HILL DICKINSON

Healthcare Update

April 2009

Welcome

Welcome to the Spring edition of the Healthcare Update.

Everywhere you look it's a case of out with the old and in with the new - the daffodils are out in force, the sun is creeping out from behind those clouds and the dark cold winter is behind us (hooray!).

It looks like the law makers have been involved in a bit of 'spring cleaning' themselves, making some key changes to the Civil Procedure Rules and introducing the new Deprivation of Liberty Safeguards (DoLS), and the new Complaints Regulations, on 1 April. Please see our Healthcare and Litigation Focus for more information on how these important legislative changes might affect your organisation. With the dawn of the new Care Quality Commission, bringing monitoring of adult health and social care under one umbrella, its important to make sure you are up to speed with the changes.

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Paying your way: The Department of Health clarifies the position on top-up drugs

NHS bodies in England are now having to get to grips with implementing the recommendations made by Professor Mike Richards, the Government's "Cancer Tsar", in his recent report "Improving Access to Medicines for NHS Patients".

David Hill considers the implications of the guidance and the issues they will raise.

In carrying out this review, Professor Richards was grappling with some of the biggest issues facing the NHS today. He was, in a sense, being asked to reconcile the conflicting aims of providing equal healthcare to all and recognising individuals' right to personal autonomy – specifically their right to buy care over and above that available on the NHS if they have the means to do so.

The headline-grabbing recommendation from Professor Richards' report was that patients should indeed retain their entitlement to free NHS care for a condition, even though they might have chosen to self-fund the purchase of certain drugs for the treatment of that condition which are not otherwise available on the NHS. This recommendation, which has been approved by the Department of Health, provides clarity for NHS bodies and supersedes previous ambiguous guidance. Prior to this clarification, some Trusts were allowing so called top-up treatment, while others took the view that, by self-funding any aspect of their care, patients forfeited their right to free NHS treatment in respect of that condition. This latter approach was extremely unpopular among both the general public and clinicians.

While recommending that top-ups be permitted, the report at the same time took the view that these were at best a necessary evil and that the NHS should still strive to make as many drugs as possible freely available to all. In the same vein, the National Institute for Health and Clinical Excellence (NICE) was asked to speed up its process of appraising new drugs. PCTs have also been instructed to reconsider their decision-making procedures in respect of individual funding requests for drugs which are not ordinarily paid for by the NHS and have been encouraged to consider agreeing common policies and procedures across a number of PCT areas in an effort to address the issue of the postcode lottery in drugs funding. The new guidance with which PCTs should now seek to comply will form the basis for a future article in the Healthcare Update.

Separate care

Although the Department of Health has now given its support to the concept of top-up treatment it has qualified this by saying that any top-up drugs which a patient may purchase must be administered separately from NHS funded treatment. There appears to be concern about the public's reaction to the prospect of Patient A in one bed receiving NHS funded care, while Patient B in the bed next to him receives his top-up drugs which he has the means to afford.

The solution which the Department of Health has suggested is that patients receiving top-up drugs should do so in their own home, in a private hospital or in a private ward within an NHS hospital. This may make the contrast between NHS and top-up care less immediately apparent to patients who cannot afford to top-up, but it does serve to raise some interesting issues which are set out below, along with other considerations.

The other apparent golden rule of top-ups is that such self-funded care should in no way be subsidised by public funds. In other words, a patient receiving top-up drugs must not only pay for the drugs themselves, but also all ancillary costs attributable to the provision of that care, which could conceivably include diagnostic tests, staff time and use of private facilities. This may mean that the true cost of top-up treatment significantly exceeds the list price of the drug which the patient wishes to purchase.

Points to ponder

The Department of Health has not required that all hospital Trusts provide facilities for the administration of top-up drugs. Depending on the decision an individual Trust takes, the following issues may be of relevance:

- If a Trust declines to provide top-up drugs itself, it is still likely to be important for the Trust to form working relationships with other providers who do provide such services so that there are appropriate procedures for referral and handover of patients who wish to concurrently receive courses of NHS and self-funded care.
- If a Trust decides to provide top-up drugs, does it have the separate facilities to provide this care which are apparently required? If freeing up ward space to make such facilities available involves reconfiguring services, appropriate public consultations should be carried out.
- If the Trust concerned has Foundation Trust status, may income from top-up drugs place the Trust at risk of exceeding its private income cap?
- Do Trusts have sufficiently sophisticated means of costing services which are ancillary to the provision of top-up drugs so as to be sure that top-up patients are "paying their way" and are not receiving care which is partially subsidised at public expense?
- Will Trusts require payment up front for the provision of top-up drugs or will patients be invoiced? If a patient fails to make payment for a top-up drug, how aggressively will the Trust pursue payment?
- If a patient requires a stay in ICU which is directly attributable to an adverse reaction to a top-up drug, will he be required to pay the costs associated with that emergency treatment over and above the initial cost of the drug?
- Will a patient be denied access to his top-up drugs if his clinical condition makes it inappropriate to transfer him to the private facility where such drugs are ordinarily administered?

The above points give a flavour of some of the difficult issues Trusts will have to face when deciding on the implementation of top-ups. It is hoped that some of these issues will be addressed by means of additional guidance from the Department of Health following a recent consultation, but it seems likely that guidance in other grey areas will come from the Courts.

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Failing to comply with the directions of their employer Trust can lead to doctors being struck off

Facts

In 2000 Dr Vaidya was suspended on full pay by his employer in Lincolnshire. He was informed by the Trust that during the period of his suspension he should not undertake paid employment.

Despite this prohibition, Dr Vaidya worked as a locum with other NHS Trusts when suspended. The GMC Fitness to Practice Panel ("the Panel") decided that this was an offence which was contrary to his contract of employment and his registration under the Medical Act 1983. The Panel also found him guilty of having altered an official document in order to mislead and of undertaking inappropriate and unprofessional conduct towards colleagues. The sentence that the Panel imposed was that Dr Vaidya's name should be erased from the medical register for a period of five years.

Dr Vaidya appealed. He argued that the Panel was wrong in believing that working whilst suspended could amount to serious professional misconduct and that a reprimand or, at most, a suspension from practice was a more appropriate remedy.

High Court decision

The appeal was heard in the High Court and dismissed; it confirmed that the sentence of five years erasure was appropriate for the aggregate of offences that the Panel had found Dr Vaidya guilty of.

The High Court commented that in working as a locum during his period of suspension, Dr Vaidya was in breach of his contractual obligations with his employer. He had not followed their clear instructions during suspension. The Panel was entitled to conclude that this was a dishonest act that deserved significant censure.

The severity of the sentence was particularly considered. The High Court stated that it was willing to correct material errors of fact and law in any Panel finding. However, it would not overturn a Panel decision on the ground that it was too severe. This was because the Panel had greater expertise and understanding than the Courts of maintaining the appropriate standards and reputation of the medical profession.

Comment

The sentence imposed on Dr Vaidya underlines the need for doctors to follow their employer's instructions. Failing to follow such instructions will be an issue of misconduct within the employment context but also a breach of professional obligations. NHS bodies employing doctors and dentists should apply the guidance of Maintaining High Professional Standards in the Modern NHS (MHPS) in connection with placing restrictions on such staff or even excluding them from work. This includes considering what other work, if any, an employee might do if excluded from work.

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LOSS OF BID TO CLARIFY THE LAW ON ASSISTED SUICIDE

In our January edition, we advised that permission had been granted to Debbie Purdy from Bradford to appeal the High Court's decision to reject her application for a ruling from the Director of Public Prosecutions (DPP). She had requested confirmation in advance of whether her husband, Omar Puente, would face criminal charges if he accompanied her to the Dignitas Clinic in Zurich for a medically assisted suicide.

Lord Justice Latham had previously accepted that there was an arguable case which should proceed to a full hearing.

On 19 February 2009, three Appeal Judges ruled that Ms Purdy was not legally entitled to the kind of specific guidance sought. Lord Pannick QC had submitted that the DPP, Keir Starmer QC, should be required to issue specific policy guidelines to clarify the law on assisted suicide.

Whilst the Appeal Judges echoed the sympathy expressed by Lord Justice Baker in response to the previous application to the High Court, they confirmed the Court was incapable of providing any case-specific policy or recognising an exceptional defence to statute.

The Judges also rejected Ms Purdy's claim that lack of proper guidance was in breach of her right to respect for private and family life under the European Convention on Human Rights.

Thus, assisting another to commit suicide remains an offence under Section 2 (1) of the Suicide Act 1961, punishable by imprisonment for up to 14 years, and the decision as to whether to prosecute in individual cases remains at the discretion of the DPP.

The recent publicity concerning the case of Dan James, 23, a former England under 16 rugby player who was left paralysed when a scrum collapsed, highlighted the DPP's discretion when a decision was taken not to prosecute his parents who had travelled to Switzerland with him to allow a medically assisted suicide to occur. Likewise, confirmation was provided within the Appeal that, even in the event of conviction, it was possible no penal sanction might be imposed by the Court. Whilst these indications might be applied to Ms Purdy's circumstances, it is clear that the authority for change remains with Parliament and cannot be instigated directly by court proceedings.

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House of Lords ruling that POVA list is incompatible with the European Convention on Human Rights coincides with newly introduced changes to the POVA scheme

Background

Under the Care Standards Act 2000 care workers employed in looking after vulnerable adults may be placed on a list of people considered unsuitable to provide such care. This is known as the Protection of Vulnerable Adults ("POVA") list.

