

November 2007

# HILL DICKINSON

Healthcare Update

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## Welcome

Welcome to the November edition of the Hill Dickinson Healthcare Update.

The front cover features a stethoscope which may become a thing of the past. It seems that traditional medical "uniforms" are changing according to an interesting and thought-provoking article on page 4.

There are also updates on the latest caselaw decisions, the Freedom of Information Act and the Data Protection Act. For those of you who deal with claims, we have included guides to Pre-Action Disclosure Applications and Fatal Accident claims.

Finally, we would remind you that our Autumn seminar, which will explore the topics of consent, capacity, detention and corporate manslaughter, will be taking place in Warrington on 27 November 2007. For further details, please email [healthevents@hilldickinson.com](mailto:healthevents@hilldickinson.com).

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## STOP PRESS... STOP PRESS

### Pleural Plaques Decision

Last week, the House of Lords endorsed the decision of the Court of Appeal that damages are not payable for symptomless pleural plaques caused by an employee's negligent exposure to asbestos in the case of Johnston -v- NEI International Combustion Ltd and others. It was also decided that even though the pleural plaques may be associated with the risk of, and anxiety related to, developing an asbestos-related illness in the future, no damages were payable.

We will look at the implications of this judgment in the next Update.

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### Proposed New Unified Tribunal Structure

On 19 July 2007, the Tribunals, Courts and Enforcement Act 2007 received Royal Assent, which raises the prospect of significant changes for the wide range of tribunals which currently hear cases from the health and social care sector and elsewhere, as David Hill explains.

Whilst the provisions of the Act are being introduced gradually, it is envisaged that Tribunals as diverse as the Mental Health Review Tribunal, the Family Health Services Appeal Authority and the Care Standards Tribunal (which are currently free-standing bodies) would be unified within a hierarchy consisting of a "first-tier" Tribunal and an upper Tribunal. Two notable exceptions which will not form part of the new structure are the Employment Tribunal and Asylum and Immigration Tribunal.

Given the wide range of cases which will in future be referred to the first-tier Tribunal, and the fact that individuals sitting as Judges in the Tribunal will have specialist knowledge of some types of case but not others, it has been necessary for the Tribunal to be split into a number of "chambers". It could well be that current bodies such as the CST or the MHRT will re-emerge as chambers within the unified structure. There will however still be significant change in that the plan is for all the chambers to follow a common set of procedural rules (with certain variations when necessary).

The more innovative part of the legislation is the creation of the upper Tribunal. This body will:

- (a) hear appeals on points of law from the first-tier chamber;
- (b) hear complex cases in the first instance rather than have these heard by the first-tier chamber; and
- (c) hear certain Judicial Review applications.

This latter provision represents a radical departure from current practice where only the High Court can hear such applications. Admittedly the legislation makes provision for High Court Judges to sit in the upper Tribunal and hear Judicial Review cases but it also allows for situations where an individual who is not a High Court Judge, but rather a specialist Tribunal member in an area such as mental health, to hear a Judicial Review application. This approach may pay certain dividends in that the person considering the case will more likely be an expert in the subject matter being considered rather than a generalist. Critics, on the other hand, feel that such cases should remain the preserve of the "traditional" judiciary.

There is reference on the Department of Constitutional Affairs' website to the fact that the changes have been made to create a new simplified statutory framework for Tribunals to provide coherence and enable future reform suggesting that further changes may be on the horizon. It remains to be seen what other novel ideas the Government has in mind.

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### Coroners' Update

**Judge refuses to place restrictions on the reporting of an Inquest into the death of a child who had been murdered by her mother.**

#### Facts

On 27 February 2004, L was found dead. L's younger sister, LM, was removed from her father's care as he wished to remain in a relationship with the mother. LM was placed with foster carers. On 8 March 2005, as part of the care proceedings in respect of LM, Mr Justice Charles found that the mother had caused L's death by way of physical ill-treatment.

On 23 January 2006, Mr Justice Charles permitted the disclosure of documents from the care proceedings to the Coroner, who had jurisdiction to investigate and register L's death.

#### Application

LM's guardian, supported by the Local Authority and LM's parents, sought a restricted reporting order from the Family Division of the High Court preventing the identification of LM, now aged 5, at her sister's Inquest – specifically, they sought an order preventing the media from reporting not only LM's name but also the names of both of her parents and deceased siblings.

The media, unsurprisingly, objected but only insofar as the proposed reporting related to the mother, father and deceased siblings. The application was heard by Sir Mark Potter, President of the Family Division.

#### Issues

- The media relied on the Article 10 right of freedom of expression and the Article 2 right to a public investigation of a death through the Inquest process to support their objection to the application.
- The guardian argued that the reporting of the family name would breach LM's Article 8 right to a private and family life. The family name was an unusual one. The guardian argued that there was a substantial risk that those who knew LM in her new home and school may make the connection. The guardian, supported by a psychologist, argued that inadvertent disclosure or discussion or deliberate discussion, in the school playground, for example, would create trauma for LM and impact upon her already fragile mental health.
- The guardian also argued that media attention would affect LM's chance of a future successful adoption by putting off potential adopters. Sir Mark Potter did not accept that and stated that it was the overall nature of LM's problems that had dissuaded previous potential adopters from proceeding.
- Sir Mark Potter took note of the fact that LM's therapist was already working towards introducing and explaining to LM that her mother had killed her sister.
- Sir Mark Potter also took the view that the case was not one of the well-known sensational cases which had attracted the attention of the media for many years. Once the Inquest had concluded, the case would not be likely to attract long-term press attention.

#### Judgment

Sir Mark Potter found that LM's Article 8 rights did not outweigh the media's Article 10 right to freedom of expression as he was not satisfied that the possibility of additional but uncertain difficulties with LM's therapy established a sufficient likelihood of lasting harm. Sir Mark Potter agreed to an order restricting the reporting of LM's name, but not that of her mother, father or deceased siblings.

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### ContactPoint

**On 1 August 2007, the Children Act 2004 Information Database Regulations (England) 2007 were introduced. These make provision, under section 12 of the Children Act 2004, for an information database to be established and operated by all children's services authorities in England. The information database has been named "ContactPoint".**

#### What is the purpose of ContactPoint?

The information database will play an important role in allowing information sharing between professionals across education, social care, health, youth justice and the voluntary sectors involved in the delivery of children and young people's services. It is hoped that the database will make it easier and less time consuming for practitioners to obtain basic details relating to a child or young person. It will also facilitate contact between practitioners, thereby delivering better-coordinated support and a more efficient public service.

In summary, ContactPoint will enable practitioners to:

- Obtain basic information about a child they have contact with
- Determine which other practitioners are currently or have previously been involved with a child's care
- Identify whether any practitioners have indicated that they have undertaken an assessment under the Common Assessment Framework (CAF)
- Identify where a lead professional has been appointed to coordinate the services provided to the child or young person
- Identify whether a child is receiving all the universal services they are entitled to
- Undertake joint multi-agency service planning and delivery
- Provide early support and intervention to children, young people and their families

ContactPoint will hold basic details relating to all children in England until they attain the age of 18 and in the case of young people with learning disabilities or those leaving care, the record can be retained up to the age of 25, with their consent. The child record will then be archived and will generally be held for a further six years before deletion. Details of any health practitioner involved in a child's care will be archived one year after that involvement ends (or when the child reaches 18 if that occurs first).

