

healthcare update

Cross-border healthcare
& patient mobility

A set of rights entitling individuals ordinarily resident in England to access health services in European Economic Area (EEA) states other than the UK has emerged slowly from a combination of the UK's EU Treaty obligations, European legislation and decisions of the Court of Justice of the European Union.

Requests for treatment abroad may be made in two ways; either on a prior approval basis or as applications by patients for reimbursement of treatment costs already paid. The Government has now sought to clarify this complex area by the enactment of the National Health Service (Reimbursement of the Cost of EEA Treatment) Regulations 2010 which insert sections 6A and 6B into the NHS Act 2006.

Reimbursement decisions

Prior authorisations are not necessary for claiming reimbursement for care which was necessary to treat or diagnose a medical condition and which is the same or equivalent to care that would be provided by the NHS in the same circumstances. Patients may therefore access these services in another EEA state without informing their local PCT in advance and claim reimbursement from the PCT at a later date. Commissioners should ensure that they have systems in place for determining and confirming entitlement to reimbursement for patients seeking treatment outside the UK.

Prior authorisations

Prior authorisation will be required for 'special services' and services which are neither the same nor equivalent to those that would usually

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Welcome

Welcome to the autumn edition of the healthcare update.

Since our last edition, we have opened a new office in Sheffield where our independent health team will be based, headed by Andrew Peel. They will be focusing on the provision of the full range of legal services to the independent health sector and medical defence organisations. The team also includes dedicated dental law experts.

Hill Dickinson LLP has also celebrated its 200th birthday with a range of events across all of our offices. If you were able to join us at one of those, we hope you enjoyed yourself!

The implications of the White Paper are being constantly considered by us all and are to be the subject matter of a Hill Dickinson seminar in the new year. This bulletin looks at other areas which have attracted attention over the last few months in the fields of healthcare, employment and litigation.

As always, your feedback is appreciated and we hope you enjoy reading this edition.

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be made available to a patient through the NHS. 'Special services' are services which involve an overnight hospital stay, medical or dental treatment involving general anaesthesia or intravenously administered sedation, or use of specialised or cost-intensive medical infrastructure or medical equipment.

Prior authorisations for special services must be granted to patients where the following conditions are met:

- the service is necessary to treat or diagnose a medical condition of the patient;
- the service is the same or equivalent to a service that would usually be made available to a patient through the NHS; and
- the NHS cannot provide the same or equivalent service to the patient without 'undue delay'.

'Undue delay' is assessed with reference to a period of time that is acceptable on the basis of an objective medical assessment of the patient's clinical needs and quality of life. Section 6B(6) sets out relevant considerations for assessing clinical need.

For services which are neither the same nor equivalent to a service available through the NHS, there is no obligation to grant authorisation, but it may be granted where the service is necessary to treat or diagnose a medical condition of the patient.

PCTs should be aware that it may also be necessary to consider retrospective applications for special services.

European case law has allowed retrospective applications where it was not reasonable to expect the patient to have applied for prior authorisation. It may not have been reasonable if there was undue delay on the part of the NHS in meeting the patient's needs or where their condition has deteriorated rapidly so that they require special services abroad without delay.

PCT obligations

The Secretary of State has also issued the NHS (Reimbursement of the cost of

EEA Treatment) (England) Directions 2010 which came into force on 1 June 2010. These set out a number of requirements for PCTs in order to meet their obligations under European law. PCTs must:

- establish and publish procedures for determining applications under section 6A of the NHS Act for reimbursement of medical treatment received in another EEA state;
- establish and publish procedures for the determination of applications for prior authorisation under section 6B of the NHS Act;
- specify and make available the forms on which applications for reimbursement or prior authorisation must be made;
- provide details of the information required to support such applications;
- provide advice and assistance to persons who are contemplating seeking medical treatment in another EEA state; and
- publish information identifying which services it considers to be 'special services' requiring prior authorisation.

Department of Health guidance states that procedures should be based on transparent, objective and non-discriminatory criteria. Applications must be dealt with objectively and impartially and comply with the relevant time limits set out in the NHS Directions. Although each PCT must establish its own procedures, the following considerations may be relevant for deciding not to grant prior authorisation:

- the service requested is not one that would be provided by the NHS in the circumstances of the patient's case;
- it is experimental treatment;
- there is evidence of a clinical risk to the patient or to wider public health if the patient travels abroad;
- the provider does not have adequate aftercare or follow-up arrangements in place for the treatment; and/or
- the provider is unsuitable due to evidence of previous negligence or fraudulent actions.

PCTs must also establish procedures allowing patients to request a review of any decision which has been taken. This method of challenge is in addition to the patient's right to seek judicial review in the domestic courts or submit a complaint to the European Commission. The expectation is that patients will seek local resolution before taking their case to these higher authorities. Where the PCT decides not to reimburse the full amount claimed or not to grant the authorisation sought, it must inform the applicant of the steps that must be taken to request a review.

Comment

Seeking treatment abroad at the NHS's expense may seem like a minority interest pursued by a small number of patients but the number of queries we receive in relation to such matters is steadily increasing. PCTs should ensure that they are proactive in developing procedures to deal with such patients. Seeking to establish procedures on the hoof upon receipt of an application gives rise to a significant risk that the resulting decisions will not be robust and will be subject to challenge.

Our healthcare team has a breadth of experience in dealing with queries regarding patients seeking treatment abroad. We are also experienced in dealing with queries regarding those from outside the UK who seek treatment from the NHS.

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DNAR – The Law

PART 1

Do Not Attempt Resuscitation (DNAR) orders are a controversial area of clinical practice. Headlines like *“Dad died after doctors placed a DNAR order in his notes without our knowledge”* are commonplace and damage the reputation of trusts and confidence in doctors. Often, the public misunderstand the invasive nature of Cardiopulmonary Resuscitation (CPR), and have unrealistic expectations of its chances of success, based on their experience of television programmes like ‘Casualty’. DNAR decisions made by doctors are often made with the very best of intentions, in order to protect vulnerable patients from having to address difficult life or death issues. But when, if ever, is it appropriate for doctors to place DNAR orders in patients’ notes without their knowledge or consultation with their families? What is the relevant law in this area? In the first of a two part series, Joanna Crichton considers the relevant law relating to DNAR orders for patients who lack capacity.

Treatment decision made in advance

Making a DNAR order is a treatment decision like any other. However, DNAR orders are often made in advance of CPR being required. By the time that CPR is actually required, the majority of patients will be likely to lack capacity to consent to or refuse CPR and it will be an emergency situation. It would be difficult to obtain their views, or views of their relatives, at that stage. Best practice dictates that, in the treatment of patients who are likely to suffer cardiac or respiratory arrests, DNAR orders are considered at an early stage.

Patients lacking capacity

Assessments of capacity should be dealt with in accordance with the test set out in the Mental Capacity Act 2005 (MCA). Capacity under the MCA is time specific and issue specific.

Capacity should be assumed unless there is evidence that the individual lacks capacity.

As a treatment decision for an incapacitated patient, a DNAR order should only be made after an assessment of a patient’s best interests, in accordance with the ‘best interests checklist’ detailed in the MCA. Under the checklist, the responsible clinician has a duty to consult with the patient, and his/her relatives, carers and others involved in the patient’s care, in order to come to a decision about best interests. Consultation can only be dispensed with when it is inappropriate or impracticable e.g. if the patient’s relatives are on holiday and unreachable. Given that DNAR orders are made in advance, it would be difficult to argue that consultation was impracticable on the grounds of time only.

Decisions about life sustaining treatment must not be motivated in any way by a desire to bring about the person’s death. The decision maker should not make assumptions about the person’s quality of life when deciding about his/her best interests.

If a patient does not have any relatives or other relevant people in his/her life who can be consulted about his/her best interests (other than paid professionals), an Independent Mental Capacity Advocate (IMCA) must be appointed to support and represent the person. Under the MCA, deciding whether to make a DNAR order is a decision about “serious medical treatment” as defined in the MCA.

Ultimately, the clinician with overall charge of the patient’s care decides what is in his/her best interests. The patient’s views, views of family members, and views of IMCAs are all important when assessing best interests and must be taken into account, but are not determinative. However, where agreement cannot be reached with the family as to whether a particular treatment will be in a person’s best interests, and a decision about serious medical treatment is involved, the MCA Code of Practice recommends obtaining a court order from the Court of Protection.

If the patient has a valid and applicable advance decision refusing CPR then this must be respected. (Advance decisions will be considered in the next edition of the newsletter). If the individual has appointed a welfare attorney with authority to make decisions about life sustaining treatment then the attorney will be the decision maker.