Under the Act employers were obliged to refer care workers to the Secretary of State when they dismiss, transfer or suspend a care worker for misconduct that harmed or placed at risk of harm a vulnerable adult. Before the Secretary of State makes a full determination, the worker is provisionally included on the list.

Sharon Thomas now looks ast the implications of the recent case of R -v- Secretary of State ex-parte Wright and Others.

R –v- Secretary of State ex-parte Wright and Others

The recent House of Lords decision in this case puts in doubt the current POVA processes. The case concerned a number of care workers who were provisionally placed on the POVA list. Some were ultimately confirmed, but others were not. The care workers claimed that the POVA scheme was incompatible with their rights under Article 6 (Right to a Fair Trial) and Article 8 (Right to Respect for Private and Family Life) of the European Convention on Human Rights ("the Convention").

The issue at the heart of the matter was that there was no opportunity for a judicial hearing before being placed on the provisional list. The worker makes no representations before being provisionally listed and it can then take months for the decision as to whether or not to confirm the person on the list.

The decisions

At first instance it was held that the automatic effect of provisional listing upon a care worker's employment was a determination of the worker's civil rights and obligations within the meaning of Article 6 of the Convention. The right to respect for private life protected by Article 8 was also engaged. POVA listing was calculated to interfere, not only with employment, but also with personal relationships with colleagues, the vulnerable people with whom they worked, and with others. The provisional listing pending the termination was found to be incompatible with the rights of the Convention.

The decision was appealed to the Court of Appeal. It found that the provisional listing engaged Article 6, but reversing the initial decision in parts, upheld that a breach could be avoided by giving the care worker a right to make representations before being placed on the list. This could be effected by a declaration that the relevant section of the Act was to be read by reading in the words "and after giving the worker an opportunity to make representations...". The Courts did not consider it necessary to consider Article 8.

The Appellants in the House of Lords argued that the defects could not be cured by interpretation and application. Only a declaration of incompatibility would do. The House of Lords found that the POVA scheme, particularly provisional listing, was incompatible with Article 6 of the Convention and the solution offered by the Court of Appeal did not cure the problem. The process did not begin fairly as it did not offer the care worker an opportunity to answer the allegations made against them before imposing upon them potentially irreparable damage to their employment or prospects of employment. It also found the scheme to be inconsistent with Article 8. The House of Lords stated that it was not for them to attempt to re-write the legislation.

POVA scheme changes and provisional listing ends

Coincidentally, the House of Lords ruling was handed down the day after a number of changes to the POVA scheme came into effect. A new scheme laid down by the Safeguarding Vulnerable Groups Act 2006 ("SVGA") is due to be launched later this year. The SVGA created a new body now known as the Independent Safeguarding Authority ("ISA"). As part of the transition to the new scheme, on 20 January 2009 the ISA took over responsibility from the Secretary of State for making decisions on all new referrals to POVA. Significantly, ISA has decided that from 20 January 2009, new referrals will no longer be considered for provisional listing on the POVA list while the referral is being investigated.

Comment

Despite the House of Lords declaration of incompatibility with the Convention rights, the POVA scheme legislation remains in effect. The decision, whilst being a victory for civil rights, did not change things. However, it is fortunate that the ISA had already given due consideration to the problem and made its own decision that new referrals will not be considered for provisional listing. ISA's decision fits in neatly and consistently with the House of Lords ruling which was handed down the day after the POVA scheme changes. The decision in Wright perhaps has most relevance in terms of wrongly accused care workers seeking compensation for the periods they could not work whilst on the provisional POVA list.

Employers should be aware that they are still obliged to refer care workers in accordance with the 2000 Act but new referrals should now be made to the ISA. Employers also have new duties to respond to the ISA's requests for further information. Their duty to check against the POVA list before employing a care worker remains the same.

One problem for employers is that without the provisional listing system, harmful carers, in the period before the determination of their place on the list, may be able to gain new employment in care facilities, as their risk has not yet been published.

NHS employers should note that the POVA legislation only applies to "care workers" in care homes and domiciliary services. The section of the 2000 Act extending the definition to workers providing care within NHS bodies and independent hospitals has never been brought into force. Some press comment as to the dramatic effect of this case on the NHS is accordingly misplaced.

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RELIGION AND BELIEF IN THE NHS EXAMINED

The NHS recently issued new Best Practice Guidance ("the Guidance") to assist NHS bodies in addressing their responsibilities to ensure equality on the grounds of religion and belief.

David Locke considers this Guidance in more detail.

Statistics demonstrate that more than 50% of the population in Great Britain consider themselves to belong to a particular religion and research has indicated differences in health and wellbeing divided along religious lines. Service providers cannot afford to overlook the relevance of religion and belief to the delivery of healthcare and, of course, the NHS must also be mindful of the needs of its workforce.

The key legislation in this area is the Employment Equality (Religion or Belief) Regulations 2003, the Equality Act 2006, the Racial and Religions Hatred Act 2006 and Article 9 of the Human Rights Act. Cumulatively these impose obligations on healthcare providers to ensure equality on the grounds of religion and belief in respect of the provision of services and as employers.

Employment

Providing a workplace in which people of all religions and beliefs feel valued is important in terms of managing the risk of litigation. The NHS must also ensure it is an inclusive employer so as to maximise its ability to attract people with the best skills. The equality legislation should be read in conjunction with the Improving Working Lives standards.

Equality issues need to be taken into account from the earliest stages as a fundamental part of the recruitment phase. For example:

- Consideration should be given to ensuring that the widest range of job applicants is achieved; this might involve placing advertisements in local papers or using community radio. Interviews and assessment days should not take place on religious holidays.
- Job descriptions should be sufficiently clear to ensure that potential applicants can make an informed decision as to whether the job may conflict with their religious convictions, for example, dealing with blood transfusions.

In the workplace the key word is "flexibility". For example, issues may arise in relation to the requirements of daily prayers, periods of mourning and religious holidays. The Guidance suggests that flexibility in terms of normal break periods and the use of annual leave will often provide solutions. However, such adjustments will not always be possible and, in those cases, it will be important to show that every reasonable effort was made to find suitable solutions.

Accordingly, there will not infrequently be a tension for managers between the need to try and accommodate the reasonable religious requirements of employees, the delivery of services and, indeed, the need to avoid placing excessive duties on other staff members. It will be important to provide appropriate training and support to ensure the correct considerations are given and decisions reached.

Other workplace issues to be considered include, for example:

- Cultural dress codes, which should be considered sympathetically, although the health and safety of patients is paramount;
- Training and staff events, which may exclude some people if they involve, for example, physical contact that might be considered inappropriate by a particular religion.

Provision of services

In a patient centred NHS, the importance of an individual's religion and beliefs must be pervasive throughout every layer of policy and decision making.

The following are some examples of areas of service delivery where issues relating to the religious beliefs of patients are likely to arise:

- It is well recognised that religious beliefs can impact upon a patient's dietary needs. Not only is appropriate training required for staff in this area, but it may well also be necessary to ensure that appropriate contractual arrangements are in place with catering suppliers to ensure requirements can be met and that food is appropriately labelled to avoid an inadvertent breach of a patient's request for, for example, kosher food.
- The provision of treatment by a doctor of the same sex is not always possible. However, patients should be provided with adequate notice and the situation should be made clear when appointments are made.
- Some religions require particular ceremonies at birth and midwives should seek guidance on this at the first appointment so appropriate arrangements can be made.
- The provision of palliative care can be controversial where religious beliefs indicate an importance in retaining consciousness to allow the participation in particular ceremonies.
- Whilst members of staff may not wish to be involved in the process of termination of a pregnancy, individual personal beliefs should not influence the advice given to a patient in any way.

It is, of course, very important that assumptions are not made on the views of any particular patient simply as a consequence of what might be perceived as a general understanding of their religion. Within individual religions and belief systems views on particular issues vary considerably. For example, it is not true that all Jehovah's Witnesses consider it mandatory to refuse blood products. These issues need to be approached sympathetically on a case-by-case basis.

Policy considerations

Existing legislation does not require NHS bodies to produce separate equality schemes on religions and beliefs. However, the Guidance suggests that it is best practice for organisations to integrate appropriate actions into their single equality schemes.

Similarly, there is no legislative requirement to undertake impact assessments on existing policies and practice. However, failure to do so may mean that issues are overlooked.

The Guidance is available on the Department of Health website.

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DoLS – What is it and are you ready?

The Deprivation of Liberty Safeguards ("DoLS") came into force on 1 April 2009. These new legal safeguards are part of the Mental Capacity Act 2005 and aim to protect the human rights of vulnerable people in care homes and hospitals in England and Wales.

From 1 April 2009, it will be unlawful for a hospital or care home to provide care to someone who meets the eligibility criteria for DoLS, and whose care regime amounts to a "deprivation of liberty" without first obtaining specific authorisation. Failure to comply with DoLS could result in legal claims against the hospital or care home, which may be costly!

Consequently, it is important that hospitals and care homes are aware of their new responsibilities under DoLS, and their staff are ready to comply with the legislation, through appropriate policies and training. It is vital that staff understand the distinction between restriction and deprivation of liberty, so that only those patients potentially eligible for the DoLS scheme are referred for authorisation.

Under DoLS, the hospital or care home, (known under the legislation as the "managing authority") must apply for "authorisation" from the "supervisory body" (which will be the responsible Local Authority or commissioning PCT in most cases), where the eligibility criteria are met.