#### What information will be stored?

Local Authorities will manage the operation of the database and are required to maintain the accuracy of the information held within it. The database will contain basic information about the child or young person.

Data will include the person's name, address, gender, date of birth, identification number, name of the child's primary carer or person with parental responsibility, the child's GP and the name of the child's school if the child is of school age.

If a specialist or targeted service has been provided (defined as any service not normally provided to all persons in a particular age group), the details of the practitioner should be provided and if it is a sensitive service (relating to mental health, sexual health or substance abuse), a statement should be made to this effect. However information about a sensitive service may only be included in the database with the child or young person's consent.

#### Who can access the database?

Maintaining security and controlling access to the database are key priorities. Access to the database for the purpose of reading or adding information, may be given by either a Local Authority or those persons or bodies known as "National Partners". National Partners include Barnado's, KIDS and The National Society for the Prevention of Cruelty to Children. Local Authorities may only allow those persons listed in Schedule 3 of the Regulations access to the database, which include health professionals, educational professionals and members of youth offending teams. A National Partner may only allow access to their employees. The Regulations also highlight that a user's access to the database can be terminated or suspended by the Local Authority or National Partner.

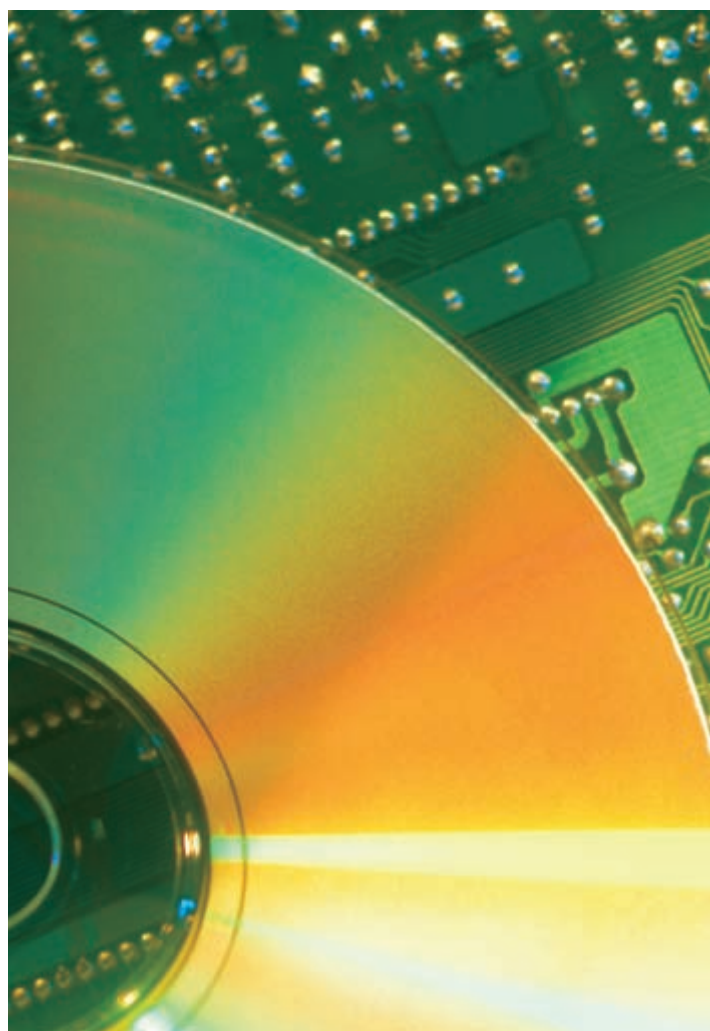
#### What conditions are there on access?

Before being granted access to the database, users must have passed through certain security checks.

Users will be required to have an enhanced criminal record certificate (obtained within the last three years) and to have received training and guidance in the use of the database. Practitioners must also be authenticated as registered users of the system, to prevent unauthorised access.

Access to certain parts of the database can be restricted or shielded by the Local Authority in certain circumstances, after taking into account the views of the child, young person or, where appropriate, the parent. Shielded information may include details relating to sensitive services. The main purpose of this provision is to protect the records of children who may be at increased risk if certain details are disclosed.

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## Healthcare Focus

### Ban that bow tie!

**The well-known image of a man in a white coat with a tie and stethoscope may represent to many people the front line of the medical profession. However, as Simeon Bower explains, recent developments suggest that times and fashions are changing in this area, and that this traditional image may well be out of date.**

In December last year Brighton and Sussex University Hospitals NHS Trust banned the wearing of ties by its staff. Even bow ties were banned. Doctors were told that they faced disciplinary action if they repeatedly wore one. Doctors and nurses were encouraged to confront colleagues who broke the no-tie code.

The rationale for this was that ties are superfluous and that as they are not cleaned as often as other items of clothing, they could be a hazard and spread infection. Tie wearing doctors did not react well. Letters to The Times were written. It was claimed that the rules were driven by political correctness rather than scientific evidence and that their professionalism could be eroded by a dress-down policy. It was feared that patients would have less confidence in open-shirted medics. One consultant, said: "If you come to see a consultant, you will be greeted by an open-neck-shirted doctor who will look as if he is the hospital DJ, but will in fact be the consultant."

Dr Michael Dixon, a bow-tie wearing GP and chairman of the NHS Alliance, which represents Primary Care Trusts, said research showed that patients had more confidence in smartly dressed doctors: "I certainly would feel less professional if I was not wearing a tie."

I return to stethoscopes in a moment but it does look like Brighton was ahead of the game. Under a new dress code recently announced by Alan Johnson, the Health Secretary, doctors, nurses and other staff will shortly be ordered not to wear watches or jewellery, and advised against wearing ties while engaged in clinical activity. The arms of medics will have to be bare below the elbow whenever they are in contact with patients and long-sleeved white coats worn by doctors will be banished from hospital wards because ministers believe that they contribute to the spread of "superbugs".

The Government believes that MRSA is spread from patient to patient on the cuffs of doctors' coats or at least that their long sleeves inhibit hand washing. The bare-arms rule is one of a number of measures unveiled by Mr Johnson to cut hospital-acquired infections such as MRSA and Clostridium difficile. According to Mr Johnson the fear of catching a hospital superbug has overtaken waiting times as the public's greatest concern over the NHS.

Even the days of the stethoscope are numbered. It has hung round the necks of doctors and nurses for almost 200 years, but it may soon be a thing of the past.

Researchers claim that even the most up-to-date electronic stethoscopes are no match for an MP3 player. Neil Skjodt, of the University of Alberta, Canada, argues that off-the-shelf music players can help doctors to record a variety of respiratory noises simply by pressing the machines' in-built microphone directly to a patient's chest. "The quality, clarity and purity of the loud sounds were better than I have ever heard with a stethoscope." Another big advantage of the MP3 player, of course, is that recordings can then be stored and sent to a specialist, analysed using more sophisticated software, or added to a patient's files for future reference.

Short sleeves, no ties and an MP3 player – doesn't sound very professional does it? Need we worry? Perhaps we should.