The recent GMC guidance, ‘Treatment and care towards the end of life: good practice in decision making’, July 2010, distinguishes between CPR which is unlikely to be successful and that which carries prospects of success, suggesting that in the former case relatives need only be informed of a DNAR decision. This is not the legal position. In all cases, relatives should be consulted about a proposed DNAR order, as part of assessing best interests under the MCA. In cases where CPR is unlikely to be successful, this would weigh in favour of a DNAR order being made, but does not mean that relatives’ views should not be canvassed.

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Electronic medical records – what next?

The highly controversial issue of an electronic medical records system has once again been in the media spotlight, following the Government's recent announcement that the proposed national, centralised system is to be shelved.

Concerns had been raised by many GPs and the British Medical Association over the opt-out process put forward in the centralised programme, by which a patient had to physically indicate they did not wish to have a summary electronic medical record created. It also follows concerns that far more staff within the NHS will have access to a patient's records than strictly necessary. A Freedom of Information Act request forced the disclosure that over 100,000 non-clinical NHS staff in just 140 acute hospital trusts had access to confidential records.

These concerns indicated the lack of consideration given to the programme's implications. The caution which many healthcare professionals expressed on the actual workings of the system has also been borne out by the UCL Report on key NHS IT programmes, published in June 2010. This combined with the coalition Government's cost-cutting measures led to the Health Department's announcement in September 2010 that the electronic medical records system will no longer be centralised. The intention is for this to be devolved to the NHS with individual trusts deciding on how much change is needed and the pace at which any change will be implemented. Whilst this has been welcomed by

many, it is not clear what the practical consequences will be.

The concept behind the Summary Care Record (SCR) was that access to a patient's medical history would be better, safer, and provide more efficient care, particularly in emergency situations where an individual may need to be treated outside their own area. With the introduction of a more localised approach, it is not clear how far the last objective will be achieved. It may also lead to inconsistent approaches between different NHS trusts.

On the other hand, a more cautious approach may prove beneficial. Many of the concerns raised were over the lack of clear information on the electronic system provided to patients. It was not clear how an individual could opt out of the system, if they so wished. Indeed, an opt-out form was not even included in the packs. Unsurprisingly, therefore, over 1.25 million people's information has already gone on to the summary care records system. But this is against the 8.5 million people contacted, and only just over 14,250 SCRs have actually been accessed since their creation. Issues over difficulties in defining the minimum data required, the task of ensuring GP records were complete and accurate, and the technical challenges of uploading the data, have all contributed to the lack of success of the programme to date.

The need to gain a patient's informed consent has also delayed progress of the centralised system. The proposed devolution will allow NHS trusts to satisfy themselves that a patient understands the process and what it is trying to achieve. It should also allow for the inclusion of a proper opt-out process.

A similar although much smaller scale issue has been previously dealt with during the course of the then Department of Trade and Industry (DTI)'s handling of the miners lung disease claims. In the course of setting up the claims handling scheme to deal with the unprecedented number of claims involved, the DTI considered a

number of options including:

- a blanket mandate for the release of medical records;
- a block mandate being signed by the claimants' solicitors; and
- the possibility of using an opt out system so that once the claimant had signed a claim registration form, and unless they indicated to the contrary, the DTI could have full access to their medical records.

However, following legal advice provided to the DTI, it was decided that an individual mandate was required for each type of record. In all cases a signed mandate was provided before the records were scanned and sent to the medical assessment providers.

This type of process should be considered by all trusts looking at the electronic records system. A clear opt-in process will get better buy-in from patients, which should then make implementation far easier and more likely to achieve the objectives for which it was originally designed.

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Procedures for placing a risk of violence marker on electronic and paper records



In April 2010 the NHS Security Management Service (SMS) issued guidance in relation to procedures for placing risk of violence markers on records. Markers are used to indicate that an individual has been involved in a specific incident of workplace violence and has been assessed as posing a risk of violence to NHS staff in the future. Workplace violence encompasses both physical and non-physical assault and is defined as “any incident in which a person is abused, threatened or assaulted in circumstances relating to their work”.

The statistics in the table below show the annual number of reported physical assaults on NHS staff in England between 2004 and 2009 .

Year	Number of reported physical assaults
2004/05	60,385
2005/06	58,695
2006/07	55,709
2007/08	55,993
2008/09	54,758

These statistics reveal the magnitude of the problem of workplace violence, particularly as figures are not included for Wales or Scotland, or for non-physical assaults such as verbal harassment.

Markers are designed to alert NHS staff to individuals who pose a risk

of violence to enable them to reduce this risk. Markers should include the following:

- who, or what the marker applies to (for example, a patient, a patient’s associate or a pet)
- classification of the incident (see Annex 1 to the NHS guidance);
- date the marker is effective from and review date;
- whether the individual has been notified; and
- relevant handling information and who to contact for further advice.

The Local Security Management Specialist (LSMS) will be responsible for managing the marker system, although a nominated officer may assume certain responsibilities.

The following systems should be implemented:

- a reporting system to ensure that all NHS staff report incidents of workplace violence to the LSMS for investigation;
- an independent panel to review LSMS decisions to mark records or not to notify individuals; and
- a complaints handling system for individuals to challenge a decision.

Process

1. Once an incident occurs, the victim should complete an incident reporting form and report it to their line manager or the LSMS.

2. The LSMS should review the incident form and conduct an investigation, in most cases interviewing the victim and any witnesses. A risk assessment

should be carried out with reference to the objective risk factors outlined in the NHS guidance, including (but not limited to):

- nature of the incident (i.e. physical or non-physical);
- degree of violence used or threatened by the individual;
- level of risk of violence that the individual poses;
- whether an urgent response is required to alert staff; and
- likelihood that the incident will be repeated.

3. If the LSMS reaches a decision that the individual poses a risk to staff, a marker should be placed on the individual's records as soon as possible. Alternatively, the LSMS may decide that a marker is not appropriate.

4. A decision to mark an individual's records should be referred to the panel to decide whether to approve or remove the marker.

Data protection issues

Placing markers on individual records involves the processing of personal/sensitive personal data and therefore NHS providers (as 'data controllers') must comply with data protection legislation. The processing of marker information is justified if it is necessary to comply with any legal obligation imposed on the data controller. NHS providers have a duty of care to their staff to protect them in the workplace and therefore the processing of marker information will be lawful if it is justified and fair.

Information Commissioner's Office guidance on the Data Protection Act 1998 recommends measures for ensuring compliance.

Decision-making

The decision must be based on a specific incident and have regard to objective criteria in line with a clear and established policy and review procedures. To achieve consistency, a senior nominated person should be responsible for decision-making.

Notification

In most cases individuals should be notified of the decision to place a marker on their record as soon as possible and informed of:

- the nature of the incident giving rise to the marker;
- reasons for placing the marker;
- details of information-sharing (see below);
- a date on which the marker will be reviewed for removal; and
- the complaints process.

In exceptional cases, it may be necessary to withhold information from the individual, for example, because it may provoke a violent reaction or harm the individual's health. In such cases, the decision-maker must be able to demonstrate why they reached the decision not to notify and records must be retained.

Where notification of the existence of the marker or certain information contained in the marker poses a risk to the individual's health, specialist advice should be sought from health and data protection professionals. Any decision not to notify should be reviewed by a panel.

Information sharing

Information-sharing is an essential part of minimising the risk of violence to staff. Information relating to markers may be shared between NHS staff internally as well as with other providers as long as the processing is fair and justified. A risk assessment should be carried out to identify who may come into contact with the individual. Information should be shared with the senior nominated person in another organisation, who should then further assess who the information needs to be shared with.



Prior to information-sharing, the individual must be notified who the marker information may be shared with and for what purpose.

Retention

Personal information should be kept no longer than necessary. Markers should be reviewed regularly (at least every 6 to 12 months) and the threat of violence reassessed.

Comment

LSMS guidance on procedures and risk assessment will assist NHS providers in meeting their duty of care to protect staff in the workplace. It provides important evidential issues for future claims brought by NHS staff against their employer. The guidance will help NHS providers achieve the balance between protecting staff from the risk of violence and inserting markers only where it is merited by the level of risk.

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The Bribery Act 2010 – are you ready?