The supervisory body must then carry out six assessments, within 21 calendar days, to decide whether to issue an authorisation, or not.

Authorisation must, as a rule, be sought in advance of admission to hospital. The DoLS Code of Practice (paragraph 3.4) clarifies that where it appears likely that at some time in the next 28 days a person will or may be deprived of their liberty, an application for authorisation should be made, where the eligibility criteria are met.

Where urgent deprivation of liberty is necessary, the hospital can issue its own short-term authorisation (which will last for a period of 7 calendar days) but must make an immediate application for a standard authorisation to the appropriate supervisory body. The supervisory body will aim to complete the standard authorisation assessment process within the 7 day period. In exceptional circumstances, the supervisory body can extend the urgent authorisation up to a maximum of a further 7 days.

Please note that DoLS will also apply to patients who are already in hospitals/care homes, as of 01.04.09. Hospitals and care homes must therefore consider whether DoLS applies to their existing residents and make appropriate referrals, where necessary.

Who is eligible?

A person who:

- Is 18 or over and present in England or Wales
- Is suffering from a mental disorder (as defined by the Mental Health Act 1983)
- Lacks capacity to consent to the admission to a hospital/ care home but for whom that regime of care is deemed to be in their "best interests" and there is no less restrictive alternative
- Is to be cared for in circumstances which amount, or may amount, to a deprivation of liberty
- Is not detained under MHA/required to live in a specific place under MHA and it is not appropriate that they be detained under the MHA to receive the proposed treatment; and
- An Attorney, appointed under a Lasting Power of Attorney, has not refused consent for the treatment and the person has not made a valid and applicable advance decision refusing the proposed treatment

NB Transitional arrangements apply for the first month - the timescale for standard authorisation assessments is extended from 21 to 42 days and for urgent authorisations the period of 7 calendar days is extended to 21 calendar days.

Hill Dickinson is currently offering training packages for NHS/ care home staff in relation to the new DoLS system, details of which can be obtained from Sharon Thomas or Louise Wright.

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The Importance of Initial Risk Assessments

The new inmate reception process is a vitally important one, when key risk factors for individual inmates, from a medical, social and security perspective should be identified.

Louise Wilson reviews a recent decision highlighting a litigation claim brought by a prisoner following a head injury.

Focusing on health matters specifically, there have been huge improvements in prison healthcare since the Primary Care Trusts took over responsibility for healthcare provision within prisons. However, it is important that improvements continue to be made in order to avoid litigation in relation to negligence which, at worst, may result in the death of an inmate and a lengthy, high profile Coroner's Inquest.

Last year the case of Ryan St. George (a patient suing by his father and litigation friend St. George) -v- Home Office [2008] EWCA Civ 1068 highlighted the need for vigilance upon initial reception into custody, and reiterated that known conditions of inmates must be properly assessed and appropriate measures taken to reduce the risk of harm to inmates.

Background

- R entered prison aged 29. He had been abusing alcohol and drugs since the age of 16.
- He informed prison staff that he was a heroin user who drank heavily, and that he had previously suffered from withdrawal seizures.
- He declined to see a doctor, but did have an initial health screen interview which confirmed that he had epileptic seizures that were under investigation, and that he was an intravenous heroin user.
- R was allocated a bed on ward 3 in the hospital wing of the prison which at that time (1997), was being used as an ordinary unit for Category D (open) prisoners.
- R was allocated a top bunk bed.
- 5 days after reception into custody, R suffered a withdrawal seizure and fell from the top bunk, sustaining a head wound.
- The seizure then developed into "status epilepticus" (recurrent seizures without recovery of consciousness).
- R sustained severe brain damage leaving him severely and permanently disabled.

Causation

At the trial at first instance the Judge accepted R's case on causation, namely that the head injury caused the seizure to develop into status epilepticus, and that but for the head injury, the seizure would have been self-limiting and could not have caused the brain damage that resulted.

There was also acceptance by the judge that the prison staff were at fault by not maintaining R's airway between the time of the fall and the ambulance arriving (approximately 50 mins), and not administering oxygen to him during that time.

However, the judge found that R would have his damages reduced by 15% because his injuries were caused partly by his addictions, which were the result of lifestyle decisions and, therefore, his fault within the meaning of s.1(1) Law Reform (Contributory Negligence) Act 1945. Accordingly, the rare decision was given reducing damages for contributory negligence in a clinical negligence case.

Appeal

R and the Home Office appealed the judgment. The Home Office appealed on the grounds that the Judge erred in his findings of causation, only accepting the breach of duty in allocating a top bunk from the original judgment. R appealed on the basis that there was no evidential basis for the Judge's finding of fault on his part in becoming addicted to drugs and alcohol. R also submitted that, even if he was at fault in that respect, the damage suffered by him was in no way connected, and that it was not appropriate to reduce his damages at all having regard to his share in the responsibility for his injuries.

The Court of Appeal held that the Judge had been entitled to hold that R was at fault in becoming addicted to drugs and alcohol when in his teenage years, and to infer that R must have known at the time that substance abuse was dangerous to his health.

However it was also held that:

- R's addictions to drink and drugs were not a potent cause of the status epilepticus;
- The consequent brain damage was triggered by the fall, from the top bunk which R was allocated (which the Home Office accepted as a breach of duty);
- Addictions were too remote in time, place and circumstance;
- Addictions were not sufficiently connected with the negligence of staff within the prison to be properly regarded as a cause of the injury.

It was also noted in the Court of Appeal that if R's injury had been in part the result of his addictions, it would not have been just and equitable to reduce his damages with regard to his share of responsibility for the injury.

The staff were at fault in that they knew of R's condition and were aware that he was liable to suffer from seizures, yet still placed him in a top bunk. The Court of Appeal stated that R's position was analogous to that of a patient admitted to a rehabilitation clinic for the express purpose of being weaned off his addiction to drugs. If the same thing happened there, damages would not be reduced for contributory negligence.

Conclusion

The importance of recognising risk factors for inmates from the outset is crucial to ensuring that similar cases do not arise in the future. Ensuring good communication between healthcare staff and prison officers will help to reduce risks, and inmate medical records must be appropriately made with risk factors highlighted when they are identified.

R should never have been placed in a top bunk, and this breach of the prison's duty of care led to tragic consequences in this case. However it was decided by the Court of Appeal that it was not appropriate to reduce the damages, on the basis of a finding of contributory negligence.

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A brief guide to the health and safety responsibilities of NHS Trusts to contractors

As part of a continuing series of articles Paul Robinson, Hill Dickinson's Health & Safety consultant, looks at everyday situations that involve health and safety considerations. In this issue, he considers what needs to be done when engaging independent contractors.

Health and safety law

In any Trust/contractor relationship, both parties will have legal duties under health and safety law.

The Health and Safety at Work Act 1974 (HSWA), places legal obligations on employers and the self-employed. Specifically, this relates to Sections 2 and 3 of HSWA.

- Section 2 places general duties on employers to ensure, so far as is reasonably practicable, the health, safety and welfare at work of all his employees.
- Section 3 places general duties on employers and the self-employed to persons other than their employees.

In addition to this, provisions contained within the Management of Health and Safety at Work Regulations 1999 require an organisation to implement a health and safety management system.

What is the nature of the contracted works?

It is the Trust's responsibility to ensure that all aspects relating to contracted works, that affect health and safety, are clearly identified and communicated to all parties involved. This should include:
- the nature and severity of hazards;
- the level of risk exposure;
- the level of information, instruction, training and supervision required;
- how the contracted works will be co-ordinated between the parties;
- provision of information to the workforce;
- ensuring contractors understand the level of health and safety performance you expect from them;
- ensuring contractors comply with site health and safety rules and procedures;
- informing contractors of all emergency procedures.

Managing contractors

What should I do if I do not have the health and safety knowledge, skills or experience to manage the works being undertaken by contractors? In this instance it is important that you are able to demonstrate to the HSE or Local Enforcing Authority that you have taken all ‘reasonably practicable’ steps to manage the risks.

For this reason, you may choose to employ the services of a suitably qualified and experienced Health and Safety Consultant. This has the added benefit of providing fast advice and bespoke solutions which meet the needs of your organisation.

In addition, the HSE, IOSH and trade bodies have a wide range of guidance documentation available to assist you in the decision making process.

Ultimately it is your responsibility to ensure that contractors are adequately supervised on site. The level of risk presented by the works may well determine the level of supervision necessary.

Reaching agreement

The Trust and contractor(s) should ensure that they reach agreement on the following:

- The type of materials, equipment and machinery to be used
- Personal Protective Equipment (PPE) required
- Establishing who will have overall responsibility for the supervision of contractors on site

Risk assessment

Risk assessments must be undertaken by both the Trust and contractor(s) prior to any contracted works beginning.

Importantly, risk assessments should only focus on the significant hazards associated with the works being assessed.

Upon the completion of assessments it is then necessary for both parties to discuss the findings and agree upon the preventative control measures to be implemented. Control measures must serve to eliminate the risks or where this is not possible reduce the risks to their lowest form.