As the public becomes more educated in medical and (of course) litigious matters the importance of a collaborative and respectful doctor patient relationship increases. It is possible to be smart without being overly formal. Smartness should be encouraged as it engenders an atmosphere of appropriate formality and professionalism.

Hospital staff should be able to identify who their colleagues are to avoid misunderstandings and breakdowns in communication. We once dealt with a claim in which a nurse unquestioningly followed the incorrect instructions of a colleague because the colleague had been wearing a Sister's uniform. She wasn't a Sister - she had just borrowed the uniform. Name badges that identify members of staff and their position are useful for all sorts of reasons and should help to avoid such misunderstandings.

I should also point out that lawyers are not immune to the shifting sands of fashion. Lord Phillips of Worth Matravers, the Lord Chief Justice, has announced that from next January Judges in civil cases will no longer wear wigs (of the judicial kind), collars and bands, although they will retain a simple gown. The Bar Council is consulting, but Barristers are likely to follow suit.

Finally, I am led to understand that some years ago the Public Health Laboratory undertook research into the spread of infection in operating theatres. Researchers found that the best arrangements for reducing the spread of bacteria occurred when surgeons were naked and lightly oiled. The less said about that the better.....

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## New guidance on definition of “personal data” under the Data Protection Act

**The Information Commissioner has released new guidance on the definition of what constitutes “personal data” as that term is used within the Data Protection Act. The Act regulates the collection, storage, destruction or alteration of manual or electronic records containing such data. The scope of the definition is therefore of major relevance to healthcare bodies in determining the extent of their data protection obligations.**

The last significant word from the Courts on the definition of “personal data” was in the case of Durant –v- Financial Services Authority which was heard by the Court of Appeal in 2003. At that time, the Court adopted a more restrictive definition of “personal data” than had previously been used as a working definition by bodies such as the Information Commissioner. This new guidance from the Commissioner appears to adopt an expansive definition. It remains to be seen what the Courts will make of a guidance document from a quango which could be construed as conflicting with a previous judgment of one of the highest Courts in the land!

The guidance itself is relatively free of “legalese” and takes the form of a flow-chart with a series of questions accompanied by examples. It calls for a commonsense approach to defining personal data, whilst at the same time citing examples which would appear to stray well beyond the boundaries of commonsense.

Personal data must either directly identify an individual or contain sufficient information to allow them to be identified (example given – “the tall, elderly man with a dachshund who lives at number 15 and drives a Porsche Cayenne”). In assessing how readily identifiable an individual is from the information held, data controllers should consider the methods that might be used by “investigative journalists, estranged partners, stalkers or industrial spies”. Presumably for healthcare bodies that would include patients with a grievance against members of staff.

Other clues for determining whether data is personal include considering whether the information “relates to”, is “obviously about”, or “linked to” an individual. One of the more curious definitions of personal data is information that is of “biographical significance” with regard to an individual. The example given is that a set of minutes of a meeting are of biographical significance to all those who are listed as attendees in the sense that they indicate where those individuals were at a given time.

Even information about inanimate objects such as machinery can constitute personal data. For example, if usage of machinery is recorded for the purposes of assessing the productivity of the operative using it, then that information is personal data for the purposes of data protection and should be handled accordingly.

Finally, the example is given of a taxi firm which monitors the locations of its vehicles in order to direct the vehicle nearest to a customer to go and pick them up. Since this system could also be used to monitor the whereabouts of drivers using designated vehicles and hence would be of “biographical significance”, the information recorded could constitute personal data. There is therefore the prospect (not stated in the guidance) of a taxi driver’s partner ringing his firm to check his whereabouts only to be told that the information cannot be released without his consent on the basis of data protection!

As can be seen from the above, whilst claiming to apply a commonsense approach to personal data, the Information Commissioner’s Office has decided upon a very expansive definition, the application of which could prove problematic. It remains to be seen whether the Courts will adopt this definition with any degree of enthusiasm or whether true commonsense will prevail.

The full text of the guidance can be downloaded at:

[http://www.ico.gov.uk/upload/documents/library/data\\_protection/detailed\\_specialist\\_guides/personal\\_data\\_flowchart\\_v1\\_with\\_preface001.pdf](http://www.ico.gov.uk/upload/documents/library/data_protection/detailed_specialist_guides/personal_data_flowchart_v1_with_preface001.pdf)

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## Healthcare Focus

### Permitting marketing in hospitals might turn out to be a risky decision!

**Last August the Ministry of Justice released a paper ('Report') commenting on the impact of the regulation of Claims Management Services ('CMS') introduced by the Compensation Act 2006 ('Act').**

**The Report and some recent client enquiries have indicated that it might be useful for us to focus on the major changes the Act has introduced in this sector. We will also look at the impact the Act may have on contracts previously entered into with unauthorised CMS providers.**



Before the Act came into effect, the CMS sector was largely unregulated.

In light of this, a new regulatory system based on authorisation has been introduced by the Act. It has been established that, starting from 23 April 2007, any person providing CMS cannot operate unless authorised by the 'Regulator' (the Secretary of State for Justice) or exempt. Lack of authorisation is an offence and it is punishable with up to two years imprisonment.

As the Report points out, one of the activities the Act was intended to regulate was marketing in hospitals, including activities such as: 'advertising for, or otherwise seeking out (for example by canvassing or direct marketing), persons who may have a cause of action'.

The Report indicates that 'the amount of such marketing in hospitals has been reduced by about 90%'. However, our experience suggests that there are still some cases where CMS providers promote their activities in hospitals without being authorised. Should this be an issue of concern for those hospitals (or other organisations) permitting an unauthorised CMS provider to advertise in their premises? Well, yes!

First and foremost, they could be unwittingly facilitating the commission of an offence.

Secondly, there could be repercussions on the contract they may have in place with an unauthorised CMS provider.

The hospital may in fact be in the conflicting position of being bound by the contract, and, at the same time, facilitating the commission of an offence by simply performing its contractual obligations. In this case, a possible solution for the hospital could be that of discharging the contract by frustration. A subsequent change in law (such as the coming into effect of the Act) or in the legal position affecting a contract is a common cause of contracts being frustrated under English law. In other words, it could be said that the Act has rendered the CMS provider unable to legally perform its obligations under the contract.

On the other hand, the hospital could still be interested in continuing with the contract already in place, providing the CMS provider applies for and obtains authorisation. What happens to the contract in the meantime? Does it continue to have effect even if the CMS provider is not authorised or may we say that the contract is 'suspended' until authorisation is obtained?

Unfortunately, the law of frustration is not clear on this point. It could be that the agreement is terminated as soon as the Act came into force and the CMS provider was not authorised. However, every case is different and if you are in doubt about the validity of any agreement you should seek legal advice on the point.

If you intend to enter into an agreement with a CMS provider, the first step to take is to check whether it has been granted authorisation (this can be done by visiting the website [www.claimsregulation.gov.uk](http://www.claimsregulation.gov.uk)). If you already have a contract in place and the CMS provider has not yet obtained authorisation, you should seek legal advice as to the best solution to adopt.

