth in the region of £5,000,000. Proceedings were issued in September 2005 and were strenuously defended by Mrs Willis' insurers.

There were 3 occasions upon which the claimant's solicitors had been obliged to provide estimates of their costs, which were as follows:

19 October 2005
Costs to date = £75,000 - £80,000
Further costs to conclusion = £125,000 - £170,000
Total costs for the whole action = £200,000 - £250,000

19 June 2006
Costs to date = £417,000
Further costs to conclusion = £146,000
Total costs to the end of the Trial = £564,000

31 July 2006
Costs to date £499,000
Further costs on quantum = £459,000
Total costs for the whole action = £959,000

The costs estimates for the defendant were significantly smaller.

The size of the figures put forward on 19 June 2006 caused the defendants to issue an Application for a Costs Capping Order.

In October 2006, Mr Justice Field, at first instance, refused to impose a cap, for two reasons:

a. He was unable to find that there was a real risk that future costs incurred from 31 July 2006 would be unreasonable and disproportionate.
b. He was concerned about the time and costs that would be involved in having a Costs Judge decide what the costs cap should be.

However, he did believe that the level of costs incurred to 31 July 2006 were "truly remarkable" and felt that the defendant "merits a measure of protection". He therefore ordered that costs incurred from 31 July 2006 to the final determination of the claim should not exceed the estimate given of £459,000.00.

The defendant appealed on the basis that either the Judge should have ordered a lower limit or should have remitted the case to a Costs Judge for him to set the cap.

The Court of Appeal decision

The Court of Appeal considered previous caselaw dealing with costs capping, such as the Judgment of Lord Justice Brooke in King -v- Telegraph Group in which he stated: "It would be very much better for the Court to exercise control over costs in advance rather than to wait reactively until after the case is over and the costs are being assessed".

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However, the Court of Appeal declined to disturb Mr Justice Field's decision. The main reason for this was their uneasiness at adjusting the claimant's solicitors' costs so close to trial (5 months later).

The Court of Appeal did however take the opportunity to make some general observations about Cost Capping Orders. They stated: "the very high costs of civil litigation in England and Wales is a matter of concern, not merely to the parties in a particular case but for the litigation system as a whole.... one element in the present high cost of litigation is undoubtedly the expectations as to annual income of the professionals who conduct it."

The following principles emerged from their judgment:

- The focus of costs limitation has to be on the way in which the case is conducted, which is a delicate matter. The Court will be careful before imposing costs restrictions, particularly when those restricted are acting for a claimant who has suffered catastrophic injuries.
- To conduct the exercise properly, the Court will need reliable information about, and an understanding of, the nature of the particular case and the general demands of that type of litigation.
- For both reasons of fairness and of practicality, a cap cannot be imposed retrospectively, so the inquiry must take place at a sufficiently early stage to have a real effect upon expenditure.
- The purpose of a Capping Order is to enable the capped party to plan ahead the appropriate level of expenditure to conclude the case at a cost, which is in line with the amount of the cap. Accordingly, there has to be careful selection of the right moment in the litigation process for the consideration of the costs cap. We would say that an application should be considered after Allocation Questionnaires.
- The amount of the cap has to be determined by a Costs Judge and the exercise can be as expensive and time consuming as the Final Assessment itself.

Tantalisingly, the Court drafted a comprehensive set of Costs Capping principles to be applied in personal injury cases, which they did not release. After consulting with the Master of the Roles and the Deputy Head of Civil Justice, they expressed serious doubts as to whether further guidance upon costs capping should emanate from a constitution of the Court as opposed to being formulated by the Civil Procedure Rules Committee after extensive consultation. We understand that this Committee considered costs capping at its July 2007 meeting.

Further support for costs capping came earlier this year when His Honour Judge MacDuff made a cost capping order limiting Irwin Mitchell's costs to just 30% of their £726,000 estimate for future costs. The costs estimate produced totalled £1.8m for claims, which the Judge felt were worth no more than £400,000. This was in relation to a Group Litigation Order under which Irwin Mitchell act arising out of holidaymakers becoming ill in Tunisia. Again, the Judge refused to retrospectively limit the claimants' costs but commented that he "did not see why, in the appropriate case, costs capping should not be a regular and normal order". He said that the parties should seek to agree the level of a cap between them and the Courts should be more proactive. The importance of supplying detailed and accurate information about costs at an earlier stage was also stressed.