Selecting a suitable contractor

It is the Trust's responsibility to ensure that suitably qualified and competent contractors are selected to undertake any works. This requires an examination of the contractor’s skills, knowledge and experience. In addition you should:
- request documentary evidence of health and safety performance from potential contractors i.e. accident rates, details of any health and safety prosecutions and convictions;
- request information concerning their sub-contractor selection procedure;
- obtain references from previous clients;
- inform contractors of your health and safety arrangements (i.e. policies and procedures);
- establish whether contractors are members of trade or professional bodies;
- Procedures and method statements
- Safe number of workers required on site
- Person(s) responsible for the reporting of reportable (RIDDOR) and non-reportable accidents/incidents. In addition, records relating to all accidents and reportable incidents must be safely stored and remain accessible at all times.

Co-ordinate arrangements

Regular meetings and briefings should take place between the Trust, contractor(s) and sub-contractor(s). This will facilitate the sharing of information whilst also allowing any concerns to be raised quickly.

Monitoring performance

Monitoring health and safety performance is a fundamental principle of effective health and safety management.

Essentially, it assists in ensuring the continued effectiveness of control measures. For this reason, site inspections and health and safety audits should be undertaken during the course of the works.

Once complete, it is then necessary to communicate the findings of inspections and audits to all contractors.

It is important to note, that it is the responsibility of contractors to monitor the health and safety performance of sub-contractors on site. [www.hse.gov.uk]

For more information and advice on health and safety issues, please contact Paul Robinson.

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Preparation for trial – A guide for clinicians

Facing a claim for clinical negligence can be a daunting prospect for all clinicians. Most of those who are unfortunate enough to find themselves in this position are unaware of what is expected of them as a witness. Some may have provided comments during a complaint process or following a Serious Untoward Incident, but very few will have given a formal statement for use in civil proceedings or given evidence at Court.

Joanne Hughes, Associate at Hill Dickinson LLP, provides some practical guidance to clinicians who may find themselves involved in a claim for clinical negligence.

Am I personally responsible?

Members of the NHS Litigation Authority (NHSLA) and their employees are indemnified by the NHSLA in respect of claims for clinical negligence which occurred on or after 1 April 1995 and which arise out of events in the context of NHS trust employment. under the clinical negligence scheme for Trusts (CNST). Coverage is also provided for claims occuring before this date by the NHSLA.

For claims arising out of treatment provided in the private sector, clinicians will be indemnified by their own medical defence organisation.

In the former case, the Defendant in the proceedings is the NHS trust. In the latter, the clinician is personally named as the Defendant in the proceedings.

What is my role?

Regardless of whether it is your employer or you personally that is named as the Defendant in the proceedings your role will be to provide factual evidence and not opinion evidence. Whilst your opinion is helpful to your legal advisors in deciding what stance should be taken, when your witness evidence is given to the Court, it must contain only matters of fact.

If you are a lead clinician, you may be asked by your litigation department to provide your opinion in respect of a claim in which court proceedings have not yet been issued but are perhaps contemplated. You may be required to comment upon the standard of care provided and whether any injury has been caused as a consequence of that care. In such circumstances, your report should be clearly marked as being prepared in response to actual or contemplated legal proceedings. Before providing your opinion, you should ensure that you have read the medical records and any comments provided by the treating clinicians and that you are familiar with all the facts of the case. Your opinion will assist your legal advisors in their investigation of the claim.

If you provide comments which do not have as their sole or dominant purpose actual or contemplated proceedings, they are likely to be discloseable to the Claimant. For example, comments provided during a complaint process. It is important therefore that in such cases you restrict your comments as far as is possible, to matters of fact only.

Any comments provided for any adverse incident reports should never be filed in the medical records. Please also remember that these will be disclosable to the Claimant when Court Proceedings are issued. If they are filed within the patient's medical records, they will automatically be disclosed if the Claimant requests a copy of his medical records.

Good record keeping

All clinical negligence lawyers have experience of claims which have been settled because the standard of record keeping has been such that it has been impossible to deny what the Claimant is alleging. Without a doubt, good record keeping can help you prepare for trial and, in some cases, can even prevent a case from proceeding to trial:

- Contemporaneous medical records are evidence in themselves and can be used to support what the Defendant is saying.
- Medical records are the basis of your witness evidence and will assist when preparing a witness statement confirming what happened.
- Where the records contradict what the Claimant is alleging, they are invaluable.
- The opposite however is also the case. Poor record keeping can make preparing for trial a difficult task.
- Memories fade. If it is not written down how can you remember, months or even years later, what actually happened?
- Even if you do remember, if there is no supporting entry in the records and the Claimant has a different version of events, who should the Court believe?
- No record does not mean no problem. It is not sufficient to say that there must have been no problem as otherwise you would have recorded it. If there are no problems, say so.
- Does poor record keeping equal poor decision making? Probably not but, for example, if you do not record why you chose one treatment option over another, how can you prove to the Court that you took all relevant matters into account when exercising your clinical judgement?
- Good record keeping is your professional duty.
- Points to note when making entries in the records:
  - Every entry should be timed and dated – including continuation sheets.
  - Print your name at the end of the entry. Many signatures are illegible and this makes tracing the author difficult.
  - Record advice given by another person/department – e.g. your consultant.
  - Record all risks advised of during the consent taking process.
  - Write clearly.
  - Avoid abbreviations where possible as these can be misinterpreted.

Preparing your witness statement

Your witness statement is your chance to have your say about what happened and why. Once disclosed, this will be the evidence that is adduced at Court on your behalf on the day of the Trial and it is vital that it is accurate. You will ordinarily only be able to provide additional evidence at Court in respect of relevant matters which have occurred or come to light since provision of the statement. The statement must therefore be comprehensive and deal with all points that are relevant to the case. Your witness statement will be considered by the parties' experts and any change to your statement may ultimately affect what their evidence is and, therefore, whether the claim is defended or not.

Some important points to note in respect of your witness statement:

- State your full name, role, professional qualifications and experience.
- Say whether your statement is based upon your review of the medical records, your knowledge of the case and/or your usual practice.
- State in chronological order what you did and the reason behind any decision made. Your evidence will be considered by people outside your area of expertise – explain even the obvious.
- If the records are silent and you cannot recall what happened

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you should say what your usual practice is and whether there is any reason why you would have departed from this.
- Explain any inconsistencies between your statement and the records.
- Translate difficult to read entries.
- Clarify abbreviations and medical terms.
- End your statement with a statement of truth in the following words "I believe that the facts stated in this witness statement are true".
- Sign and date the statement of truth.
- If you sign a statement of truth knowing the contents of the statement are not true, you can be held in contempt of court.

Preparing to give evidence at trial

If the case is to proceed to trial and you are asked to give evidence, you should ensure that you prepare in advance. Your legal advisor will not be able to tell what to say but can tell you the types of questions you are likely to be asked. Before the day of the trial, make sure of the following:
- Know the case. Ask to see a copy of the Particulars of Claim setting out the allegations of negligence, the Claimant's witness statement and the expert reports.
- Know the medical records. You are likely to be referred to these when you are giving your evidence. Make sure that you know not only your own entries, but also those made before yours.
- Know your own witness statement. This is your evidence and you should know it. You can ask to look at your statement whilst you are giving evidence, but it is more convincing if you are able to clarify matters without reference to it.
- Know your colleagues' witness evidence. Do you agree with what they say? If not, tell your legal advisors immediately.
- Ask to be shown around the Court so that you are familiar with where everyone sits/stands.
- Day of trial
  - Know which Court you are attending and what time you are expected to meet your legal team. Be punctual – your legal team may need to discuss matters with you before entering the Court room.
  - Make sure you have a contact number for your legal team and vice versa, in case of any unexpected problems.
  - Switch off your mobile phone/bleeper when in the Court room.
  - Unlike with a criminal case, you will be able to sit through all of the trial even before you have given your own evidence.
  - Listen to the evidence being given and inform your legal team of any matters you feel are crucial.
  - Show respect for the Judge and Court at all times.
  - Do not eat, drink or chew gum.
  - Wear a suit.

Order of play

1. Opening speech
The Claimant may be allowed to make an opening speech to the Court in which his/her barrister will provide a background to the case, the facts which are in issue between the parties and upon which the Court is required to adjudicate.

2. Factual evidence
The Claimant and his witnesses will give their factual evidence first, followed by the Defendant's factual evidence. This will take the following form:

i. Examination in chief – Unless any relevant matters have come to light since production of your witness statement, your statement will be adduced as evidence-in-chief and you will be asked simply to confirm your name and that the statement you prepared is correct. If the Court allows any questions to be asked by your legal team, you will not be asked any leading questions (questions which assume a fact which has not yet been proved).

ii. Cross-examination – The Claimant's legal team will question you on your evidence. The intention is to discredit you as a witness.

iii. Re-examination – You can be questioned again by your own legal team on matters arising out of your cross-examination which require clarification.

3. Expert evidence
The parties' experts will give their evidence starting first with the Claimant's expert, followed by the Defendant's experts. Where there are a number of different specialities, these will be dealt with in totality before moving on to the next speciality.

4. Closing submissions
The parties' barristers will provide closing submissions, highlighting the evidence which has been given and which supports their own case and undermines their opponent's case. Submissions may be given orally or, if requested by the Judge, in writing.

5. Judgment
Judgment will be given by the Judge in open court. In complex cases, judgment is often reserved so the Judge has time to consider all the evidence given and reach his/her decision. It is not unusual in such cases for judgment to be given weeks or even months after the actual hearing. The parties' legal advisors will attend at Court for the Judge to hand down his/her judgment.