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### Mental Capacity Act 2005 - Consultation on a Code on the Deprivation of Liberty Safeguards

The Department of Health has launched a consultation based on its draft Code on the Deprivation of Liberty Safeguards. The safeguards have been introduced as part of the Government's response to the Bournewood judgment. The Code supplements the provisions of the Mental Capacity Act and offers advice, guidance and good practice recommendations for the use of restrictive care regimes.

The Department is seeking the views of all interested parties as part of its consultation which will run until 2 December 2007. A questionnaire is also provided to seek participants' views on particular points. A copy of the consultation document can be obtained at [http://www.dh.gov.uk/en/Consultations/Liveconsultations/DH\\_078052](http://www.dh.gov.uk/en/Consultations/Liveconsultations/DH_078052)

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## Healthcare Focus

### Freedom of Information Act Update

**In the last edition of the Healthcare Update, Rhiannon Paddock reviewed some of the important decisions made by the Information Commissioner since the introduction of the Freedom of Information Act 2000 (“FOIA”). There have been some further interesting decisions over the summer, which will be of particular interest to health sector bodies.**

#### Deceased person’s medical records

We previously reported that the Information Commissioner had upheld the decisions of two NHS bodies (Epsom and St Helier University Hospitals NHS Trust and County Durham PCT) to withhold health records relating to deceased patients, in reliance upon the section 41 exemption, on the basis that disclosure would amount to an actionable breach of confidence.

The Commissioner’s decision in respect of Epsom and St Helier University Hospitals NHS Trust was subsequently appealed. On 17 September 2007, the Information Tribunal handed down its decision which found in favour of the Commissioner’s earlier ruling and the Trust’s original decision to resist disclosure. The Tribunal found that disclosure of a deceased person’s medical records could give rise to an actionable breach of confidence, which would be exercisable by the deceased’s personal representative.

#### Retirement details

In two recent decisions, the Information Commissioner found in favour of two Councils who decided to withhold details of the retirement packages given to previous directors, in reliance upon the section 40(2) personal data exemption.

The first decision relates to the City of York Council. The Council had received a request for the details of the financial settlement agreed with the director of commercial services upon his retirement. The Commissioner agreed that disclosure of this information would breach the first data protection principle, namely that personal data must be processed fairly and lawfully. In reaching this conclusion the Commissioner took into account:

- the existence of a compromise agreement between the parties;
- the director’s reasonable expectations as to what would happen to his personal data, particularly in light of a binding confidentiality clause within the compromise agreement; and
- the director’s position as a senior employee of the Council.

Within the Decision Notice it is noted that whilst public authorities should take into account the seniority of employees when a request for personal information is made under the FOIA, the “Commissioner also considers that information which might be deemed ‘HR information’ (for example details of pension contributions, tax codes, etc) should remain private, even though such information relates to an employee’s professional life, and not their personal life.”

The second decision relates to Calderdale Council. The Council received a request for the details of a severance package, including the final salary and lump sum payment, agreed with a Director who had retired a number of years previously. The Commissioner again found that the information was exempt from disclosure in accordance with section 40(2) of the FOIA.

The Commissioner held that where terms have been reached between a public authority and one of its senior employees, “a balance has to be struck between the public authority’s obligation to be transparent and accountable about its decisions and the expenditure of public money in a particular way and its duty to respect its employee’s reasonable expectations of privacy.”

In this particular instance, the Commissioner was satisfied that the specific salary details of individuals at the grade at which the director had previously been employed were not routinely made available. The Commissioner also noted the director’s strong objections to such disclosure, which clearly indicated the director’s expectation of confidentiality, and the fact the Director had been given a guarantee of confidentiality at the time his personal data was recorded. The Commissioner endorsed the Council’s decision to seek the Director’s views about disclosure, before making its decision.

These two decisions should be distinguished from requests for the details of the salary and benefits paid to senior employees of public authorities. Previous decisions by the Commissioner have confirmed that disclosure would not be in breach of the data protection principles.

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

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## Healthcare Focus

# Duties of Doctors and Other Professionals in Investigations of Child Abuse

**In July 2007 a joint Statement was issued from the Department of Health and the Department for Children, Schools and Families (DCSF) on practitioners' duties when suspecting child abuse and to clarify the professional and legal framework in which they work.**

The Statement acknowledges that some health professionals are concerned about the potential repercussions of following the guidance in Working Together to Safeguard Children (2006), e.g. legal action brought by aggrieved parents or on behalf of children taken into care, particularly if this is brought against them in a personal capacity.

The Government has therefore issued this Statement to explain that these concerns should not deter anyone from reporting suspected child abuse as long as they act in good faith and within their field of competence. It reinforces that the provisions of Working Together to Safeguard Children should be followed in order to safeguard and promote children's welfare and that health professionals are well placed to notice potential child abuse. It is therefore vitally important that they follow up any concerns according to the appropriate procedures.

The Statement focuses on:

- Professionals' duty of care
- The basis for sound professional judgements
- Giving evidence and acting as expert witnesses

### Duty of care

A practitioner's primary duty of care is to the child. Usually, there will be no conflict between this duty and the interests of the parents and/or carers of the child. All will want to cooperate to do whatever is in the best interests of the child. However, if a conflict does arise, for example, if a professional suspects a parent is harming their child, the Courts have made clear the primary duty on the professional is to the child [D -v- East Berkshire Community Health NHS Trust; MAK v Dewsbury Healthcare NHS Trust; RK v Oldham NHS Trust (2005)].

There is no competing duty owed to the child's parents or carers, although practitioners must still act in good faith, in a competent and professional manner, exercising reasonable care and skill, in accordance with best practice and the relevant legal framework.

This means, for example, that when investigating suspected child abuse, authorities should cooperate with the parents when making decisions regarding their child and keep them informed as appropriate, so they can properly protect their interests. This will also help ensure compliance with Article 8 of the European Convention on Human Rights (the right to respect for private and family life). It is also in line with advice in Working Together to Safeguard Children which states that professionals should, in general, discuss concerns about a child with families/parents, and seek their agreement to any referral to social services. However, this should only be done when such discussion and agreement seeking will not place the child in question at an increased risk of harm.

### Reaching sound professional judgements

The law requires that professionals make sound professional judgements. The Statement includes the following principles, which will raise the quality of judgements and leave health professionals less exposed to successful challenges.

- Demonstrate proper reasoning
- Take account of all relevant factors
- Give each factor appropriate weight
- Consider all the options or alternatives
- Keep an open mind until it is appropriate to close it
- Know and act in accordance with the law
- Consider human rights implications
- Consider any relevant guidance
- Consult appropriately
- Acknowledge lack of expertise and its impact
- Acknowledge lack of information and its impact
- If the position is provisional, identify what is required to make it final
- Ensure full and accurate recording of these issues

### Giving evidence and acting as expert witness

Healthcare professionals may sometimes have to give evidence in either public or private proceedings. This may include hearings regarding the welfare of a child or criminal proceedings for a suspected child abuser.

In the majority of cases, health professionals will be called to give evidence as a witness of fact, i.e. they will be required to give evidence about their involvement in the care and treatment of the child. This may include what they have seen or heard and what subsequent action was taken.

Professional witnesses mainly appear on a private basis, although occasionally they may be required to attend Court as part of their NHS duties. In such cases, support in going to Court and giving evidence may be provided through their NHS employer.