In this article we look at a new piece of legislation due to come in to force in April 2011. The Bribery Act 2010 consolidates and modernises the law on bribery and has important implications for everyone engaged in commercial activities. The Act will:

- make it a criminal offence to give or promise or offer a bribe, or to request, offer or receive or accept a bribe, whether in the UK or abroad (the measures also cover bribery of a foreign public official);
- make it an offence for a director or senior officer of a business to allow or turn a blind eye to bribery or be negligent in eliminating it within the organisation; and
- introduce a corporate offence of failing to prevent bribery by persons working on behalf of a commercial organisation.

The penalties for breach of the Act are potentially severe. There is no upper limit on the level of fines that can be imposed in particular cases. An individual convicted of an offence will face a prison sentence of up to ten years. If a bribery offence by a staff member is proved to have been committed with the consent or connivance of a director or senior officer, that person (as well as the organisation) is also guilty of the offence and liable to be prosecuted and fined or imprisoned.

Why is this relevant to NHS/health bodies?

In essence, the Act provides that the offence of failing to prevent bribery can be committed by any partnership, company or body corporate which is based in the UK or carries on business in the UK. It is easy to assume that NHS trusts, GP surgeries and not-for-profit companies set up by the public

sector will therefore not be caught by the Act because they do not carry on 'business'. However, alongside their substantive functions in healthcare, these organisations also engage in commercial activities, an obvious example being the procurement of supplies and services. The question therefore arises as to whether these types of commercial activities constitute business activity for the purpose of the Act.

There is, as yet, little guidance as to what is regarded as a "business" under the Act, but given the commercial activities that these organisations undertake we strongly suspect that NHS Trusts, GP surgeries and not-for-profit companies set up by public sector bodies will be caught.

Organisations will have a defence against prosecution for failing to prevent bribery if they can show that they have "adequate procedures" in place to prevent it taking place. However, what sort of steps will an organisation have to take to be able to rely on the "adequate procedures" defence? The Government has recently published draft guidance to help organisations decide what bribery prevention procedures to put in place in order to limit the likelihood of prosecution under the Act. The guidance sets out six general principles, which it is suggested should form the basis of anti-bribery procedures. These are under the following headings:

1. Risk assessment
2. Top level commitment
3. Due diligence
4. Clear, practical and accessible policies and procedures
5. Effective implementation
6. Monitoring and review

The guidance (which can be accessed on-line at <http://www.justice.gov.uk/consultations/docs/bribery-act-guidance-consultationletter1.pdf>) will also provide useful illustrations on how organisations could implement the six principles in practice. The draft guidance is currently the subject of consultation, with the final guidance likely to be published before the end of the year. However, we suspect that the majority of it will be officially issued as statutory guidance without much amendment.

Next steps

By addressing the risk now, organisations can ensure that they are ready when the Act comes into force in April. A starting point should be to review existing policies and procedures dealing with this issue, or to take steps to implement new anti-bribery policies and procedures.

If you would like further information about the Bribery Act 2010 and what Hill Dickinson may be able to do to assist your organisation, please contact Linda Glover in our employment and pensions practice.

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The Airedale Inquiry – implications for NHS trusts

In June this year, the Airedale Inquiry was published. The independent inquiry was commissioned by NHS Yorkshire and the Humber to investigate the events at Airedale NHS Trust between 2000 and 2002 which led to the arrest of Sister Anne Grigg-Booth. She was charged with three offences of murder, one offence of attempted murder and 13 offences under the Medicines Act 1968 of administering noxious substances. Sister Grigg-Booth died in 2005 before she was able to stand trial.

The events

From the mid 1990s, senior nursing staff at the trust were working as night nurse practitioners (NNPs). Sister Grigg-Booth was the most senior NNP. The purpose of the NNP's role was to reduce junior doctors' workload, in particular, the need to call junior doctors out at night. This allowed the trust to comply with the 'New Deal.'

The role carried out by Sister Grigg-Booth and other NNPs included:

- Administering intravenous opiates. Although it was against official hospital policy, the practice was accepted by senior managers and the NNPs believed that they were permitted to do so by the Trust Board.
- Accepting verbal orders from doctors for the prescription of opiates and other medication.
- Prescribing opiates without reference to a doctor. Sometimes, but not always, a doctor was asked to approve their actions retrospectively.

At the time there were no circumstances in which a nurse was permitted to prescribe opiates but many doctors and nurses working at the trust at the time believed that the NNP were permitted to carry out these duties. The hospital policies around prescribing and administering medication were found to be completely ineffective at night and the board was disconnected from what was happening at the hospital at night. The inquiry found that the reality was Sister Grigg-Booth was effectively running the hospital at night and was driven by the need to avoid calling junior doctors unless

she thought it absolutely necessary.

The inquiry concluded that Sister Grigg-Booth did not set out to deliberately harm her patients and was utterly convinced of her own clinical prowess. It was found, however, that she acted unlawfully from time to time. Sister Grigg-Booth carried out her actions entirely openly and recorded them in patients' medical records. She believed that she was doing so with the authority of the Trust Board. The inquiry found that the Trust Board "failed in December 2002 and thereafter to recognise and act upon the fact that, whatever Sister Grigg-Booth had done, she was part, if not a symbol, of a system that was not working."

Implications for clinical practice

The prescription and administration of medication, particularly nurse prescribing, has been an area of change since the events investigated occurred. Trusts should ensure that their policies are robust and comply with the up to date law as set out in medicines legislation such as the Prescription Only Medicines (Human Use) Order 1997 and the Misuse of Drugs Regulations 2001.

Policies should be effectively publicised and promoted within the trust. If clinical staff are not aware of policies, and managers regularly condone departure from the policies, they are meaningless.

The inquiry recommended that there should be clear lines of accountability for extensions to roles such as nurse prescribing and that governance systems in NHS provider organisations need to be designed to reflect Trust Boards' 24 hour a day responsibility for all areas of service delivery.

Working with the police

When the police first attended the trust in 2003, they asked the Board not to interview those staff who may be involved in the police investigation. The trust acquiesced on this. It did nothing to establish what had been going on, and what was still going on at the hospital at night.

The inquiry found that it was not acceptable to leave everything until after the police investigation. NHS trusts should be familiar with the Memorandum of Understanding between the Department of Health, the Association of Chief Police

Officers and the Health and Safety Executive published in 2006. In particular, trusts should seek high level discussion with the police at an early stage (the Incident Co-ordination Group). The Incident Co-ordination Group allows all three organisations to set out their needs so that actions can be agreed that do not prejudice the work of each organisation. The NHS cannot simply await the outcome of a police investigation before acting and must take responsibility for patient safety.

The trust was also criticised for failing to retain copies of the documentation that was provided to the police, or keeping a record of what has been taken. The trust was entirely reliant upon finding duplicates of documents in other parts of the hospital or the notes and memory of members of staff for a record of what had been taken. As a result, the trust was deprived of its own records for years which hampered its ability to carry out an effective investigation.

It is rarely the case that the police are entitled to seize medical records immediately and NHS trusts are perfectly entitled to ask police officers to return at a more convenient time to collect a copy of the notes where they are reasonably required by the police. If the police are concerned that evidence will be concealed or destroyed, it is still imperative that an NHS trust retains a copy of the notes and can ask that an officer supervise a member of staff whilst a copy is made.

The inquiry also criticised the trust for the supervision of staff by certain managers when they were giving evidence to the police. Although trusts should ensure that their staff members are properly supported when giving statements to the police, the supporter should be an appropriate member of staff. The inquiry found that the presence of certain managers when staff members were giving statements to the police may have led to them being less than forthcoming with their evidence.

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Prisons and Probation Ombudsman releases report for 2009 - 2010

The Prisons and Probation Ombudsman's Office (PPO) exists to carry out independent investigations into deaths and complaints. This annual report sets out how the PPO has carried out its role over 2009 - 2010. It includes a selection of complaints and fatal incidents investigations, and discusses the many recommendations which have been made.

Fatal Incident Investigations

The report highlights that 2009-2010 has been a year of considerable achievement for the Fatal Incident Investigations (FII) team. Timeliness has improved dramatically and the quality of reports and investigations has been sustained and developed. Progress has also been made in feeding back the lessons learned from the investigations.

The PPO opened investigations into 193 deaths in 2009-2010 compared with 181 in the previous year. All of these were in a prison setting except for 11 which occurred in approved premises. Natural causes accounted for 116 of the 193 deaths with 63 being self-inflicted.

The FII team issued 205 draft reports in 2009-2010, 8% higher than the previous year although only 17% were within the 20 weeks' target and 44 remain overdue at the time of the PPO Report being written. The delivery of final reports increased by 27% to 214. In light of the problems in meeting targets, the PPO has invested in training covering investigative skills, time management, writing skills and assertiveness which has improved practice and performance. For the first time since 2004 when the Ombudsman began investigating deaths in custody, there is a full complement of investigative and administrative staff which will no doubt be reassuring to those prison and healthcare staff involved in investigating deaths in custody.