Giving oral evidence

Giving oral evidence at Court can be a daunting task. Remember the opposing counsel will have as his aim to discredit you as a witness in order to make your evidence less convincing to the Court. He is likely to highlight any inconsistencies in the evidence you give, both oral and written. It is important that you stay calm and focused. Some tips to assist you are:
- Refer to the Judge as 'Your Honour'.
- Direct your answers to the Judge, not counsel asking you the questions.
- Speak very slowly – watch the Judge's pen – he will be making a note of everything you say.
- Answer only the question you are asked and nothing more, however tempting it may be.
- Do not waffle! Straight answers only.
- Keep answers short and to the point.
- Do not fill the gap.
- If you are asked a question that is capable of being answered with a Yes or No, do not expand.
- Do not be afraid to answer a question, even if you think it is going to harm the case – answer truthfully.
- Do not rush into your answer - make sure you have understood what is being asked of you.
- If you did not hear the question, or did not understand it, ask for it to be repeated.
- Do not answer multiple questions with just one yes or no. Make sure the Judge knows whether you are answering yes to all the questions or just the last.
- Do not challenge opposing counsel – do not answer a question with a question.
- Do not lose your temper – keep calm and focused.
- Do not feel that you have to give your opinion on something you do not know the answer to. For example, do not give a time estimate or a description if you have already said you cannot remember.
- Do not answer questions outside of your area of expertise or competence.

This guide is available as a factsheet if you wish to provide copies to witnesses in clinical negligence cases. Please contact Joanne Hughes for copies.

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CHANGES TO CIVIL PROCEDURE RULES

The 49th update to the Civil Procedure Rules has now been introduced and these changes came into force on 6 April 2009. They bring changes to a large number of areas. However, the focus of this article, in the main, is to concentrate on those areas which are relevant to NHS litigation claims.

The changes affect both the Rules and the Practice Directions. Consequential amendments have been made to a number of the Rules making them gender neutral. Therefore, where previously the word "he" was used, this has now been amended to "the Claimant" (Part 16(3) and Part 46) or "his landlord" to a "a landlord" (Part 22.6).

New Practice Direction on pre-action conduct

In addition to the changes to the Rules, a new Practice Direction (PD) has been introduced on the pre-action conduct of the parties. This PD only applies to cases where no other Pre-Action Protocols apply, but encourages parties to attempt to correspond prior to issue and serving proceedings and/or to settle a case by either ADR or some other method of negotiation in and effort to reduce the cost of litigation. The Court will take into account whether this has been complied with in any proceedings.

We already have pre-action protocons dealing with personal injury and clinical negligence claims, but this new Practice direction may mean that the Courts take more notice of parties who fail to try to resolve claims before proceedings are issued.

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Changes to the Rules

1) The first change affects the Court's general powers of management under Section 3.1(4) of the Rules. Previously it was advised that where the Court gives directions, it may take into account whether or not a party has complied with any Pre-Action Protocol. This has now been amended to say that the Court will take into account whether or not a party has complied with any relevant Pre-Action Protocol. Therefore the obligation on the parties to comply with the Pre-action Protocol will be greater than before. The Court will also take into account the new PD relating to Pre-Action conduct.

2) An amendment has been made to Part 14 of the Civil Procedure Rules which relates to admissions. The amendment is made to Rule 14.1(A)(2)(a) consequential on the new PD on Pre-Action conduct which extends the types of proceedings where Pre-Action admissions will be considered binding by the Court, so long as it is made after the party making it has received a Letter of Claim in accordance with the relevant Pre-Action Protocol or it is made before such a Letter of Claim has been received but is stated to be made under Part 14.

3) Part 26 which deals with Case Management has been amended to state that for claims issued on or after 6 April 2009, the financial limit of the fast track procedure is increased from £15,000 to £25,000.

4) Part 44 - General Rules About Costs and the Practice Direction supplementing Part 43 to 48 has been amended. New rules are included to allow applications for and variation of cost capping orders on future costs and the Practice Direction supplementing 43 to 48 is also amended to reflect this.

i) Rule 44.18 defines a costs capping order as "an order limiting the amount of future costs (including disbursements) which a party may recover pursuant to an order for costs subsequently made." Future costs means costs incurred in respect of work done after the date of the costs capping order, but excluding any amount of additional liability. (sucess fee)

ii) A costs capping order may be in respect of either the whole litigation or any issues which are ordered to be tried separately.

iii) The Court may at any stage of proceedings make a costs capping order against all or any of the parties if it is in the interest of justice to do so, if there is a substantial risk that, without such an order, costs will be disproportionality incurred, and if it is not satisfied that this can be adequately controlled either by any case management directions or detailed assessment of costs.

iv) In considering whether to exercise its discretion under this rule, the Court will consider all the circumstances of the case including:

   (a) Whether there is a substantial imbalance between the financial position of the parties.
   (b) Whether the costs of determining the amount of the cap are likely to be proportionate to the overall cost of litigation.
   (c) The stage which the proceedings have reached.
   (d) The costs which have been incurred to date and future costs.

v) A costs capping order, once made will limit the costs recoverable by the parties that are subject to an order, unless one of the parties successfully applies to vary the order. No variation will be made unless there has been a material or substantial change of circumstances since the date when the order was made or there is some compelling reason why the order should be made.

vi) Rule 44.19 states that an application for a costs capping order must be made on notice and must set out whether the costs capping order is in respect of the whole litigation or a particular issue which needs to be tried separately and must make clear why a costs capping order should be made. The party must also serve an estimate of costs setting out the costs and disbursements incurred by the applicant to date as well as the costs of the future conduct of proceedings.

vii) The Court has the discretion to direct any party to the proceedings to file a schedule of costs in the form set out in the Practice Direction or to file written submissions.

viii) Rule 44.20 states that any application to vary a costs capping order must be made by Application Notice, pursuant to Part 23 of the Civil Procedure Rules.

This is a new part of the CPR and, by its inclusion, suggests a Court may be more willing to make a costs capping order. This could be a useful tool for Defendant solicitors to limit the amount of costs incurred by the Claimant's solicitors in any given case.

5) Part 46, which deals with fast track costs, has also been amended and the table setting out the amount of fast track costs which may be awarded by the Court has changed. An additional figure of £1,650 is inserted for those fast track cases where the value of the claim is more than £15,000. The original figure is modified to cover claims in the £10,000 to £15,000 band. This will only apply for proceedings issued on or after 6 April 2009.

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A surprise victory in the Court of Appeal for the Claimants in Yearworth and others -v- North Bristol NHS Trust: a right to damages for damaged semen

Background

Historically, British common law has adopted the principle that no one can "own" their own body. This has meant that a person cannot be sold or owned by another and that there is no right to commit suicide. Furthermore, there can be no property in a corpse, which avoids public health concerns relating to cross-claims of ownership by relatives delaying disposal.

The Claimants in this case were six men (one of whom was acting through his administratrix), who had all been diagnosed with cancer. They were advised to undergo chemotherapy and, due to the significant risk that their fertility would be damaged, were also advised to produce semen samples for storage in the hospital's fertility unit. There was no charge for this service at that time. They agreed that they did indeed wish to have such samples stored.

Unfortunately, the cooling system failed and the samples perished.

Decision at First Instance

The Claimants argued that they had suffered variously mental trauma and psychiatric injury as a consequence of these events. The claims were brought in negligence and were defended by the Trust on the basis that the loss of the semen could not be considered a "personal injury" and that it did not amount to damage to "property". The Defendant's position was upheld at Trial.

Decision by the Court of Appeal

Last month the Court of Appeal agreed with the Judge at First Instance insofar as it was concluded that the loss of the semen could not constitute a personal injury. However, the Court of Appeal departed from the original decision and with the established principles, by determining that the men did have a proprietary interest in their semen samples. In particular, it was considered decisive that whilst they could direct its use only in compliance with the relevant legislation (for example, the semen could only be stored for 10 years), they retained an absolute negative control over the samples. The semen could not be stored nor used without their consent. Therefore, it was determined that the men had a right to sue for negligent damage to their property.

The Court of Appeal also asked to hear argument on bailment as it applied to the circumstances of the case. The law of bailment arises from the concept that a person is not obliged to take possession of something over which another person has rights. Therefore, if they choose to take possession of that thing they assume duties in relation to it and its owner.

Having heard such argument, it was concluded that the men could successfully recover damages (akin to those recoverable under breach of contract), under the law of bailment. The particular significance of this was that the men were not, therefore, obliged to demonstrate that they had suffered a recognised psychiatric injury before they could recover damages. All they needed to show was that they had suffered "distress".

It is not known whether the decision will be appealed.

Wider implications

In the context of fertility units, it appears many now charge for storage services, in which case a claim for breach of contract will arise irrespective of this decision. However, even where no fee is charged, a right of action for negligent damage to property and in bailment may arise from the unauthorised destruction of semen samples.

There was every suggestion by the Court of Appeal that the decision regarding the proprietary interest in these samples should be interpreted as having wider applicability. It was suggested that, for example, there should be a right of action against a surgeon who negligently destroyed a body part that had been traumatically amputated, before it could be re-attached.

However, this proposition is troublesome and seems to raise more questions than it answers. The patient with the severed arm could perhaps be said to exercise a negative control by the ability to refuse to have it re-attached, but arguably the control exercised is really over the patient's own body in the refusal of surgery, rather than over the arm. Also, is it intended by the Court of Appeal that ownership would survive the point at which the arm could no longer be attached and, if so, is that not tantamount to allowing ownership of a corpse?