In giving evidence, the professional witness' role is to assist the Court with their expertise. This is done by ensuring the Court has all the appropriate information and understands it. The Court is then able to make the appropriate decision in the circumstances.

The issues covered in this Statement are broad, although they should provide reassurance and further guidance to healthcare professionals about how to respond appropriately when they have suspicions about potential child abuse. Full details of the Statement are available at <http://www.everychildmatters.gov.uk/resources-and-practice/IG00251/>

For advice and further information on any of the issues raised in this article is available by contacting

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### Estatecode 2007 - Core Elements Part 2 Strategic Investment: 'Gazing into the Future'

**Many of us will have been to a fairground or seen an advert in a magazine or on television for a psychic or fortune teller. You may have even sneaked a look at your horoscopes in your daily newspaper before turning quickly to the business section? For many, such antics are nothing more than nonsense or trickery. But have you considered that as an NHS manager you may be required to take on the role of a "star gazer"?**

Since the emergence of the NHS Plan in 2000, there has been an increasing requirement for NHS bodies to take a more commercial approach towards meeting their statutory obligations. No longer just the mantra of private sector leaders, NHS managers are now required to tame the beast that is the NHS and strive for 'efficiency' and high levels of 'customer service'.

For some, the very idea that principles, generally applied to big business and capitalisation, can apply to the NHS, are inconceivable. The NHS has for over 60 years been core to the British consciousness, allowing us to sleep well in our beds in the knowledge that there will be someone to come to our aid if we should need it, a concept to which we all seem emotionally attached. Yet equally, we hear countless reports of the NHS failing to meet patients' expectations and the service being judged by private sector standards.

Managers, in consequence, have the unenviable task of trying to balance service users' expectations against the realities of a service with finite resources. Paragraph 3.4 of the Estatecode requires that NHS organisations be able to:

"plan and purchase high quality, accessible healthcare facilities through a range of providers including NHS organisations, the private sector and third parties (social enterprise units, voluntary organisations and charities)."

The question is – where do you start?

**Strategic Service Development Plans (SSDPs)** are documents which contain predictions regarding the demand within a particular geographical area over a 10-year period and examine options for meeting that demand. In delivering NHS services to the desired standard, SSDPs are useful tools, focusing attention on key areas of delivery.

SSDPs should outline:

- Method of service delivery
- Practical applications of current guidance/initiatives
- Details of local expertise (patient, clinical and strategic)
- Contributions from available partners (including private and voluntary sector)
- Workforce requirements

Consideration should also be given to issues such as IT requirements, changing expectations for buildings, facilities and finance.

To develop an SSDP, a variety of techniques and initiatives may be used:

- **Strategic Health Asset Planning and Evaluation (SHAPE)**

SHAPE is a web-enabled strategic asset planning toolkit which is being developed by the Department of Health's Estates and Facilities Division. It is a tool intended to assist with the forecasting abilities of NHS bodies and addresses three strategic questions; "Where are we now?"; "Where do we want to be?"; and "How do we get there?".

Scenario planning, spatial planning and modelling features enable users to identify investment requirements and to determine the future capacity and service life of existing assets.

- **Health Impact Assessments (HIAs)**

A method of evaluating the implications and effects of policies and initiatives on a particular group of service users or the general population. The aim is to "maximise health gain and minimise health risks".

- **Estates Impact Assessment**

An Estates Impact Assessment should be carried out whenever new buildings or services are being planned. The focus is on how existing services and facilities will be affected.

- **Achieving Excellence Design Evaluation Toolkit (AEDET)**

An industry wide framework which evaluates healthcare buildings in terms of impact, build quality and functionality.

- **'Developing An Estates Strategy'**

A strategy document should describe the overall use of an NHS organisation's estate, occupancy costs, service and organisational constraints and capital investment decisions. It should also consider future investment through acquisitions and disposals in the face of changing needs.

- **Strategic Asset Management (SAM)**

A co-ordinated approach to asset management, SAM integrates land and property development with service planning. In the early stages of service planning, SAM should lead to, amongst other things, improved co-ordination of public sector investment and better partnership between stakeholders. Underused or unsuitable assets should be liquidated to provide for reinvestment.

SSDPs are not intended to provide a rigid framework to which NHS bodies find themselves bound, but rather they are intended to provide a focus and structure for NHS managers in undertaking what can, no doubt, feel like an impossible task.

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## Litigation Focus

# Pre-Action Disclosure Applications

### Duty of disclosure: the procedural position

Paragraph 3.10 of the Pre-Action Protocol for personal injury claims states that in the event the defendant denies liability he should disclose all documents in his possession which are “material to the issues between the parties and which would be likely to be ordered to be disclosed by the Court...”

The principle of Pre-Action Disclosure is also provided for within the Civil Procedure Rules (CPR31.16), which confirms that for the Court to make an Order for disclosure under this rule, the following is required:

- The application should be supported by evidence
- The respondent is likely to be a party to subsequent proceedings
- The applicant is also likely to be a party to those proceedings
- If proceedings were started the documents sought are likely to be within the classes of documents which the Respondent would be required to disclose

The Court, where appropriate, will order Pre-Action Disclosure in an effort to assist the parties to consider their position at an early stage or to narrow the issues between them.

### Standard disclosure

Disclosure at the Pre-Action stage will usually include documents which would form part of standard disclosure following the issue of proceedings. The concept of standard disclosure imposes an obligation on a party to disclose the following classes of documents which are or have been in his control:

- Documents upon which a party relies
- Documents which adversely affect his own case
- Documents which adversely affect another party’s case
- Documents which support another party’s case and
- Any documents which he is required to disclose by a relevant practice direction

The personal injury Pre-Action Protocol contains standard lists of documents which may be disclosed for different types of claims. Only those documents which are material to the issues at the time that a denial of liability is made should be disclosed.

### What should be disclosed?

The Letter of Claim should set out which documents are sought by the claimant in the event that liability / breach of duty is denied. Very often, claimant’s solicitors will simply use the generic lists of documents which are annexed to the personal injury Pre-Action Protocol. In those circumstances the claimant’s solicitor should be asked to confirm precisely which documents are required and why they are relevant unless it is obvious.

It would be reasonable for a defendant to ask the claimant’s solicitors to revise a request for disclosure in circumstances where it is too vague. In Snowstar Shipping Company Ltd -v- Craig Shipping Plc (2003), the Court warned that an Application for Pre-Action Disclosure should be drafted carefully so that it was properly limited to what was strictly necessary. The Court refused the Application in that particular case because it was too widely drawn and because it felt that the applicant was “fishing for disclosure of documents”.

### Definition of a document

Part 31.4 provides some clarification as to what may be considered “a document”. The word document can mean “anything in which information of any description is recorded” and the word copy in relation to a document means “anything onto which information recorded in the document has been copied, by whatever means and whether directly or indirectly”. The information sought by claimant’s solicitors is very often in the form of paper documents. You should bear in mind however that electronically stored data and even items such as photographs or CCTV footage may fall within the scope of the rules relating to disclosure.