Clinical reviews

Although there have been obvious issues with staffing levels and training contributing to the delays in reports, the PPO also identified that their reports are sometimes delayed by overdue clinical reviews. The PPO's terms of reference require NHS trusts to provide suitably qualified and independent clinicians to conduct reviews. Draft reports are frequently being held up due to late clinical reviews and there have also been issues with the quality and relevance of some of the reviews received. Some have not provided in depth or enough analysis and recommendations are sometimes vague or ill-directed.

The availability of clinical reviewers is a national problem and one which continues to cause concern. It is important to bear in mind that the findings of the clinical reviewer often play a large part in any inquest following a death in custody. It is therefore essential that the reports are thorough and that any recommendations have been acted on where appropriate and that this can be demonstrated at the inquest.

National Patient Safety Agency - patient safety in prisons

The National Patient Safety Agency (NPSA) now receives FII reports and is planning to use the recommendations to assist with the project 'Patient safety in prisons'. The NPSA, in conjunction with the Department of Health, has revised and reissued guidance entitled 'Undertaking a clinical review following a death in custody'. Trusts need to ensure they make clinicians aware of this guidance when completing reports, especially as the PPO is now actively monitoring the quality of the reports.

Reception screening

Offenders are a notoriously 'hard to reach' group as far as healthcare in the community is concerned. Reception into custody is often the first time someone's health has been evaluated in a considerable time. The PPO reports have found that the healthcare received by prisoners at this point was at least on a par with that which they would have received if at liberty. Despite this praise, the PPO identified incidences where prisoners in their last days remained

restrained until only a few hours before death. While public protection is paramount, prisoners, like a person at liberty, should be allowed to die with dignity. A number of recommendations have been made in relation to this issue.

Palliative care

Palliative care services in prisons have improved dramatically since 2004 with Macmillan nurses, hospice care staff and palliative consultants now regularly visiting terminally ill prisoners. These specialists have also begun providing expertise and training alongside the in-house healthcare to improve end of life care.

Action plans - national not just local

The vast majority of recommendations made by the PPO have been accepted and led to the development of action plans. Several regional offender health teams now have well-established routines whereby a recommendation from one establishment is introduced across the region. This needs to continue to encourage a consistent approach in all prisons.

Comment

Whilst the PPO has made improvements over the past year, there are still more improvements which can be made. Co-operation between the PPO and NHS trusts needs to be encouraged to ensure that prisoners have access to the same level and quality of healthcare as they would receive in the community.

In order to assist the PPO with their investigations, trusts should ensure that they are nominating an appropriate clinician to prepare a review and that those clinicians are provided with guidance with regards to the issues that need to be included.

Following the recommendations made in relation to palliative care, trusts should ensure they respect the family's grief in relation to a terminally ill prisoner. They should liaise with prisons and families in relation to palliative care and release on compassionate grounds should be discussed in line with public protection.

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Inquests update

The inquest process has come under greater scrutiny with the advent of the Coroners and Justice Act 2009 and a number of recent cases looking at disclosure, the scope of the inquest, causation and verdicts, Rule 43 of the Coroner's Rules 1984 and costs. On a practical level we are finding that, in general, systems and processes are coming under greater scrutiny. It is essential that witnesses are thoroughly prepared for all inquests and that where systems are likely to be examined, the appropriate evidence (witness statement, Serious Untoward Investigation report/Root Cause Analysis) has been submitted on behalf of the organisation. Being prepared is the key!

Rule 43 letters are being issued with increasing frequency in our experience, again reiterating the need for detailed evidence regarding lesson learning and what practical steps have been taken to improve patient care. It is not enough to simply refer to a policy – the coroner will want to know what has been done practically to ensure its implementation and effectiveness.

Rule 43 letters - Ministry of Justice bulletin September 2010

The Ministry of Justice (MoJ) has recently published its third summary bulletin covering reports and responses received by the Lord Chancellor

between 1 October 2009 and 31 March 2010. Rule 43 reports were issued in a total of 195 inquests. As with the two previous bulletins, hospital deaths accounted for the majority of reports – 30% of reports issued (58 reports). In addition an increase was noted in the number of reports issued in relation to deaths in custody (22 reports). A reduction in the number of reports involving mental health deaths was noted – accounting for 10% (20 reports) of the reports issued.

Greater Manchester South coroner district once again issued the most reports, issuing 17 reports in total which equated to 9% of all reports issued. Interestingly the bulletin acknowledges that, *“Often the evidence heard at an inquest will satisfy the coroner that remedial action has already been taken, so he or she may decide no useful purpose will be served by issuing a Rule 43 report after the inquest.”* This reiterates the importance of lesson learning and being able to demonstrate change to the coroner.

The bulletin also breaks down the rule 43 reports by organisation, highlighting that NHS hospitals and trusts were the most frequent recipients, having received 32% of the reports issued by coroners (74 reports).

The bulletin highlights a number of emerging trends in relation to hospital deaths including communication,

procedures and protocols, and staff training, all of which were highlighted in the MoJ's earlier summary reports. Further, concerns again emerged concerning patient discharge namely discharge, procedures, ensuring appropriate medical support and/or instructions for patients and record keeping.

It is crucial that organisations respond to Rule 43 letters within the required timescale of 56 days. If you are unable to comply within that timescale, an extension from the coroner can be requested. All organisations who have failed to comply are 'named and shamed' in the bulletin.

A list of all Rule 43 reports is set out in Annex C of the bulletin, including the name of the receiving organisation, brief details of the report and whether a response has been received. It is important to bear in mind that this provides clear evidence of areas where organisations are considered to have failings, which may have an impact on any future inquests. If an organisation reports, in response to a Rule 43 letter, that systems have been changed, the consequences could be serious if the same issues arise again at a subsequent inquest.

A copy of the report is available here (<http://www.justice.gov.uk/publications/docs/third-summary-coroners-reports-rule43.pdf>)

Inquest Case law review

Why you should respond to Rule 43 letters – a cautionary tale

The importance of responding to Rule 43 letters has been highlighted at a recent inquest into the death of Roland Holbrow. Mr Holbrow, 87, was admitted to Musgrove Park Hospital in Taunton at 19.15 on 14 August where he was not seen by a doctor until after midnight, by which time he had died of bronchial pneumonia. The inquest commenced on 20 August and was conducted by Michael Rose, HM Coroner for Western District of Somerset.

The inquest into the death of Mr Holbrow was Mr Rose's second inquest in three months into the death of an elderly patient occurring at the Musgrove Park Hospital in circumstances where a shortage of staff meant that the patient did not receive timely treatment. In June this year, Mr Rose conducted an inquest into the death of Mrs Marion Clarke, 88, at the same hospital. He voiced concerns that there was only one junior doctor dealing with more than 100 patients. Following the inquest, Mr Rose wrote a Rule 43 letter to the Chief Executive of Taunton and Somerset NHS Foundation Trust raising concerns about staffing levels at the hospital.

At the time of Mr Holbrow's inquest on 20 August, the trust had not issued any response to the earlier Rule 43 letter. Although only 45 days had elapsed since the Rule 43 letter was received by the trust, it prompted Mr Rose to publicly reproach the Chief Executive of the trust, Jo Cubbon:

"I expressed my concern to the Chief Executive and she has not even shown me the courtesy of acknowledging my letter or replying to my query. I was also concerned that it took the hospital nearly 14 months to produce the evidence of witnesses.

"I can't allow such delays to occur in the future and that is the reason why I am calling this matter at a hearing in three weeks' time."

Mr Rose adjourned the inquest in order to call Ms Cubbon to give evidence in response to his concerns. He also called all physicians and nurses who were on duty on the ward on the night of Mr Holbrow's death to provide information about the circumstances surrounding his death.

Ms Cubbon apologised for the circumstances leading to Mr Holbrow's death. She informed the inquest that a Serious Untoward Incident Investigation was being carried out by the hospital and was expected to be completed within two weeks of the inquest date. She said that any recommendations relating to overnight staffing levels would be implemented.