If we start to accept ownership of body parts as a concept, then the natural extension may indeed lead us to the unseemly arguments that the common law has historically attempted to avoid. Moreover, if common law accepts the proprietary interest in body parts, then the legislative prohibition on the commercialisation of organ donation may need to be considered afresh.

The unusual way in which the Appeal was conducted would tend to indicate that there were strong policy considerations behind the decision. If the decision is overturned, it is likely that decision too would be based on policy.

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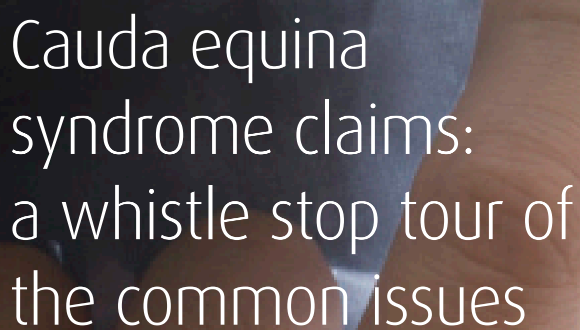

Cauda equina syndrome claims: a whistle stop tour of the common issues

The new American President's route to Washington for his inauguration may have brought the whistle-stop tour back into vogue.

A tour of common issues in cauda equina syndrome litigation does not have quite the same appeal as Barack Obama's journey; indeed cauda equina syndrome ('CES') itself is completely lacking in attractive features. However, anyone dealing regularly with clinical negligence claims of orthopaedic or neurosurgical subject-matter is likely to encounter it from time to time. It has given rise to several High Court trials during the last few years, including Chester -v- Afshar in which the House of Lords extraordinarily decided that the conventional rules on causation need not be applied in cases of failure to give necessary warnings prior to medical treatment. President Richard Hackett says "yes we can..." explain about CES cases.

We begin this tour at www.nhs.uk where CES (which is Latin for a horse's tail) is described as follows:

What is CES?

Cauda equina syndrome is a serious condition where the nerves at the very bottom of the spinal cord become compressed. The symptoms of the syndrome may include lower back pain, numbness in the groin, paralysis of one or both legs, rectal pain, bowel disturbance, being unable to pass urine, and pain in the inside of the thighs.

If you develop any of these symptoms, you should contact your GP immediately. If cauda equina syndrome is not promptly treated, the nerves to your bladder and bowel can become permanently damaged.

However, a closer study of CES reveals that it has two stages. It starts as:

Incomplete cauda equina syndrome ('CESI')

The patient with CESI may have some or most of the symptoms listed above but still have executive control of the bladder. If there is to be surgical intervention, it should preferably (according to many experts) be performed at the CESI stage.

CESI then progresses to:

Cauda equina syndrome with retention ('CESR')

This is where cauda equina compression has resulted in urinary retention. It is widely believed (putting aside the question of whether or not decompressive surgery may be effective at an earlier stage) that it is too late to operate within a short time following the onset of CESR and the patient is then unlikely to gain any benefit from surgical treatment.

Causes of CES

CES is a rare consequence of lumbar disc prolapse. In some cases, it develops as a consequence of trauma or a spinal disorder, such as a tumour. In other cases, it develops as an unfortunate complication of medical treatment designed to alleviate a back problem – as happened to Ms Chester in Chester -v- Afshar.

CES has spawned some extremely complex claims in which it is alleged that healthcare providers delayed unduly in diagnosing or treating patients with CES symptoms. As it tends to develop rapidly and yet requires early surgical intervention, there is very often a causation defence, i.e. that it was already

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too late by the time of the alleged breach of duty for the patient to undergo surgery likely to result in any benefit. The probable course of events but for the alleged breach of duty will need to be fully addressed. The timings need to be realistic and must allow for factors such as the amount of time it would have taken to confirm the diagnosis by an MRI scan and then to get the patient onto the operating table of a specialist surgeon.

Expert opinions for or against the causation defence will often refer to the scientific literature published concerning the effectiveness or otherwise of surgical treatment for CES. The literature includes the following:

Article by Gleave and Macfarlane

This was a review paper published in the British Journal of Neurosurgery in 2002 entitled: 'Cauda equina syndrome: what is the relationship between timing of surgery and outcome?'

The authors reviewed the available literature and considered it essential to distinguish between CESI and CESR in any assessment of the prospects of achieving a good outcome by surgical decompression. This school of thought believes that CESR occurs when the patient loses bladder control and develops painless urinary retention (cauda equina compression having caused complete failure of the autonomic innervation to the bladder) – although CESR may not manifest itself until the bladder is full and there is overflow incontinence.

According to Gleave and Macfarlane, examination of the literature does not support surgical treatment if the condition has already progressed to CESR at the time of presentation. They concluded that, in such cases, the critical period has already passed, it is too late to recover the situation by emergency decompression, and subsequent surgical delays do not affect the final outcome.

However, other papers have come to differing conclusions to those of Gleave and Macfarlane. The medical literature also includes the following:

Nottingham article

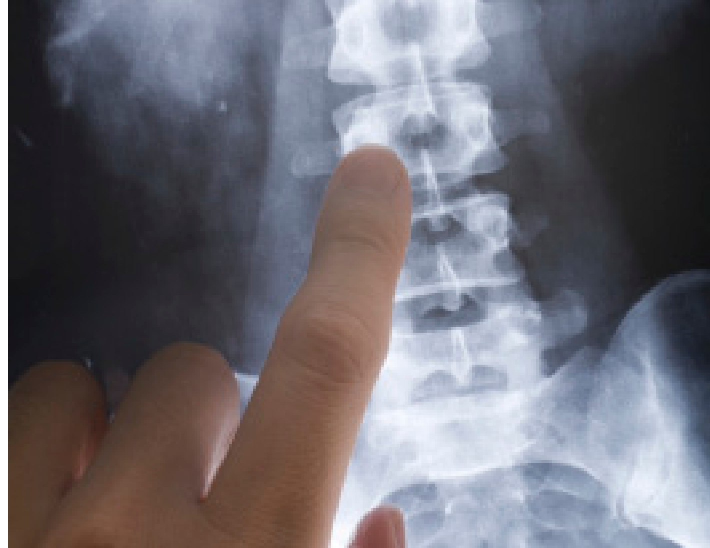
In 2007, McCarthy, Grevitt and other members of the Department of Spinal Studies and Surgery at Queens Medical Centre in Nottingham published an article in SPINE entitled: 'Cauda equina syndrome: factors affecting long-term functional and sphincteric outcome'.

According to this article, in any case of CES (whether CESI or CESR), the duration before operation and the speed of onset do not appear to influence the outcome 2 years after surgery.

Our whistle-stop tour terminates in the High Court with a view of its latest decision in a CES case, namely:

Oakes -v- Neininger and Others

In this 2008 judgment, the causation defence of several healthcare providers was unsuccessful on the basis of the Court's specific findings of fact. In particular, Mr Justice Akenhead found that the patient's condition was CESI at the time of presentation in this case and that, but for breach of duty (of which there was more than one), there would have been time to transport him to the nearest A & E unit, make the provisional diagnosis of CES, arrange and



complete his transfer to a specialist spinal surgery centre, confirm the diagnosis by MRI scanning, and then carry out emergency decompressive surgery. The Judge decided that all of those steps would have taken place within the window of opportunity before the development of CESR – despite the duration of the window of opportunity being just 6½ hours from the final breach of duty.

The expert evidence in Oakes made reference to the article by Gleave and Macfarlane and, in several passages of Mr Justice Akenhead's judgment, he also referred approvingly to it and expressed the understanding that their conclusions supported his finding that surgical intervention at the CESI stage would have given the patient a good chance of avoiding most of the irreversible consequences.

Although the Claimant in Oakes may have been assisted by the article by Gleave and Macfarlane, this rested on the Court deciding there would have been sufficient time to achieve surgical decompression before the onset of CESR. Had the Judge found otherwise in relation to the timing of CESR, his approval of Gleave and Macfarlane would have worked in favour of the Defendants. In rejecting further evidence given by the Claimant's experts, Mr Justice Akenhead said that he was unable to find that an earlier operation after the onset of CESR, i.e. earlier than the actual operation (which was carried out approximately 20 hours following CESR and which had a poor outcome), would probably have resulted in a discernible improvement.

However, it must be kept in mind that such findings of fact do not create a legal precedent and, whilst Oakes makes extremely interesting reading for those conducting CES litigation and provides a useful illustration of the way the judiciary addresses the issues, it certainly does not mean that the Courts in future are bound to accept the school of thought to which Gleave and Macfarlane belong. The current controversies regarding the timing of surgical decompression for CES and the likely outcome may well continue to generate argument for many years to come, both amongst spinal surgeons and in legal proceedings.

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What is the employer's responsibility if an employee identifies a risk of injury associated with a manual handling task?

DONNA EGAN -v- CENTRAL MANCHESTER & MANCHESTER CHILDREN'S UNIVERSITY HOSPITALS NHS TRUST (2008)

Whilst an employer's failure to perform a risk assessment will generally represent a breach of duty, if that breach did not cause an injury then no liability follows. However, the Court of Appeal has recently been faced with an additional argument relating to manual handling tasks. One was based on an employer's responsibility to take all appropriate steps to reduce the risk of any injury, arising from a manual handling operation, to the lowest level reasonably practicable pursuant to Regulation 4(1)(b)(ii) of the Manual Handling Operations Regulations 1992.