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Litigation Update

Ellis -v- Bristol City Council – July 2007 – slippery floors

Regulations 12(1) and (2) of the Workplace (Health, Safety and Welfare) Regulations 1992 specifically state that every floor in a workplace should be of a construction which is suitable for its purpose, with no holes, slopes, unevenness or slipperiness. Regulation 12(3) has until now created a "reasonable practicability" defence for employers by arguing that there are systems in place for inspecting and cleaning up spillages.

The Court of Appeal decided in this case that the surface of a workplace floor must not be slippery and that this requirement applied not only to permanent states of slipperiness but also to states of slipperiness which occurred with a sufficient degree of frequency and regularity.

Therefore, if a smooth floor is frequently slippery then the floor may be said to be unsuitable. The argument that the duty of an employer is limited to doing that which was reasonably practicable to keep the floor free from substances was rejected.

In this case, the claimant successfully appealed the dismissal of her personal injury claim which was brought after she had slipped on a patient's urine in the care home she worked. It was well-known that patients would urinate on the floor and an injury was foreseeable. As well as taking these factors into account, the Court also noted that urine was not easy to see and employees would be focused more on the patients than what was on the floor. The Court of Appeal found that there had been a breach of Regulation 12(1) and strict liability applied, with a reduction of one-third for contributory negligence as the urinating was well-known about by staff and they had been warned about it.

This is likely to lead to claims being brought on the basis that spillages on the corridor or ward floor occur with a sufficient degree of frequency for strict liability to apply. This is another example of the Courts applying strict liability to Health and Safety Regulations, making the reasonable practicability defence more difficult to run.

Johnson -v- Warren – May 2007 – no award for disadvantage on the open labour market

A claimant who has sustained injury will often make a claim for disadvantage on the open labour market (a Smith -v- Manchester award) on the basis that s/he would have more difficulty in obtaining employment than if s/he had not sustained the injury in question. The Court of Appeal found that it was right to refuse to make such an award because although the claimant was not able to carry out physical work, she was still fit enough to do clerical work which was freely available to her. She had in the past worked in a number of clerical jobs and it was unlikely that she would be out of work.

Comment – a potentially useful case to argue against a Smith -v- Manchester award in the right circumstances but it would perhaps still be open for a claimant to seek an award for "loss of congenial employment".

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Happy Birthday Bolam! Classic Cases Revisited - Episode 1

2007 is a year of birthdays. It is a big year for Liverpool which celebrates 800 years since it was awarded its charter by King John, it is fifty years since the signing of the Treaty of Rome and, of significance to clinical negligence lawyers, it is fifty years since Mr Justice McNair laid down the Bolam test, the standard by which the conduct of all healthcare professionals is judged by the civil courts.

Perhaps now is time to assess whether the criteria established fifty years ago remain valid today and to consider what the future might hold.

Before Bolam

The tort of negligence celebrates a birthday of its own, with the famous House of Lords decision of Donoghue -v- Stevenson (1932) hitting 75. That decision arose after an unsuspecting Mrs Donoghue apparently found a decomposing snail in a bottle of ginger beer and subsequently developed gastroenteritis. The case was famous for Lord Atkin's speech which introduced the "neighbour" principle, saying: "the rule that you are to love your neighbour becomes in law, you must not injure your neighbour; and the lawyer's question: Who is my neighbour? receives a restricted reply. You must take reasonable care to avoid acts or omissions which you can reasonably foresee would be likely to injure your neighbour".

The case set down the three-stage test by which negligence could be found. This assumes that (1) a duty of care can be established which (2) had been breached and that (3) injury resulted from that breach.

The concept that claims in negligence could be brought against doctors was not unheard of before Bolam, but the case law demonstrated that such claims were fraught with difficulty and ultimately were unlikely to succeed. In the 1954 case of Roe -v- Minster for Health, in finding for the defendants Lord Justice Denning noted that "it is so easy to be wise after the event and condemn as negligence that which was only a misadventure. We ought always to be on our guard against it, especially in cases against hospitals and doctors."