The coroner's approach highlights the risks of failing to deal with Rule 43 letters including:

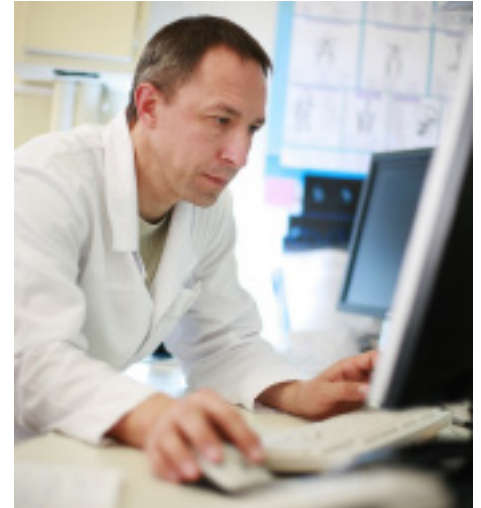
- public reproach for trusts as well as chief executives personally;
- chief executives being called to attend the inquest; and
- all staff on duty being called to attend at short notice which raises management issues for trusts who may have to cancel clinics and address other issues arising from a shortage of staff.

The coroner's criticisms were also directed at the trust's failure to acknowledge his Rule 43 letter. Since only 45 days had elapsed, the trust could still have issued a response within the time limits prescribed by the Coroner's Rules. It is therefore advisable that trusts have systems in place for acknowledging Rule 43 letters as soon as possible as well as diarising dates for response.

Legal representation

R (on the application of Humberstone) -v- Legal Services Commission [QB, April 2010]

In this recent decision by the High Court, it was determined that where the facts of a case indicate an effective investigation cannot be conducted



without the legal representation of an interested person, public funding must be granted. The coroner's view of his or her ability to conduct an effective inquest without an interested party being legally represented will be particularly important.

Facts

In July 2008, a ten year old boy with a history of severe asthma died in hospital after his admission by the emergency services who had responded to a call following a particularly bad attack. Examination of the boy's medical history indicated concerns had been voiced directly to his mother (H) regarding the level of home therapeutic care being provided by H who, it was claimed, failed to attend key medical appointments with her son and left him to his own devices in administering his medication.

On the day of his death, the boy had been kept off school by H as he had a cough which she knew could lead to an attack. Nebuliser treatment at the doctor's surgery was refused as the boy was not deemed poorly enough although antibiotics were prescribed and collected. On the way home, an asthma attack started that was initially treated with salbutamol inhaler. An ambulance was subsequently called. Paramedics administered oxygen through a mask however this was ineffective and CPR was commenced. The boy was taken to Sheffield Children's Hospital where he was declared dead.

The concerns expressed by the medical practitioners regarding H's care of her son provided reasonable grounds for her arrest on suspicion of manslaughter by gross negligence. She was released without charge.

H instructed solicitors to represent her at the inquest and applied to the Legal Services Commission (LSC) for public funding. The application was refused. Without legal representation and against the backdrop of an arrest for gross negligence manslaughter, H was facing a detailed inquiry into her son's death in circumstances that would raise complex medical issues. All other interested parties were legally represented and highly likely to try and deflect blame or criticism in H's direction. H applied for judicial review of the decision of the LSC not to recommend that she be granted public funding for representation at the inquest.

The Funding Code and Article 2

The LSC's Funding Code states that funding for representation is granted either where there is a significant wider public interest in the applicant being legally represented at the inquest, or where such funding is likely to be necessary to enable the coroner to carry out an effective investigation into the death, as required by Article 2 of the European Convention on Human Rights (ECHR). Article 2 specifies a right to life that is protected by law, and places a duty on the state to investigate a death. H appealed on the second strand of the LSC's Funding Code test.

The LSC argued that Article 2 was not engaged by the circumstances of the death because, beyond the simple fact of death raising the possibility of negligence, there was no other evidence indicating the state had breached its primary duty under Article 2 beyond the mere fact of a death having occurred. In any event, the issues involved were not of such factual or legal complexity, or of such seriousness that the coroner would not be able to conduct an effective inquest without the funded representation of H. The refusal of funding was not a breach of Article 2 or the Funding Code.

Decision

Mr Justice Hickinbottom quashed the LSC's decision not to recommend that funding be granted for representation at the inquest concluding that when reaching its decision, the LSC had failed to take into account the possibility that the inquest would involve allegations against H that her historic failure adequately to supervise her son's treatment for the control of his asthma might have caused or contributed to his death. The decision failed to have proper regard to the nature and seriousness of the allegations against H, that fatally undermined the conclusion that H would be able to participate appropriately and effectively in the inquest without representation. This was also compounded by her personal circumstances and attributes. The decision failed to take those material considerations into account and was quashed.

The occurrence of a death whilst in the special care of the state raises the possibility a state agent was, in some way, responsible for the death. This is enough to engage Article 2 and the state's duty to investigate by whatever effective means.

The state may have a duty to investigate a death even where there is no reason to suspect a breach of the primary duty simply because the state is sufficiently implicated in the death, for example, a death whilst under the direct medical supervision of the state. Where it is sufficiently implicated, the purpose of the state's investigation goes beyond ensuring accountability and includes ensuring full facts are brought to light, that suspicions of wrong doing are allayed, discreditable or culpable conduct is brought to public notice, the remedying of dangerous practices or procedures and knowing that lessons for the future have been learnt.

Whilst the Coroner's investigation must be practical and effective, there is no formula by which to ascertain when or how these requirements may be met as they will be fact-sensitive. It is not correct or lawful, therefore, to render a particular factor (e.g. complexity of facts / law) determinative in each case

when considering an application for funding. Other matters apply, including (but not restricted to):

- the coroner's view regarding his own ability to conduct an effective investigation without the person being represented. This was a special matter for consideration;
- the existence, nature and seriousness of the allegations against the person requesting funded representation. This may be impacted upon by the publicly funded legal representation of other protagonist parties who are suggesting the culpability of the applicant; and
- the personal attributes and circumstances of the persons requesting funded representation, giving consideration to those circumstances where the verdict requires examination of technical issues that person would be unable to address sufficiently themselves.

Impact

It is possible that we may see an increase in the number of families being legally represented at inquests as often the barrier to obtaining representation can be funding. Whether such representation is publicly funded or not will depend, in part, on the type of factors set out above including the complexity of the events leading to the death (medical or otherwise). The guidelines outlined in Mr Justice Hickinbottom's judgment may result in a greater number of successful applications for public funding, although each application will have to be decided on its own merits. Whilst this will not alter the non-adversarial nature of inquests, their fact-finding nature means that you can reasonably expect future inquests to be characterised by more detailed questioning by legal representatives (instead of the interested party themselves), who have a keen eye not only on the inquest itself but also on how the facts ascertained and the verdict handed down can inform subsequent civil action.

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Legal right to representation at disciplinary hearings

The Implementation of Maintaining High Professional Standards in the Modern NHS (MHPS) in 2005, was introduced to streamline internal disciplinary hearings for medical staff by removing the onerous obligations placed upon trusts by the previous procedure, HC90(9). However, MHPS dealt with a medical practitioner's right to be accompanied at a disciplinary hearing in a curious fashion. MHPS stated that, whilst a practitioner was entitled to be accompanied at a disciplinary hearing by a legally qualified person, that person must not represent the practitioner "formally in a legal capacity". The phrase appeared contradictory.

Kulkarni

The issue was clarified in the case of Kulkarni -v- Milton Keynes Hospital NHS Foundation Trust [2009]. In that case, Dr Kulkarni was accused of inappropriately examining a patient and he was made the subject of internal disciplinary proceedings. He was represented by his Medical Protection Society who asked if he could be legally represented. The trust refused and relied upon the wording of MHPS.

The Court of Appeal held that the expression "not acting formally in a legal capacity" was meaningless and should be deleted from MHPS. The court went on to say that practitioners have the right to be represented by a legally qualified person employed or retained by their defence organisation under the MHPS procedure. Further, practitioners have the right to be represented by a legally qualified person who happens to be a spouse, partner, colleague or friend.

However, the court went further and said that where the effect of disciplinary proceedings was so serious that it could deprive the employee of the right to practice his profession. Article 6 of the European Convention on Human Rights (ECHR) (the right to a fair hearing) would be engaged and the practitioner would be entitled to be legally represented at a disciplinary hearing by a lawyer of his choice. He would not

be restricted to representation by a lawyer instructed by a medical defence organisation.

In the Kulkarni case, the court was concerned that if Dr Kulkarni were found guilty of the disciplinary charge, he would be unemployable as a doctor. The court felt that he would be unable to complete his training which would end his career. Moreover, it was likely that an alert letter would be issued in relation to the case further reducing Dr Kulkarni's prospects of securing employment elsewhere.