The nurse, Donna Egan, appealed against a decision dismissing her claim for damages for personal injury against Central Manchester & Manchester Children's University Hospitals NHS Trust. The circumstances of the incident were that Ms Egan, had decided to bathe a patient. The patient had difficulties with mobility and had to be transferred into a mechanical hoist and then wheeled, on the hoist, to a bathroom and positioned at the end of the bath, which stood on a plinth. Ms Egan had to manoeuvre the forks of the hoist under the bath avoiding contact with the plinth, which was not visible from a standing position. She was aware of the presence of the plinth having performed this task on numerous previous occasions. She subsequently pushed the hoist forward, but suffered a jerking injury to her back when the hoist suddenly stopped moving, after colliding with the plinth.

At first instance the Judge held that, although there was a breach of duty by the Trust in failing to carry out a risk assessment for his task, the breach was not causative of the injury. During proceedings Ms Egan had suggested a number of improvements that the Trust could have adopted, prior to the incident, which could have prevented the incident and subsequent injury from occurring. These included placing a warning in the bathroom to highlight the existence of the plinth, marking the floor to indicate how the hoist legs could be guided around the plinth, bringing the plinth forward to the front of the bath and clearly marking it, or even installing a fixed system for lowering a patient into the bath. The Judge found that it was debatable whether a risk assessment would have said anything about the risk of collision with the plinth, save to warn that there was a plinth and that it was necessary to take care to align the hoist centrally. However, Ms Egan would have been aware of that already having performed the task on occasions before without sustaining injury. She lost her case originally.

On appeal Ms Egan argued that the Judge, when making his decision, had failed to consider reg.4(1)(b)(ii)) of the Manual Handling Regulations. This requires an employer to take all appropriate steps to reduce the risk of injury arising from a handling operation to the lowest level reasonably practicable. She further argued that once it had been established that there was some risk of injury, the onus was on the employer to prove that it had taken all appropriate steps to reduce that risk and that the Judge was wrong to reject her various suggestions.

The Court of Appeal found in favour of Ms Egan and said that it was clear that the Judge at first instance had not considered separately the duty to risk assess and the duty to reduce the risk of injury to the lowest level reasonably practicable. He should have considered the two issues separately as the requirement to reduce risk is separate from and additional to the requirement to carry out a risk assessment. They further stated that a risk assessment would show the employer what steps it ought to take in order to reduce the risk of injury to the lowest level reasonably practicable. In this matter there was no risk assessment and so the judge should have focused on the Trust's duty to reduce the risk to the lowest level reasonably practicable. It was not sufficient for the Judge to examine whether a risk assessment would have made any difference. Once it had been shown that the manual handling operation carried some risk of injury, the burden of proof was on the employer to plead and prove that it had taken appropriate steps to reduce that risk to the lowest level reasonably practicable.

The Court held that if the claimant alleges that there were steps that could have been taken, the onus is on the claimant to advance those suggestions, even though the legal burden would remain on the employer. Finally, there was no duty on the Trust to provide a hoist dedicated to the bath in question. The Court found that there was nothing inherently wrong with the manual hoist and it could be used safely and, with some small alterations, the risk to an employee would be very small. The suggested adaptations by Ms Egan were appropriate, involved modest costs, were reasonably practicable and would have reduced the risk of injury by collision by a significant degree.

Accordingly the Trust was found in breach of duty and liable for Ms Egan's injury. However, the Court did find that Ms Egan had also been responsible for her injuries as she had not looked carefully to see exactly where the forks were going under the bath and accordingly discounted her damages by 50%.

Although this claim concerns manual handling tasks and the applicable Regulations, it is possible that the same approach will be adopted by the Courts on other tasks in the future. This emphasises the importance of performing risk assessments and subsequently following those assessments up by taking steps to reduce the risk of injury to the lowest level reasonably practicable. In this instant case, had the Trust adopted the suggestions made by the Claimant, despite having not performed a risk assessment, it would appear unlikely that the Claimant would have been successful. It is essential that the two issues are dealt with separately but considered together. By performing a thorough risk assessment it is hoped that most issues would be addressed subject to the standard of reasonable practicability.

The case also raises the question as to whether experienced employees can assist with the risk assessment process and perhaps could be consulted to consider whether they have any suggestions on how regular tasks can be made safer.

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LITIGATION UPDATE

In contrast to the lack of reported quantum cases, there have been a number of recently reported cases for the litigation update:

Marcan Shipping Ltd -v- Kefales [2007] Unless Orders

This case shows an increased willingness on the part of the Court to apply some "bite" to the Rules. The case held that if an Unless Order is breached then the effect is dismissal of the claim.

Trustees of Portsmouth Youth Activities -v- Poppleton [2008] Claimant responsible for own injury

Mr Poppleton was injured in a fall from a climbing wall whilst trying to emulate a leap from one wall to another. The Court of Appeal held that there was to be no recompense if a party chose to engage in physical activities with an unavoidable risk and that risk materialised.

Ul-Haq -v- Shah [2008] Genuine Claimant can still recover even if attempted fraud

This was a case involving attempted fraud where in a motor accident it was alleged that there was an additional passenger in the vehicle who was not actually there. The Court held that the genuine Claimant even though complicit in the attempted fraud could still recover his own losses.

Smith -v- Northamptonshire County Council [2008] Work equipment

A carer/driver went to collect a patient and was hurt when a wooden wheelchair ramp collapsed as the Claimant pushed the patient down it. The ramp had been installed by a third party NHS Trust and showed no sign of disrepair. The Claimant brought a claim against her employers under the Provision and Use of Work Equipment Regulations 1998. The Court held that it would be absurd to find that the ramp was the responsibility of the employer, liability rested upon these with control of the equipment. We understand that his decision is being appealed.

Allison -v- London Underground Ltd [2008]
Work equipment

This was a case on the interpretation of the Provision and Use of Work Equipment Regulations 1998, Regulation 9(1) which requires every employer to ensure that those who use work equipment shall have received adequate training as to the use of equipment and should be made aware of the risks and precautions to be taken. The Court held that to identify the risks generated an appropriate expert ergonomist should have been instructed.

Grant Couzens -v- T McGee & Co Ltd [2009]
Work equipment

The Court of Appeal held that a piece of scrap metal used by a lorry driver as a makeshift work tool in the course of his duties did not amount to "work equipment" under the Provision and Use of Work Equipment Regulations 1998, Regulation 3(2) because his employer had no knowledge of the scrap metal. The employer therefore did not expressly or impliedly give permission to use it. The Claimant was not entitled to damages from his employer under the Regulations. following an injury caused by using this.

Gravill -v- Carroll [2008] EWCA Civ 689 – Employer liable for acts of employee

The Claimant was injured in an "off the ball" incident in a rugby match. The Defendant rugby club was liable for the injury caused by its employee as it was closely connected to the job.

Ferdinand Ammah -v- Kuehne + Nagal Logistics Ltd [2009] Employee responsible for accident

The Court of Appeal held that where the risk associated with standing on a box to reach a high shelf had been identified by the employer and adequate instruction and warning given, an employee who stood on that box and suffered an accident took a risk for which he, and not his employer, was to blame.

Digicel Ltd -v- Cable & Wireless [2008]
Electronic disclosure

This was the first substantial decision on electronic disclosure of records. The Defendant had unilaterally performed a keyword search without having discussed with the Claimant what keywords it wanted searching. The Claimant complained about the limited nature of the search and wanted it done afresh with further words added. The Court criticised the Defendants for not having adhered to the Practice Direction that the parties should co-operate holding that the Defendant should have discussed the keyword search with the Claimant, ordering a new search to be carried out.

Cain -v- Francis Limitation

The Court held that in exercising discretion under the Limitation Act to disapply the time limits for commencing proceedings, the loss of a limitation defence to the Defendant

was not to be regarded as a head of prejudice. The question to be asked was whether it was fair and just in all the circumstances to expect the Defendant to meet the claim on the merits notwithstanding delay in commencement. A limitation defence would therefore require forensic or else procedural prejudice.

TCD -v- (1) Harrow London Borough Council, (2) Worcestershire County Council, (3) Birmingham City Council [2008] Limitation

This case should be contrasted with the Cain case above. The High Court held that although the Court's discretion under the Limitation Act was unfettered and had to be addressed in light of all the circumstances, the Court should never lose sight of the public interest in legal certainty and finality, especially not out of sympathy for an individual litigant with a strong case on liability and causation. In the case where a Claimant had delayed her action for damages for decades and there was no realistic prospect of success the discretion would not however be exercised.

Mitchell -v- James [2008] Part 36 Offers

The Court of Appeal held that a party could not make a drop hands offer or a costs inclusive offer by way of Part 36. However, that does not rule out such offers being made.

Matthews -v- Metal Improvements Company Inc [2007] Part 36 Offers

The Court held that a Part 36 offer put the Claimant on risk as to costs even though the Claimant was unable to value the claim at that time. The Claimant needed to receive a medical report to consider the offer but the offer still put the Claimant on risk as to costs.

Jason Goby (A Child by his Father and Litigation Friend, Andrew Goby) -v- Barrie Ferguson [2009] EWHC 92 – Doctor liable for failing to investigate

The High Court held that a doctor had breached her duty of care by failing to investigate the history of a child's illness which included constant headaches. If the history had been investigated and, in the absence of any viral symptoms, it would have led to the child being admitted to hospital and being diagnosed and treated for tuberculosis meningitis.