So what, if anything, did Bolam do to change this?

The facts

Mr Bolam sued the Friern Hospital Management Committee after sustaining fractures to both sides of his pelvis during electro-convulsive therapy (E.C.T.) treatment which he had undergone voluntarily for depression.

He alleged that the defendants had (1) failed to administer any suitable relaxant or anaesthetic drug to prevent or control the violence of the convulsion, (2) failed to supply sufficient nurses to control him and (3) failed to warn him of the risks of the treatment.

There was a dispute between the parties' medical experts as to whether at the time of the surgery it was appropriate to provide relaxant drugs (given their inherent risks), whether restraint should have been provided and whether a warning should have been given if the patient hadn't asked for it.

Medical negligence defined

Mr Justice McNair recognised that at the time the use of E.C.T. therapy was considered to be a 'progressive science'. He proceeded to direct the jury that the standard to be applied to the defendants is that of the ordinary skilled man exercising and professing to have that special skill.

In respect of each of the three major issues outlined above it was agreed that there were conflicting schools of thought in the medical profession as to what approach should be taken. Mr Justice McNair went on to explain that as far as the question of negligence was concerned the jury would have to decide not whether the defendants' practice was better than the suggested alternative but that, in acting as they did, they were acting in accordance with "competent respected professional opinion".

The words he chose were that a doctor:

"...is not guilty of negligence if he has acted in accordance with a practice accepted as proper by a responsible body of medical men skilled in that particular art."

On this occasion the jury held that the defendants' practice met that standard and, accordingly, the claim failed.

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Since Bolam

The test was interpreted initially as suggesting that if a doctor could find a 'body of opinion' to support his or her practice then that would be enough to defeat a negligence claim.

Perhaps the most important decision since Bolam is that in Bolitho -v- City and Hackney Health Authority (1997) in which the House of Lords took the opportunity to revisit the appropriate legal test.

Patrick Bolitho was admitted to hospital suffering from croup. He suffered from a number of episodes of breathing difficulties and, despite repeated requests, he was not reviewed by the medical staff. He experienced a cardiac arrest and subsequently died due to catastrophic brain damage. The defendants accepted that the failure to see the claimant sooner would represent a breach of the duty of care but there was a dispute as to what the doctor would have done had she seen him. In particular, there was an issue as to whether he would have been intubated and on this question there was a difference of opinion between the parties' experts. The trial Judge held that the claimant would not have been intubated but having heard expert evidence from both sides he found that this course of action would not have been negligent. The claim failed as the claimant was unable to prove that his injuries would have been avoided but for the admitted breach of duty.

The main judgment in the House of Lords was given by Lord Browne-Wilkinson who held that, when faced with conflicting expert opinion:

"...the Court has to be satisfied that the exponents of the body of opinion relied upon can demonstrate that such opinion has a logical basis. In particular in cases involving as they so often do, the weighing of risks against benefits, the Judge before accepting a body of opinion as being responsible, reasonable or respectable, will need to be satisfied that, in forming their views, the experts have directed their minds to the question of comparative risks and benefits and have reached a defensible conclusion on the matter."

It is arguable as to whether this changed the theoretical basis of the Bolam decision, which did of course refer to the requirement that a body of opinion be "responsible". However, the practical effect of the decision was to confirm the Court's willingness in appropriate cases to analyse the credibility of expert opinion in more depth.

The question remains as to the extent to which the courts will take it upon themselves to 'raise the bar' in respect of the standards which the public are entitled to expect. As things stand the legal test is determined predominantly by where the medical profession draws the lines as to what represents substandard care and not the courts.

The future

The Bolam test has received its share of criticism from those who consider that it gives the medical profession a level of protection that is not seen in other spheres of professional negligence. It remains the case that a claim in medical negligence requires much more than an adverse outcome to be successful.

To date, however, calls for a no-fault scheme for compensation following medical accidents have failed to bear fruit.

The NHS Redress Act 2006 sets out the framework for a Scheme to exist as an alternative to resolving claims by litigation in the civil courts. The Act proposes an alternate process and promotes other remedies such as explanations, apologies and rehabilitation but, crucially, it does not redefine the standard to be applied.