### Costs of an Application

A common misconception of claimant’s solicitors is that they are entitled to the costs of an Application for Pre-Action Disclosure. CPR 48.1 (2) provides:

**“The general rule is that the Court will award the person against whom the disclosure is sought his costs;**

- (a) of the Application; and**
- (b) complying with the Order made on the Application.”**

This principle was recently restated in the case of SES Contractors Ltd. -v- UK Coal Plc. & Ors. (2007).

Claimant’s solicitors, however, almost always incorporate a claim for costs within the Application for Pre-Action Disclosure. In doing so they will generally seek to rely upon the rule set out in CPR 48.1(3) which provides that:

**“The Court may however make a different Order, having regard to all the circumstances, including:**

- (a) the extent to which it was reasonable for the person against whom the Order was sought to oppose the Application; and**
- (b) whether the parties to the Application have complied with any relevant Pre-Action Protocol.”**

If disclosure is refused, unreasonably, the Court may therefore make an Order for the defendant to pay the claimant’s solicitors costs. Similarly, if a party has failed to comply with the personal injury Pre-Action Protocol, usually by failing to confirm whether breach of duty is accepted or denied within the prescribed period, the Court may again make an Order for costs in the applicant’s favour.

On occasion, some, but not all, of the documents which have been requested or which may be disclosable under the Pre-Action Protocol are sent to the claimant’s solicitor but no explanation is given as why only certain documents are available. In the absence of any proper explanation it is likely that a Court would accept that the claimant has acted reasonably in issuing an Application and may make a costs order against the defendant. This may be avoided by taking the simple step of explaining to the claimant’s solicitor that either the documents had not been created or are no longer available and why. When doing so it is important to explain what searches have been made to obtain those documents. This will leave the defendant in a much stronger position to argue that it was unreasonable for the claimant to issue an Application.

### Practical considerations

1. Ensure that a search for relevant documents is made at an early stage, preferably when the claim is first intimated. This may require the implementation of systems for obtaining documents, e.g. Incident Report Forms, without delay. Reference should be made to the relevant Pre-Action Protocol to ascertain the classes of documents which are likely to be relevant and in respect of which the Court is likely to order disclosure should an Application be made.
2. If you require more time to complete investigations before making a decision regarding breach of duty, contact the claimant's solicitor as early as possible to explain the position and to request an extension of time.
3. If liability is denied and some documents are disclosed, but not all of the relevant documents mentioned in the Protocols or Letter of Claim are available, you should contact the claimant's solicitor to explain why those documents are missing or to confirm that they have never been created in the first place. Partial disclosure without an adequate explanation is likely to lead to an Application being issued.
4. It is important to bear in mind the time periods for responding to the Letter of Claim set out in the Pre-Action Protocols and to try to ensure they are adhered to. If an Application is made the defendant will need to consider whether or not he has complied with the Pre-Action Protocol and/or supplied sufficient information to satisfy the claimants' solicitors' request. If not an early decision should be made to compromise the Application and minimise costs.
5. If an Application is made, always consider whether or not a Court Order would have been required even if the Trust had located and was prepared to disclose the documents sought. A common example is in relation to disclosure of third party patient records or personal data in respect of which a defendant may have a duty of confidentiality. In those circumstances it would be reasonable to withhold disclosure until the Trust is ordered to do so by the Court. The cost of the Application should be paid in accordance with CPR 48.1(2) i.e. by the claimant/applicant to the defendant.
6. Maintain a dialogue with the claimant's solicitor regarding proportionality. If the defendant determines it is necessary to disclose a class of documents then any disclosure should be restricted to what is reasonable and that will vary from case to case.
8. When considering who is likely to be ordered to pay the costs of an Application the Trust should ask the following questions:
  - Was the Application necessary? Beware of costs building on the part of claimant's solicitor.
  - Was appropriate warning given of the Application? If a Protocol has been breached this may not be a strong argument but may be used to persuade the Court that the claimant has acted unreasonably.
  - Is the request for disclosure unreasonable or drafted too widely and, if so, has the claimant been asked to revise it?
  - Has the claimant been prejudiced a breach of the Protocol?

You should bear in mind that most District Judges will exercise general discretion under CPR 48.1(3) if a defendant has breached the Protocol and will award the claimant their costs.

It should also be borne in mind that to pay both claimants and defendants solicitors costs of an Application can be costly and in many cases these Applications are avoidable provided the requirements of disclosure are considered at an early stage and an open dialogue is maintained with a claimant's solicitor. The costs will often have to be paid by the Trusts themselves rather than the NHSLA.

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## Classic Cases Revisited - Episode 2 Smith -v- Manchester Corporation, (June 1974)

**In this second instalment in a series of articles Jonathan Heap reviews a well-known decision of the Court of Appeal which deals with damages awarded in personal injury claims where the claimant is left at a disadvantage on the labour market.**

The summer of 1974 said goodbye to two famous leaders: in August Richard Nixon resigned as U.S. President following the 'Watergate' affair and only a few weeks earlier we saw the retirement as Liverpool manager of ex-Carlisle United winger (?) Bill Shankly.

At the same time, the legal world greeted the Court of Appeal's decision in Smith -v- Manchester Corporation, which confirmed that a separate head of loss could be awarded to a claimant whose future employment prospects were damaged as a consequence of personal injury.

### The facts

Gladys Smith was employed as a part-time domestic cleaner in a care home. She was carrying a tray when she slipped on the floor and fractured her right arm, damaging the elbow joint.

Liability was admitted and the parties' medical experts agreed that she was unlikely to make a full recovery. Mrs Smith was 49 at the time of the incident and had returned to work by the time of the trial.

It was accepted that she was limited in her ability to perform some physical tasks, which were required in her job. However, her employer gave an undertaking to keep her employed until her retirement.

At first instance, the trial judge awarded £2,000 for General Damages and £300 to cover possible future loss of earnings.

The claimant took her case to the Court of Appeal arguing that this latter sum was "derisory" and, ably assisted by George Carmen QC, this part of the award was increased to £1,000.

### Basis of the decision

Whilst the Court noted the assurance given by the claimant's employer, it was felt that given her limitations she had been left "anchored" to her job and there may be circumstances beyond her employer's control which would jeopardise her position, such as closure of the home or changes to its management.

There was therefore a "real risk that, at some time between now and the end of her working life, the (claimant) will find herself having to compete, disabled as she is, in the open labour market".

This left the claimant with a loss of earnings capacity (rather than loss of actual earnings) for which she was entitled to be compensated as a separate head of loss.

The difficulty of course is quantifying this loss. Lord Justice Scarman said the Court had to look at the issue "in the round" and look at the various contingencies. The previous award amounted to approximately four months loss of earnings and was increased to £1,000 although no explanation was given as to why this, rather than any other figure, was appropriate.

This is therefore an issue entirely within the Court's discretion.

### How much?

This will depend upon a number of factors such as the claimant's age, work history and qualifications. The Judicial Studies Board suggest somewhere between 6 months' and two years' net salary.