Savage -v- South Essex Partnership NHS Trust [2008] Duty to prevent suicide

The House of Lords held that the approach to a Public Authority's obligations under the European Convention on Human Rights Article 2 (right to life) apply to a Health Authority's obligations to prevent patients detained in hospital under the Mental Health Act from committing suicide. As well as requiring a Health Authority to employ competent staff and to adopt systems of work which would protect patients' lives, Article 2 imposed an "operational" obligation on Health Authorities and their staff to do all that could be reasonably expected to prevent the patient committing suicide if they knew (or ought to have known) that a particular patient presented a real and immediate risk of suicide.

R -v- (1) Secretary of State for Justice, (2) Isle of Wight Primary Care Trust [2008] Care of a prisoner

The Court held that the Prison Service had a public law duty to a prisoner to ensure that he was afforded proper medical treatment. It was appropriate that allegations of errors in the provision of the medical treatment afforded to the prisoner would be examined in an audit performed under Prison Service Order 3050.

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SHAPING THE COSTS LANDSCAPE

There is dismay amongst defendants at the costs regime in civil litigation, not least in the healthcare sector. Conditional Fee Agreements (CFAs) have led to an exponential rise in the costs claimed by successful claimants, with hourly fees (once the success fees are applied) frequently exceeding £500. The Court of Appeal has washed its hands of the CFA satellite litigation and there are concerns the ATE insurance market could collapse.

In this climate there are a number of key initiatives underway and the next 12 months are likely to be very important in shaping the costs landscape for years to come. As well as contesting issues as they arise on a case by case basis, Hill Dickinson is also lobbying for fundamental changes to the costs rules.

Cost Capping

The Civil Procedure Rules Committee has recently had a consultation on the issue of cost capping in civil litigation. Hill Dickinson participated in that process and put forward a robust response to the draft Rules, suggesting amendments to give the powers wider applicability.

On 6 April 2009 the 49th Update to the Civil Procedure Rules came into force, as set out on pages 12 -13 For the first time there will be a codified power for the Courts to impose a prospective costs cap in suitable cases. This is a power vehemently opposed by Claimant firms universally.

As drafted, the Rules are not wholly satisfactory and, indeed, in some ways it could be said that they represent a retrograde step from some encouraging decisions in recent years. In particular, they envisage that costs caps will be used only in "exceptional" circumstances and therefore, for the time being at least, they are likely to be reserved for the highest value cases and even within that category, probably only cases where costs are manifestly excessive.

However, it is to be hoped that as the case law builds up, incrementally, the use of cost capping can become a more fundamental tool.

Lord Jackson's Review

Lord Justice Jackson is presently undertaking a review of the complete civil litigation funding system. Again, Hill Dickinson has played a part, submitting a detailed paper setting out comments and proposed amendments to the current system, addressing issues including case management, CFAs and alternative dispute resolution. We have also recently attended a meeting with Lord Justice Jackson at which we expressed concern regarding the extraordinary costs claims by claimant firms working in the field of clinical negligence.

There is certainly potential for some radical proposals to come out of this review. One possibility being considered is the introduction of a contingency fee scheme, much as operates in the USA, where claimant's solicitors recover costs as a proportion of their client's damages.

Another alternative, and one which it appears Lord Justice Jackson may favour, is that of "one way cost shifting". That would mean that the claimant would recover costs if successful but, if unsuccessful would not have to pay the defendant's costs. This would remove the need for expensive ATE insurance to cover a potential liability for the defendant's costs. We understand that Lord Justice Jackson has commissioned a study to determine whether, given that defendants lose more cases than they win, this proposal would result in a net saving for defendants.

There are significant problems with both schemes, not least of all the likely inflation of damages awards and the fact that removing the risk of adverse costs orders seems likely to embolden claimants. No doubt these concerns will be taken into account and Lord Justice Jackson is due to report in the autumn.

Costs challenges

The Courts do not like technical challenges to the enforceability of CFAs. The sheer volume of cases in what was rather over-dramatically dubbed as "the costs wars", led to the repeal of the CFA regulations, which had been the basis for much litigation. Our impression is that the number of challenges has reduced significantly, although the designated Civil Judge in Liverpool, HHJ Stephen Stewart is still unhappy with the number of cases he is asked to consider!

We continue to raise technical issues regarding funding on a case-by-case basis, as well as challenges on the grounds of reasonableness and proportionality. There have been some notable successes. For example, a recent claim was taken to detailed assessment on a technical point arising from the fact that the claimant's solicitor had failed to serve a Notice of Discharge when LSC funding was withdrawn and a CFA was entered into. The Judge gave an indication that costs would not be recoverable under the CFA and the claim for costs was then settled with a 50% discount. There are a number of other cases proceeding to detailed assessment on the same issue at the present time.

We will continue to provide further updates as matters develop throughout the coming year.

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COSTS UPDATE

There have been no substantive reported settlements in the recent months so in place of that in this edition we have a number of cases relating to costs:

Carver -v- BAA [2008] Claimant beats offer by nominal amount

The Claimant beat his own offer but only by a nominal amount and so was not awarded costs. The Court held that the idea of "success" in beating an offer was an open textured concept such that time and emotion could be relevant.

Master Cigars Direct Ltd -v- Withers [2008]
Costs estimate is a yardstick

The Court held that a costs estimate provided by a party did not impose a "cap" on the costs but rather the costs estimate was a yardstick by which the Court could gauge the reasonableness of the costs being claimed.

Reynolds -v- Stone Rowe Brewer [2008]
Costs estimate can be a cap if relied on

This case is to be contrasted to the Master Cigars case above. The Court held that the parties' costs were limited to the costs estimate. In the particular circumstances of this case the costs estimate was much lower than the actual costs being claimed and the Court held that the party would not have litigated if an accurate costs figure had been given, i.e. the costs estimate had been relied on and so the costs could be "capped".

Crane -v- Cannons Leisure Centre [2008]
Solicitors can claim success fee on outsourced work

Solicitors were able to treat work which they had outsourced as being done internally and therefore claim a success fee on that work, so long as it was work of a kind that solicitors could properly have undertaken.

Orikhel -v- Vickers CA 4 July 2008
No costs order against witness

The Court held that a witness cannot be ordered to pay costs.

SES Contracting -v- UK Coal [2007]
Pre-action disclosure costs

On an Application for pre-action disclosure, the starting point for the Court in terms of costs is that the person making the Application has to pay the costs.

C -v- W [2008]
20% uplift where liability admitted

In an RTA case where liability had been admitted prior to a CFA being entered a 20% success fee was appropriate. The Court also mooted the possibilities of there being a "split" or two level success fee.

Tankard -v- John Frederick Ltd, December 2008 (Court of Appeal) – CFA arguments not to be raised without compelling reason

The Court of Appeal held that trivial breaches in those CFAs which had been entered prior to November 2005 could be ignored. District Judges should not be troubled with CFA arguments unless there was a compelling reason for those arguments to be raised.

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Disposal of Surplus Land – Update

The Government has long been promoting the delivery of increased housing quality in new developments. Minimum housing quality standards were published by English Partnerships (now the Homes and Communities Agency) in November 2007 and as part of the ongoing initiative, Ministers have now made four of these quality standards (covering design, quality and environmental performance) mandatory.

Directions were issued on 10 February 2008 regarding the role of NHS bodies in imposing these standards upon sales of surplus land to the private sector for housing development.

The following bodies are affected:

- National Health Service Trusts (this includes acute, mental health and ambulance trusts and NHS trusts designated as care trusts but not including Foundation Trusts)
- Primary Care Trusts
- Strategic Health Authorities
- Special Health Authorities

The directions state that NHS bodies disposing of surplus public sector land for housing development should ensure that the private sector bodies responsible for constructing homes comply with four quality standards:

Code for Sustainable Homes – Level 3

All new homes must meet a minimum of Level 3 of the Code for Sustainable Homes, issued by the Department of Communities and Local Government, and non housing developments must meet a minimum Building Research Establishment Environmental Assessment Method ("BREEAM") rating of "very good". For further information and guidance, the Code for Sustainable Homes and the related Technical Guide can be found at www.communities.gov.uk.

Lifetime Homes

All new homes must meet the Lifetime Homes standards, which go further than the Building Regulations Part M by improving the adaptability and flexibility of new homes for use by a wide range of individuals, from young children through to frail older people and those with temporary or permanent disabilities.

Building for Life (Silver or Gold)

All new homes must meet the Building for Life Silver or Gold standard which represent a national standard for the design quality of housing and neighbourhoods supported by industry. The silver standard is the minimum quality of development recommended by the Building for Life partners.

Integrated Tenures

This requires that developments provide an appropriate mix of tenures or forms of ownership to reflect different needs and requirements of the community and individuals. Development and designs should be such that the type of tenure cannot be deduced from such factors as the design location and access, for example.

Commentary

It will be the responsibility of the NHS body to firstly investigate the proposed use of surplus land, if selling to a private sector organisation. Secondly, if the proposed use is to involve housing, the organisation must be made aware of the set of minimum standards produced by English Partnerships. Lastly, the NHS body must contractually ensure that, upon sale, the private sector organisation is bound to comply with at least the four standards referred to above.

A full set of the minimum quality standards for housing development may be found on www.homesandcommunities.co.uk

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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, Singapore and Greece. Collectively the firms have over 150 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. 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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