G -v- X School

The above case caused the Court of Appeal to consider this issue again, albeit in slightly different circumstances, in January 2010. The court further extended the application of the principle laid down in Kulkarni. In that case, G was a part time teaching assistant dismissed following allegations that he had sexual contact with a 15 year old male pupil. The school was obliged to inform the Secretary of State that it had grounds to believe that G was unsuitable to work with children. If the Secretary of State agreed with the school's concern, G would be placed on a register of individuals deemed unsuitable to work with children.

G was denied the right to legal representation at the internal disciplinary hearing. G applied for judicial review of

the school's decision.

The Court of Appeal held that being placed on a register of individuals deemed unsuitable to work with children would fundamentally limit G's ability to practice his profession.

Further, the court said that the school's internal process would have a substantial influence or effect on the decision making of the Secretary of State and G was therefore entitled to legal representation at the internal disciplinary and appeal hearings in accordance with Article 6 of the ECHR.

Hameed -v- Central Manchester University Hospitals NHS Foundation Trust

Further clarification was provided by the above case more recently, in August 2010.

Dr Hameed was disciplined for using un-sterile instruments in an operation. She argued that she was entitled to be legally represented at her disciplinary hearing by her lawyer of choice. The Court decided that although the fact of the dismissal would place a considerable handicap in obtaining work in the future, it did not accept that Dr Hameed's dismissal would have the same effect as the doctor in the Kulkarni case.

However, following Kulkarni, Dr Hameed still had the right, under MHPS, to be represented by a lawyer retained by a medical defence organisation.

Summary

NHS trusts should carefully consider all requests for legal representation by professional employees within internal disciplinary proceedings. If charges against an employee are of such gravity that they would effectively deprive an employee of the right to practice his or her profession, it is possible that the employee is entitled to be accompanied by a privately instructed lawyer at the hearing. These provisions potentially extend beyond doctors to other healthcare professionals, such as nurses.

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Outsourcing - the benefits, the pitfalls and how to optimise your return

Outsourcing the provision of services is not new, but with the challenges currently being faced by NHS bodies to reduce expenditure while meeting often demanding targets, outsourcing is becoming a topic that is increasingly at the forefront of many trusts' minds. However, to optimise the return and maximise the benefits, any outsourcing needs to be carefully planned and structured and a variety of issues need to be considered.

The benefits

Outsourcing seeks to place on a third party the obligation to provide certain services to the customer. This may be in a number of areas including IT or HR services, cleaning, or equipment provision and maintenance.

A good outsourcing arrangement should reduce risk and cost to the trust whilst maintaining or improving service quality. This is possible because the contractor is able to exploit economies of scale, and use specialist facilities and expertise in their particular area of service provision.

The pitfalls

Although outsourcing arrangements can have many benefits, the appointment of a third party to provide services can present difficulties.

The customer will lose direct control of the provision of the services, and so must ensure that it has the ability to control the third party supplier so that the customer receives the service that best suits the customer's requirements.

There are a variety of legal pitfalls which the customer needs to be aware of. For example:

- When provision is transferred to a third party service provider, staff currently involved in providing the services may transfer to the new provider under the Transfer of Undertakings (Protection of Employment) Regulations 2006 (TUPE).

- Similarly, when the service contract terminates or expires, those staff might transfer to a further, replacement service provider, or back to the customer.

The contract therefore, needs to deal with how the associated liabilities are to be dealt with. For instance, if the service provider wishes to make the employees redundant after the contract has been signed, who will be responsible for the associated costs? Additionally, there are requirements on both parties to give the employees that will potentially transfer certain information - the customer needs to ensure that the service provider complies with its responsibilities in order to avoid potential penalties.

The customer also needs to consider;

- How issues of access to land will be dealt with. If the service provider needs to access land belonging to the customer (or a third party), how will those rights be granted? Who will be responsible for obtaining any planning permissions that are required?
- What will happen if the service provider becomes insolvent and is consequently unable to satisfy its contractual obligations. This needs to be dealt with in the contract. Would the customer be able to provide the services itself, or would it need to appoint another service provider immediately? If so, how would doing so allow it to comply with its procurement obligations under the Public Contracts Regulations?

How to optimise your return

Every outsourcing arrangement should have elements built into it to ensure that the customer's return is optimised and its exposure to risk reduced.

In particular, the customer needs to retain some control over the standard of services it receives. The most common way of doing this is to set Key Performance Indicators (KPIs) which set out the required service standards. For example, in the case of an IT outsourcing arrangement, the response and fix times for reported IT faults would be critical KPIs. If the service provider fails to meet those KPIs, the contract will usually provide for the payment of service credits back to the customer, the level of which will depend on the severity of the breach. The contract should also allow for termination in the event that such breaches are severe or recurring.

The contract should allow for the auditing of performance, regular review meetings between the parties, and an escalation procedure to deal with disputes. It should also include a procedure dealing with changes in the scope of the services; the scope of the services is likely to change more than once, particularly if the contract lasts for a significant period.

The customer should also consider whether to add a benchmarking provision that will allow the customer to measure the service provider's prices and performance against their competitors part way through the term by going out to the market and running an informal tendering process.

Summary

Outsourcing the provision of services can be an effective way of reducing costs and risk while maintaining or improving standards.

However, the legal documentation must address critical legal and practical pitfalls. It must precisely set out the standard and the extent of the service to be provided and what is to be paid. It must also protect the customer from the consequences of service provider failure.

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Claims for restitution

Where there is an overpayment of money, whether it be salary or other monies paid by mistake, and the recipient refuses to repay or simply ignores a demand for repayment, the only option for the payer is to litigate. In the first of a two part article, we take a look at the difficulties a recipient faces in successfully defeating the payer's claim for restitution.

The law applicable to a claim for repayment (or restitution as it is correctly known) has seen the emergence of two defences, namely the Defence of Change of Position and the Defence of Equitable Estoppel. The two defences are similar in that both entail a change in the recipient's position which impacts upon his liability to repay.

The Defence of Change of Position

A recipient must have changed his position in good faith which in the circumstances makes it inequitable for him to be required to make restitution in part or full.

Change of Position

A Court may require a recipient to repay money where he has changed his position as follows:

- Payment of debts – the recipient is still enriched as he is no longer indebted to the creditors he has repaid
- Purchase of assets – if still in possession of the assets at the time of the litigation a recipient may still be enriched, although any reduction in the value of the assets since their purchase may be taken into account, or
- Investments – where the money has been invested and can be realised without incurring a penalty then no change of position or detriment may occur

However, there does not always have to be expenditure. Where the recipient has kept the money but misses an opportunity then, subject to it being causally linked to the receipt, a detriment may occur. For example,

receiving an overpayment and then giving up employment at an age when it would be hard to obtain another job may suffice as might the rejection of a better paid job on the basis that a higher salary is not now required.

Causation

The mere expenditure of the overpayment does not in itself render it inequitable for the recipient to be required to make repayment. The recipient must also show that the mistaken receipt is causally linked to the change of position and that 'but for' the overpayment he would not have changed his position. For example, where the recipient has enhanced his general standard of living he may be able to show that 'but for' the overpayment his lifestyle would not have changed.

Normally, this requires the change of position to follow the receipt. However, the defence has developed to include the concept of anticipatory reliance so that where a change of position occurs before receipt, a recipient may be able to show he has in good faith changed his position based on the anticipated payment which he was thereafter mistakenly paid.

Conduct

The recipient's conduct is also relevant although the courts have dismissed the concept of relative fault. As it will not take into account the payer's carelessness it would therefore be unfair to take into account the recipient's carelessness. However, a recipient seen as acting in bad faith and who cannot prove that he has in fact acted in good faith will struggle to successfully raise the defence.

Examples of bad faith may include

- where the recipient knows that the payer did not intend him to receive the overpayment (but there need not be an element of dishonesty on the part of the recipient in order to establish bad faith)
- where the recipient has been put on enquiry that an overpayment has potentially been made to him; and/or
- where a recipient should have known that the payer did not intend him to receive the overpayment

In conclusion, such claims will be determined after taking into account all of the relevant facts surrounding the receipt and change of position and will be decided upon whether it is unjust to allow the recipient to retain the monies in full or in part.

Philip Sheard sits in our commercial litigation team and acts for a number of clients in relation to overpayments and mistaken payments. In our next issue, he will look at the second defendant of equitable estoppel.