The shift sought by this Act is to improve the process and the patient experience following an adverse event, it does not seek to dilute what is required to prove negligence. On this evidence there must be a strong prospect that in an era of constant change Bolam is here to stay.

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Quantum Update

The following cases will hopefully provide some assistance when valuing General Damages on your claims:

Hughes -v- Property Regeneration Homes – May 2007 – back injury

The 22 year-old male claimant was awarded £4,076 for the back injury sustained at work in February 2005. He was in severe pain for 4 weeks and was unable to work. He made a full recovery within 18 months of the accident (Liverpool County Court).

Chatburn -v- Spicer – May 2007 – neck injury/ whiplash

The 21 year-old male claimant received £2,617 for whiplash injuries sustained in a road traffic accident in February 2006. He suffered pain and reduced mobility in his neck and back as well as travel anxiety but made a full recovery within 12 months of the accident (Maidstone County Court).

Re A – May 2007 – foot injury

A 61 year-old man suffered a fracture and injuries to the metatarsals of his left foot but made a full recovery within 6 weeks of the accident. He received £3,300 (out of Court settlement).

Chivers -v- Allaghen – April 2007 – arm/leg fractures and psychological injuries

A 66 year-old man suffered multiple fractures to his leg and arm in a road traffic accident as well as an adjustment disorder including travel anxiety. He experienced ongoing minor residual symptoms from his physical injuries and was awarded £27,000 for the physical and psychological injuries suffered (Taunton County Court).

Hill Dickinson's green tips on paper recycling

In this article, Monia Sood focuses on the importance of paper recycling. Paper and packaging make up a huge proportion of most municipal and commercial waste streams and therefore the paper industry is the UK's largest recycler.

On average, each person in the UK uses over 200kgs of paper every year and only 66% of this is collected for recycling. That means nearly 5 million tons of waste paper is still sent to landfills or incinerated each year. A large proportion of this could be reduced bearing in mind that about one-fifth of all household rubbish bins consist of paper and card, of which nearly half is newspaper and magazines. These items could easily be recycled.

Most home recycling bins, provided by your Local Council, also accept paper products (although some do not recycle cardboard and yellow pages/phone directories need to be recycled separately).

Paper can be separated into the following groups:

- Magazines
- Newspapers
- Office paper
- Cardboard
- Phone directories

Below are some helpful tips as to how you can look to recycle paper both in the office and at home.

In the office

- The main thing is to try not to use as much in the first place! Consider using double-sided printing or use scrap paper to take down phone messages.
- Where possible, do not print out e-mails. Create a folder to store e-mails that you need to keep.
- To encourage others to do the same, include the following as a footnote to your e-mails:
    - PS Save a tree... please do not print this e-mail unless you really need to.
- White paper used in offices is often made from the highest quality of paper. Consider down-grading the quality of paper or use recycled paper instead.
- Re-use envelopes for internal circulation and if possible externally with a re-use sticker.
- Re-use wallet folders, hanging file dividers or other storage items.

In the home

- Reduce paper waste by cancelling unwanted deliveries.
- Read newspapers on-line as opposed to buying them.
- Put a "no junk mail please" sign on your letter box to reduce unwanted deliveries or contact the Mailing Preference Services (mps@dma.org.uk) to avoid receiving junk mail.
- Re-use paper around the home as scrap paper or packing materials. Envelopes can also be re-used.

Recycling paper is clearly easier to do with support from your Local Council or company/office but can still be done without it. Just remember, the next time you are tempted to throw a piece of paper in the bin...we would need a forest more than three times the size of Devon to give us all the paper we use in Britain in one year. So it really is worth giving it a go.

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Welcome Joanna!

Joanna Crichton, Solicitor
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Joanna has joined the general healthcare team and will be working with Joanna Trewin and Sharon Wilson. Joanna will be dealing with inquests, mental health, child protection and other aspects of general healthcare.

Joanna qualified in June 2006 after taking the Legal Practice Course at the College of Law in Chester and gaining a Law degree at the University of Liverpool. She completed her training contract at Carpenters.

Joanna lives in Waterloo, Liverpool with her husband and cat. She enjoys reading, walks on the beach and going to the cinema or theatre.

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.

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