In more substantial cases the Ogden Tables set out suggested discount rates to reflect lifetime risks of unemployment

### Practical considerations

- Be sure that the disadvantage is attributable to the admitted negligence – consider whether the claimant would have been left at a disadvantage by reason of his/her underlying medical problems or the onset of constitutional symptoms.
- Is the claimant likely to recover? If so, any disadvantage may only be temporary.
- No award should be made if the claimant is unable to work at all and is entitled to recover for loss of earnings to retirement.
- The claimant must provide evidence that he/she is at a disadvantage: usually the medical experts will address this.
- Consider the claimant's work history. No award was made in the case of Johnson -v- Warren (Court of Appeal, 2007) where the claimant's injuries prevented her from undertaking strenuous physical work but where she had a long history of employment in the clerical sector and there was no reason why she could not continue obtain such employment for the foreseeable future.

### Conclusion

Allowance should be made for disadvantage on the open labour market in appropriate cases. As with loss of earnings, generally, the head of claim brought by an employee can be reduced where an alternate position can be found, and, as far as is possible, assurances can be given as to the security of that employment.



## Litigation Focus

### Quantum Update

**A busy two months for settlements! The following cases will hopefully provide some assistance when valuing General Damages on claims:**

#### **ML -v- County Durham & Darlington Hospitals NHS Foundation Trust – July 2007 – Misdiagnosis of cancer**

A 65 year-old woman was wrongly diagnosed with oesophageal cancer. She underwent two operations and had a substantial part of her oesophagus removed. Subsequent histopathological analysis concluded that there had never been any evidence of malignancy. She suffered gastric reflux, had to eat little and often, could not bend or stoop and had sleeping problems. She received £25,000 (out of Court settlement).

#### **Hatton -v- (1) Pilkingtons PLC, (2) O-I Manufacturing UK Ltd – September 2007 – mesothelioma**

A 58 year-old man received £65,000 general damages after being diagnosed with mesothelioma. He had previously worked in glass factories where he had been exposed to asbestos and his life expectancy from diagnosis in August 2006 was 1½-2 years (out of Court settlement).

#### **T (a child) -v- British Airways PLC – July 2007 – ear injuries**

A 12 year-old girl received £2,000 for injuries to her ear sustained in an aviation accident. She had a history of glue ear prior to the accident but made a full recovery approximately 3 months following the incident (out of Court settlement).

#### **Braithwaite -v- Relph – July 2007 – neck/hip pain**

A 39 year-old man received £3,000 for the neck and hip pain sustained in a motor accident. His pain was expected to resolve by 9 to 11 months from the date of the accident (out of Court settlement).

#### **Rowbotham -v- Estate of Ian Alisdair Wheldon (deceased) – July 2007 – multiple fractures**

A 49 year old man received £40,000 for the injuries sustained in a motor accident. He suffered fractures to his femur, elbow, metatarsals, pelvis, ribs and one lumbar vertebra. He underwent a number of operations (out of Court settlement).

#### **Gregory -v- Redfearne – July 2007 – neck injury/whiplash**

A 23 year old man was awarded £1,500 for neck and right shoulder pain suffered in a motor accident. He had fully recovered within 6 months of the accident (Salford County Court).

#### **Moore -v- Gilbert – September 2007 – tinnitus/psychiatric problems**

A 39 year old man was awarded £12,500 for tinnitus following a motor accident. His condition was moderate but permanent and caused associated psychological problems including depression, poor motivation, fatigue and irritability (Birkenhead County Court).

### Litigation Update

#### **Thompson & Others -v- Arnold – August 2007 – subsequent claim by dependants does not succeed**

A claim under the Fatal Accidents Act 1976 by dependants of a victim of a personal injury that subsequently proved fatal could not be brought where damages had already been awarded or had been agreed in respect of the victim's injury during her lifetime (High Court decision).

#### **R (on the Application of Fudge) -v- South West Strategic Health Authority & Others – July 2007 – duty to secure public involvement in and consultation on proposals relating to National Health Services**

The duty upon a Primary Healthcare Trust to make arrangements to secure public involvement in, and consultation on, proposals relating to National Health Services under the Health & Social Care Act 2001 Section 11 existed so long as Health Services were provided by that Trust. The obligation remained even where the Trust was not responsible for decisions made and schemes devised by the Department of Health (Court of Appeal).

#### **(1) Whitehead and (2) Mcleish -v- (1) Searle and (2) Hibbert Pownall & Newton (a firm) – July 2007 - costs**

It was appropriate to make orders in relation to an action whereby the Claimant would be able to recover his costs of bringing the claim against both Defendants in an action where the Claimant did not know which of the two parties was at fault. However, it was inappropriate to make such orders when the Defendants had succeeded in defending a large part of the claim (High Court).

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## Litigation Focus

### Claims following a Fatal Injury: A Guide

**Claims often involve circumstances in which the patient who received the substandard treatment has died – either as a result of the treatment or subsequently. This area of the law is complex. Nina Sahu looks at who can bring the claim, the time limits for bringing a claim and what can be recovered.**

It is important to recognise that there are two distinct claims:

1. Claims on behalf of the deceased's estate – under the Law Reform (Miscellaneous Provisions) Act 1934
2. Claims by or on behalf of a dependant of the deceased – under the Fatal Accidents Act 1976

#### The Law Reform (Miscellaneous Provisions) Act 1934

This refers to claims that the deceased had at the time of his or her death and which now 'belong' to his estate. This means that if the deceased was entitled to sue a hospital for treatment received by him had he been alive, this right becomes vested in his estate upon his death.

- **Who can bring the claim?** The deceased's personal representative/administrator/executor of the estate.
- **Limitation:** 3 years from the date of death or 3 years from the date of the personal representative's knowledge, if later. If the limitation period had already expired by the time of the deceased's death, then the estate will not have a claim. The court can apply its discretion under Section 33 of the Limitation Act 1980 to disapply these time limits in the usual way.
- **Damages:** Pain, suffering and loss of amenity endured by the deceased from the date of negligence to the date of death. Damages can be recoverable even if the time period is a matter of hours and even if the deceased did not regain consciousness (damages are awarded for loss of amenity of life).
- **Financial loss:** This is calculated in a similar way to normal past losses from the date of negligence to the date of death and can include, for example, loss of earnings, care, medical expenses etc. It can also include funeral expenses but claims for loss of income after death are specifically excluded by the Act.

#### Fatal Accidents Act 1976

This Act gives a specific class of dependants the right to bring a claim for losses incurred as a result of death. The liability to the dependants arises if death is caused by any wrongful act, neglect or default which would have entitled the deceased to maintain an action and recover damages had he lived.

- **Who can bring the claim?** The Act specifies the class of dependants as follows:
  - a. Wife/husband or former wife/husband
  - b. Partner of the deceased if living with the deceased in the same household at least 2 years prior to death and had been so living as husband/wife
  - c. Parent or any other ascendant
  - d. Any person treated by the deceased as a parent
  - e. Child or other descendant
  - f. Person not a child of the deceased but who in relation to a marriage of the deceased was treated as a child of the deceased
  - g. Any brother, sister, uncle or aunt or any children of theirs

The action is still brought by and in the name of the executor or administrator of the estate.