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Managing stress at work – new guidance issued for all directors and managers

The incidence of stress-related illness caused by work has steadily risen in recent years. We are dealing with a steady flow of claims brought by NHS staff and there is concern that the numbers may increase as budgetary restraints begin to have an effect. The Chartered Institute of Personnel and Development's (CIPD) annual absence management surveys show that stress is one of the most important reasons behind sickness caused by work and stress-related absence. The Health & Safety Executive have indicated that workplace stress is likely to become the most dangerous risk to business in the early part of the 21st century. One in five workers report feeling extremely stressed at work. This equates to five million workers in the UK.

CIPD guidance

New guidance on how to identify, tackle and prevent stress has recently been produced by the CIPD, with support from the HSE, ACAS and the government's 'Health, Work and Wellbeing' programme. The guidance summarises employers' legal duties and discusses recent cases involving significant compensation payments paid to employees who successfully brought claims for work-related stress injuries.

The guidance is called 'Work-related stress: what the law says' and it encourages employers to tackle staff anxiety through good people management. It highlights the potential legal risks that organisations face by ignoring their responsibilities in this area.

It does not create any new obligations but helpfully restates these in one document. It is aimed at directors and managers in the public sector. We would advise that copies are distributed to board members and any staff who are responsible for managing people.

Copies of the guidance are available by clicking here >> (http://www.cipd.co.uk/subjects/health/stress/_work-related-stress-what-law-says.htm)

Many trusts also have stress policies and this guidance may provide the opportunity to review that policy and ensure that its obligations are being met. Are managers undertaking annual stress risk assessments if the policy provides for this? Are the assessments being centrally collated? We have experience of trusts implementing such policies but the evidence is unavailable to demonstrate compliance which can cause difficulties in defending cases when made.

We are able to provide training on issues of stress/bullying at work, including a review of your policies. Education and awareness of all managers is vital to maintain a healthy workforce and to avoid an expensive claim.

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A victory for common sense?

Whilst it is fair to say that the provisions of the Occupiers Liability Acts in public liability claims do not impose as high a standard as the duties under the Workplace (Health, Safety & Welfare) Regulations 1992, the courts' approach to slipping and tripping claims has often been inconsistent and this decision will be welcomed by occupiers and landowners alike.

Jonathan Harvey -v- Plymouth County Council [2010] EWCA Civ 860, Court of Appeal

The facts

At the time of the incident, Mr Harvey was 21 years old and had been on a night out with friends. It appears that on his way home in the early hours of 18 April 2003 he had run onto the council's property, seemingly having left a taxi without paying. The property in question was an area of grassland bordered by shrubs and trees.

Unbeknown to the claimant, beyond it was a drop of around five and a half metres to a supermarket car park below. There was a chain link fence along the perimeter of the land, approximately one to two metres from the edge, which was lowered at the point where he fell to around 14 inches above the ground. It seems that he had tripped over the fence and, either under his momentum or after getting up and moving forward, he fell over the edge. He suffered severe head injuries, which sadly left him with permanent brain damage.

The council's land was available to the general public and it was ultimately accepted that Mr Harvey was not a trespasser. Accordingly, the 1957 Act applied; section 2 of which provides that "(2) The common duty of care is a duty to take such care as in all the circumstances of the case is reasonable to see that the visitor will be reasonably safe in using the premises for the purposes for which he is invited or permitted by the occupier to be there."

Mr Harvey had succeeded in his claim at first instance, subject to a deduction of 75% to reflect contributory negligence. The trial judge concluded that conduct of this nature could and should have been foreseen by the council and they should have taken steps to protect him from the risk of serious injury. In particular, he felt that the council ought to have had a system of maintenance or inspection of the fence to ensure that visitors were not at risk of falling over the edge.

The Court of Appeal found, however, that whilst it was known that the area was frequently used for "various types of night-time activity" (whatever that means!) these carried no obvious risk of incident. In the leading judgment Lord Justice Carnwath placed reliance on the well-known words of Scrutton LJ in *The Carlgarth* (1927):

"... when you invite a person into your house to use the staircase, you do not invite him to slide down the banisters."

He concluded that the duty under the Act does not extend beyond the scope of the activities for which the licence has been given. He said that:

"When a council licenses the public to use its land for recreational purposes, it is consenting to normal recreational activities, carrying normal risks. An implied licence for general recreational activity cannot, in my view, be stretched to cover any form of activity, however reckless."

Accordingly, the court found for the council.

Comment

This is a helpful decision for occupiers in cases where there is no suggestion that the claimant was a trespasser. It is a useful precedent for NHS bodies facing claims from visitors who are entitled to be on their premises but who are injured when engaging in reckless behaviour. The occupier's position will be strengthened however where appropriate warnings are provided and the system of maintenance and inspection can be evidenced.

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Judicial consideration of the Working at Height Regulations

Harsukhray Bhatt -v- Fontain Motors Limited [2010] ECWA Civ 863

An appeal was brought by the defendant (a car sales and repairs centre) against a first instance decision in the Central London County Court arising out of the claimant's accident on 7 November 2005, in which he sustained personal injuries.

Accident circumstances

The claimant, aged 54 at the time of trial, had been employed by the defendant as an after-sales assistant for over 25 years. In 2005 the defendant purchased new premises and transferred items across during the move, including 20 to 30 light, aluminium 'Audi' spoilers (bumper kits) for re-sale, each costing approximately £80 to £100.

The defendant told the court that these were kept in the loft space above the car showroom as they were liable to

be damaged or cause obstruction elsewhere and were only sold off once or twice a month in any event.

The court was advised that the loft area could be accessed by following a series of steps:

1. an ordinary A-frame stepladder would be used to remove the polystyrene ceiling panel;
2. a light, which was attached to a long lead would be plugged in and used to light the loft space;
3. the A-frame ladder would then be replaced with a long aluminium ladder with non-slip feet, propped up against the lip of the hatchway; and
4. the assistance of a colleague would then be requested to secure the foot of the ladder whilst the other employee climbed up and used the light to identify and retrieve an appropriate spoiler and either throw it onto a leather sofa below or pass it to their colleague

At the trial, the showroom manager accepted that the method of accessing the loft space was 'less than ideal' and that as a consequence he had restricted the number of people who could access the loft to three (including the claimant) and had given a practical demonstration of how it should be done to avoid incident.

The precise mechanics of the claimant's accident were somewhat unclear. He reported having neared the top of the ladder when he fell, with the ladder falling beneath him. He said he had never been up the ladder previously or been told to ensure it was footed. This was disputed by the claimant's colleagues, who told the court that he had performed the task several times before, always with the ladder footed, and had in fact informed another colleague of the importance of this.

Further, it was heard that a short time before the incident itself he had requested assistance footing the ladder and had been advised that this would be provided 'in a couple of minutes'.

Findings at first instance

The judge resolved the factual dispute between the parties by preferring the evidence of the claimant's colleagues and finding that the claimant had climbed the ladder before and knew that it should be footed.

Allegations were made under the Health and Safety at Work Act 1974 and in the judgment regulations 4, 5, 6(1) - (2) and 7 were considered. A number of 'significant and serious breaches of statutory duty' were identified. The judge found that the manager had not undertaken even the most cursory health and safety training and so was not competent to engage in the organisation and planning of work at height. The judge focused in particular on breaches of provisions 6(2) and 7(2):

It was held that the expression "reasonably practicable" placed a burden on the defendant to show that it was disproportionate to the risk to require the goods to be stored elsewhere than in the loft. On considering the evidence the judge found that, on moving to premises with more goods than they could conveniently store, the defendant ought to have redoubled their efforts to store them elsewhere or sell them off. This was reinforced by the fact that the defendant did move and then eventually sell the spoilers post incident. The defendant's own, internal inquiry also concluded that storage must be managed elsewhere than at height.

On considering regulation 7(2) the judge found that, if the loft was to be a serious storage area, it would have been possible to install a fixed, pull down ladder at a cost of no more than a few hundred pounds and that, in his view, this was not done due to economic considerations.

He held that the regulations are designed to protect the health and safety of employees against decisions

which are taken on the basis of keeping costs low as opposed to protecting their safety.

Contributory negligence

Although the defendant was found to have principal responsibility for exposing the claimant to a risk to which he should not have been exposed, he was found one third contributory negligent on the basis that, if the system that was devised had been properly followed, he would have avoided injury.

On appeal

Lord Justices Richards, Sullivan and Sedley heard the appeal. The defendant's primary argument was that the claimant was wholly to blame for the accident given that, if the ladder had been footed, the accident would probably not have occurred; something which the claimant had accepted in evidence.

In the alternative it was suggested that the judge had erred in finding the defendant in breach of the Regulations, as the findings lacked an adequate foundation in the evidence or failed to take into account relevant considerations such as the size of the business, the number of spoilers being stored, that it was dwindling stock, that the system had been used previously without incident and also that access to the loft was not required on a regular basis.

The Appeal Lords dismissed the appeal. Lord Justice Richards confirmed that it was correct for the trial judge to have started with the Regulations, rather than the claimant's conduct. He warned that the regulations are directed at avoiding or minimising the risks inherent in working at height, such that it should be avoided altogether if reasonably practicable, or if not, the selection of work equipment must be appropriate:

"The employer's breach of duty will ordinarily be found to be causative... Albeit the employee's failure to follow the prescribed system may amount to contributory negligence."

LJ Richards went onto say that there had indeed been a breach of Regulations 6(2) and 7(2). Although the showroom manager had given evidence that he had exhausted all other possibilities before deciding to store the spoilers in the loft, his evidence on the subject was held to be far from conclusive. He also agreed that a moveable ladder was not appropriate as a fixed ladder could have been installed relatively cheaply. The breaches were said to have exposed the claimant to an unacceptable risk and precisely the very kind of event that the Regulations are aimed at preventing.

Word of warning from the courts

The message from both the courts is that, if there has been a breach of the Regulations and an accident has occurred as a result, fault will always attach to the employer in the first instance, regardless of the claimant's conduct, even if the accident would otherwise have been avoided, leaving contributory negligence arguments only.

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The judge in the witness box

For entertainment value if not for realism, it would be difficult to beat the episode of 'Blackadder Goes Forth' in which the eponymous Captain is court-martialled for the murder of his commanding officer's carrier pigeon. The trial judge, General Melchett, doubles up as the chief prosecution witness. Not unexpectedly the outcome of the trial is a conviction, but as solicitor Richard Hackett describes, legal purists may be reassured by the eventual reversal of the decision on grounds of procedural irregularity.

In reality, of course, a judge would never enter the witness-box. A few years ago, however, I represented a hospital claims manager in a boundary dispute where the judge must have been sorely tempted to do so. At an early stage of the trial, the judge made a site visit and suggested it would be helpful if the lawyers were to take a few measurements of the disputed territory, anticipating that they would be agreed. The judge then supervised while the barristers measured various dimensions and shouted them out for the solicitors to note down.

All went according to plan until the resumption of the trial when the other side decided to sack their legal team and go forward without representation. They also challenged the accuracy of

the site measurements taken earlier in the day. Without agreement, the measurements had to be proven. The ideal witnesses would have been the judge or counsel but, neither of them being at liberty to give evidence, I suddenly found myself in the box having to answer questions from my own counsel such as: "*Please tell the court what you were doing at 11 am this morning*". This was followed by a few minutes of cross-examination as the opposing litigants-in-person sought to establish that my evidence had been completely fabricated! It was no great surprise when the judge made findings of fact from the measuring over which he had himself presided and ordered the other side to pay costs on the indemnity basis.

The judge and findings of fact

In the normal type of legal case, the court should only make findings of fact on the basis of evidence received during the trial. The only exception is that 'judicial notice' can be taken of facts that are so much part of common knowledge that they require no proof at all.

The judge as expert

How about matters of opinion? In many clinical negligence cases the outcome does not depend on questions of fact, but upon conflicting expressions of opinion by expert witnesses. There have been two Court of Appeal judgments in 2010 concerning the extent to which a judge must be guided by expert evidence in deciding such cases. It is

interesting to compare the decision in [Huntley -v- Simmons](#) in February 2010 with that in [Smith -v- Hammond](#) four months later.

[Huntley -v- Simmons:](#) first instance decision

In assessing future care in a personal injury claim, Mr Justice Underhill concluded that there was likely to be a future decrease in the claimant's behavioural problems if he received the appropriate level of support. He reached this conclusion despite the agreement between the experts in neuropsychology – confirmed in their joint statement – that there were no prospects of an improvement in his behaviour.

As for the parties' care experts, their respective assessments of the claimant's future care requirements were at different ends of the spectrum, but the judge was unimpressed by their evidence and did not accept either view. Instead he made his own assessment of the amount of care the claimant would need.

The judge also held that care should not have been claimed for time spent by family members in visiting the claimant when he had been in hospital, especially as for much of that time he was in a coma.

[Huntley -v- Simmons:](#) Court of Appeal judgment

The claimant brought the appeal, contending that the judge was not entitled to disregard the joint statement of the experts on the prospects of behavioural improvement. A further ground of the appeal was the contention that, having rejected the evidence of the defendant's care expert as inadequately based on the medical evidence, the judge was wrong to ignore the recommendations of the claimant's care expert and to make his own assessment of future care unsupported by any expert evidence. The judge was accused of plucking figures from the air.

The appeal was dismissed. The basis

of this judgment is the principle that ultimately issues of fact and assessment are for the judge. The evidence of experts may be important but is nevertheless only evidence which the judge must assess with all other evidence.

Lord Justice Waller observed that *"...If there is no evidence to contradict the evidence of the experts it will need very good reason for the judge not to accept it and he must not take on the role of expert so as to, in effect, give evidence himself."*

However, he went on to confirm that a court is not bound to make findings in accordance with the experts' joint statement even where there is no disagreement between the experts. He indicated that, in such a case, it is possible for a litigant to agree to the joint statement being received in evidence without the need to call the experts but still to reserve the entitlement to argue that the joint statement is simply evidence that must be assessed as part of all the evidence.

[Smith -v- Hammond:](#) first instance decision

The judge decided issues of liability arising from a road traffic accident in favour of the claimant, a teenager knocked off his bicycle by a lorry. The judge found that the lorry driver was negligent in failing to sound his horn as a warning to the cyclist.

The lorry insurers relied on the evidence of Dr Searle, a well-known expert in accident reconstruction. According to his expert opinion, there would have been insufficient time for the cyclist to react and avoid the collision if the horn had been used. There was no other expert evidence conflicting with that of Dr Searle on this issue.

The judge rejected Dr Searle's evidence and made the finding that, if the lorry's horn had been sounded, there would have been sufficient time for the cyclist to steer away from danger. The judge preferred to rely on his own experience of reacting to the sound of a horn when driving. He thought it probable that the

claimant's response time would have been faster than Dr Searle believed.

[Smith -v- Hammond:](#) Court of Appeal judgment

The lorry insurers appealed. They argued that the judge had been wrong to reject unopposed expert evidence.

The Court of Appeal agreed and, in allowing the appeal, criticised the judge for regarding his own perceptions and experience as more reliable than the opinion of an expert who sought to describe such matters in 'scientific terms'. The temptation to do so when dealing with matters of everyday experience should be resisted by judges, said Lord Justice Moore-Bick in his judgment, if only because the layman's perception of that kind might be wide of the mark. He considered that there had been no satisfactory grounds for rejecting the expert's evidence on the horn issue and the judge had not been entitled to resort to his own experience to provide a basis for a different finding.

Comment

These two Court of Appeal rulings are not especially easy to reconcile with each other but, even in the second, it was expressly affirmed that a judge is not bound to accept an expert's opinion if he has good grounds for not doing so. In the other case, the trial judge's decision was allowed to stand because he set out fully in his judgment the grounds for rejecting the expert evidence and he could refer to other evidence on which to base his views.

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Clinical negligence workshop

Hill Dickinson is holding a complimentary interactive clinical negligence training day on Thursday 18 November at our offices in Liverpool.

Based on our successful mock trial event, the workshop will be presented by Richard Watson, head of the NHSLA team at Hill Dickinson, and Charles Feeny, barrister from Liverpool Civil Law Chambers.

Delegates will be given practical guidance on clinical negligence issues which arise in all cases such as gathering documentation, the involvement of factual and expert witnesses and preparing staff to give oral evidence in court.

We will also apply a 'real-life' perspective by examining a number of cases we have taken to trial over the last 12 months. Throughout the day, we will be running an interactive quiz (including prizes!!).

The workshop is ideally suited for those involved with handling NHS clinical negligence matters including legal managers and claims handlers.

Thursday 18 November

09:30 Arrival and refreshments
 10:00 Seminar begins
 12:30 Networking lunch
 15:00 Close

Venue

Hill Dickinson LLP, No.1 St. Paul's Square, Old Hall Street, Liverpool, L3 9SJ

RSVP

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The Hill Dickinson Group offers a comprehensive range of legal services from offices in Liverpool, Manchester, London, Chester, Sheffield, Piraeus and Singapore. Collectively the firms have more than 1,300 people including 190 partners.

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