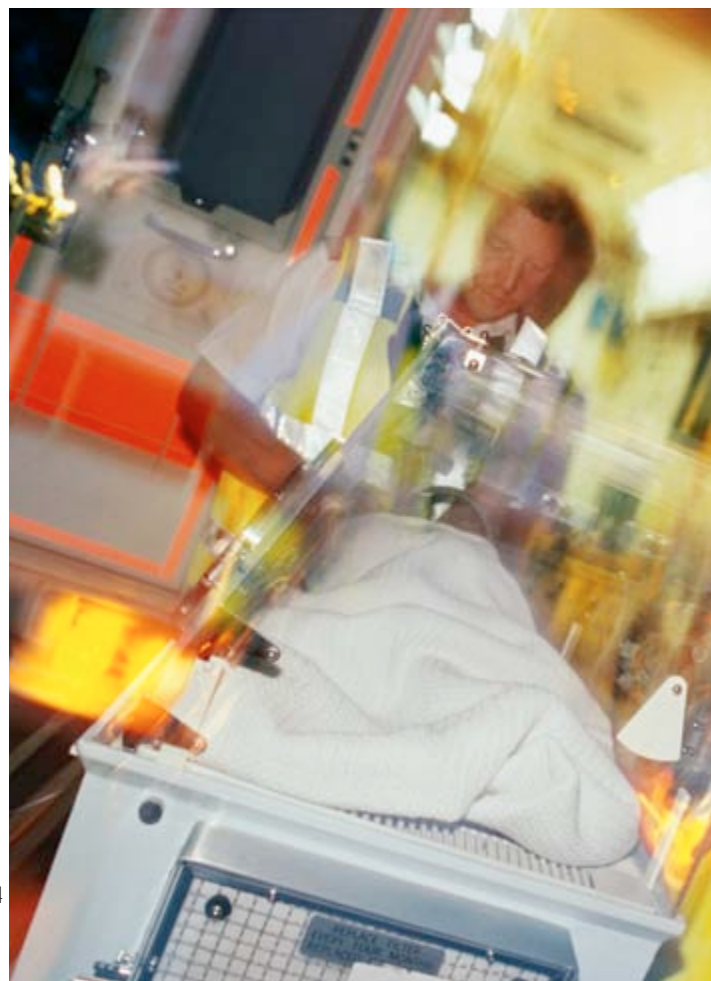
- **Limitation:** 3 years from the date of death or date of knowledge of the dependant (for adults).
- **Damages:** The claim is for the loss of the reasonable expectation of a financial benefit as a result of the death of the deceased. The financial benefit must arise as a result of the dependency relationship and not due to another relationship, eg a business relationship. The 'pecuniary benefit' can take a variety of forms but usually falls into one of the following categories:
  - a. Loss of the deceased's income – the deceased may have been the main breadwinner in the household and there will be a claim for the lost income. This could also include items such as loss of company car, state benefits, pension, health benefits, accommodation etc
  - b. Loss of the deceased's services – services which have a pecuniary value such as housekeeping, parental services, DIY, gardening, maintenance of a car

Finally, in addition to the above, a certain class of dependants can claim a bereavement award. It is important to note that not all dependants can claim a bereavement award and at present the claimants are limited to:

1. The wife or husband of the deceased
2. If the deceased was a minor, the parents (if legitimate) or mother (if illegitimate)

The amount of the **bereavement award** is currently £10,000 for claims arising from deaths after 1 April 2002. For deaths occurring before this date and after 1991 the amount is £7,500.

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## Hill Dickinson Focus

### Hill Dickinson's green tips on waste recycling

**The definition of recycling is to pass a substance through a system that enables that substance to be re-used. Waste recycling involves the collection of waste materials and the separation and clean-up of those materials. Waste products include paper, plastics, glass, metals, food, chemicals, oils, bricks, wood, soil and effluent.**

Taking action on waste is essential since we are consuming natural resources at an unsustainable rate and contributing unnecessarily to climate change.

Each year, approximately 100 million tons of waste is generated from households, commerce and industry. Most of this currently ends up in landfill sites where biodegradable waste generates methane, a powerful greenhouse gas. Valuable energy is also used in making new products which are later disposed of, which also contributes to climate changes.

There are a number of Government initiatives aimed at reducing the amount of waste. The main ways that this can be done is by **Reducing, Re-using and Recycling**.

Approximately 94% of households in the UK now receive a doorstep or kerbside collection service from their local Council for recyclable materials and there has been a 50% expansion in kerbside recycling services in just one year.

Workplaces have also become environmentally aware of their duty to restrict wastage. Part of this may be to do with the fact that businesses have a legal duty to provide appropriate arrangements for the disposal of their waste. However, in part, it must also be due to developing an environmental conscience.

The easiest way to reduce the amount of waste is to implement a programme of waste reduction. An important step in instituting a waste minimisation programme is to conduct an audit to measure the usage of consumables and the type and amount of waste produced. This is currently a programme that is being developed within Hill Dickinson and the aim is to determine the volume and weight of waste disposal before the initiatives are launched so that the amount of waste is actually measurable afterwards.

On a practical level, a useful way of reducing the amount of waste is to use longer life products. In the workplace, many products are used which are designed for only single or short life usage including non-refillable ball-point pens, marker pens, plastic cups/ cutlery, disposable wiping clothes, paper towels and metal staples. All these products require raw materials and energy for their production and resources to deal with their disposal which have an environmental impact. In many instances, longer life products can be substituted with items such as refillable markers/pens, low energy light bulbs, using real mugs or glasses instead of disposal cups.

Most businesses have a long way to go before they are able to demonstrate a measurable amount of waste reduction and it does take a committed business to really make a difference. Below are some practical easy day-to-day ways in which we can all reduce our amount of waste. These tips can be used both at work and at home:

- Squeeze tea bags.
- Use mugs/ glasses rather than plastic cups.
- Flatten cardboard packaging.
- Purchase items with less packaging.
- Renovate furniture or donate to charity.
- Use recycling bins paper, plastic and glass
- Crush can before disposing.
- Recycling of toner cartridges and mobile phones (your business may have a programme in force or alternatively these can be disposed of at some charity shops).

Even with effective waste minimisation measures, we will still produce a considerable amount of waste however it is important to make a start somewhere and you will be surprised at how much waste you can actually reduce if you make the effort.

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## New starters



**Katie Donne – NHSLA**  
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Katie has joined the NHSLA team in Liverpool as a newly-qualified solicitor. She will be assisting Andrew Craggs with his caseload of clinical negligence and EL/PL claims.

She is originally from Bristol but moved to Plymouth in 2000 in order to study law. She graduated in 2003 when she moved back to Bristol to complete the Legal Practice Course.

Katie undertook her training contract at a highly-respected claimant firm in Bristol.

Katie enjoys cycling and kayaking. On a recent trip to New Zealand she took up hang gliding and intends to pursue this hobby in the UK.



**David Hill – Healthcare**  
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David has joined the general healthcare team as a newly-qualified solicitor on completing his training contract with Hill Dickinson. He will be working with Emma Di Giacomo on matters such as inquests, care standards and Foundation Trust queries.

David graduated with a law degree from Queens University Belfast and then completed the legal practice course at the College of Law, Chester. He has previously worked as a healthcare paralegal in Northern Ireland as well as spending 6 months with the Hill Dickinson healthcare team as part of his training contract in 2006.

David lives in Chester and works in the Liverpool office. His interests include reading, eating out, cinema and travel.

## 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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