

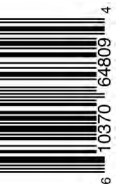
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# THE EXPERT WITNESS

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# Welcome to the Expert Witness Journal



Hello and welcome to the 31st edition of the Expert Witness Journal, I hope everyone is keeping safe and well. It is an unprecedented situation that we find ourselves in. We are operating as usual, and hope that all experts are continuing in their roles as much as they can. We have posted articles and news items regarding video conferencing and remote working on our website.

In this edition we are focussing on Personal Injury, with a great range of articles including an excellent piece on Food Hypersensitivity from Belinda Stuart-Moonlight, The Medicolegal Challenges of Fibromyalgia by Dr Chris Jenner and a very interesting article from Dr MJ Rowland-Warmann.

As usual we also include articles on a wide range of topics, including “What does a Court Want From an Expert Report”, the Perils of Playing Professional Football and an inspiring article by Sarah Green of the Katie Piper Foundation on the new Rehabilitation Centre for the Survivors of Burns and Scars.

Our next issue is concentrating on the non-medical side of Expert Witness work. If you would like to submit or comment on any articles, please contact myself at the email below.

Many thanks for your continued support and I hope you all stay safe.

Chris Connelly

*Editor*

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# Dentists Urged to Support National Survey of Antibiotic Prescribing

Six national dental organisations are encouraging dentists to participate in a new survey of antibiotic prescribing in dentistry.

The Faculty of General Dental Practice UK (FGDP), the British Dental Association (BDA), the Association of Clinical Oral Microbiologists, the Association of Dental Hospitals, the British Association of Oral Surgeons and the dental sub-group of the Scottish Antimicrobial Prescribing Group all support the initiative, which aims to build an understanding of dentists' knowledge of, and attitudes toward, the prescribing of antimicrobials.

The survey, open to all practising dentists as well as trainees and students, is available until 31 May 2020. Participants are awarded a certificate for one hour's CPD, and the incorporated educational material covers the main national resources for antimicrobial prescribing and prophylaxis in dentistry, indications for the use of antimicrobials to manage dental infections, and key points from the NICE antimicrobial stewardship guidelines.

Antibiotic-resistant infections already cause an estimated 25,000 deaths each year in Europe, and 700,000 worldwide. Their incidence is expected to increase markedly over the next 20 years due to over-prescribing, leading to even simple surgical procedures becoming high-risk due to the potential for post-surgical infection with resistant micro-organisms.

Since 2015, all healthcare providers in the UK have had a statutory duty to reduce the risk of antimicrobial resistance by ensuring appropriate use of antibiotics. While there has been a steady reduction in the number of antibiotic prescriptions issued in NHS primary dental care over recent years, the sector still accounts for around 5-7% of NHS antibiotic prescriptions, and an estimated one in six patients are prescribed antibiotics each year as part of their NHS dental treatment.

Dr Nick Palmer, a member of the BDA's Health and Science Committee and Editor of the FGDP's Antimicrobial Prescribing for General Dental Practitioners guidance, commented:

"Dentists have a significant role to play in keeping antibiotics working by ensuring that every prescription for antibiotics is based on clinical need and national guidelines, and by educating patients to take and dispose of antibiotics responsibly. I urge colleagues to take the prescribing survey in order to support this vital work and refresh their knowledge of this important aspect of clinical practice."

## Antibiotic resistance in dentistry

Dentists have a role to play in reducing the amount of antibiotic prescribing. We are campaigning for properly funded urgent treatment slots and we have called for a removal of the pressures that push dental patients to GPs, to help bring down antibiotic prescribing rates.

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Ms Mary Lo is a consultant and specialist orthodontist with over 25 years' experience in the dental profession.

She is the lead clinician of the Orthodontic Department at the Chelsea and Westminster Hospital. Her broad experience includes running various monthly multi-disciplinary clinics with craniofacial surgeons, maxillofacial surgeons, paediatric dentist and respiratory medical physician.

She has a thorough knowledge of clinical dentistry to assess the standards and liability of the condition, causation and prognosis in relation to orthodontics, orthognathic osteotomy surgery, craniofacial deformity, cosmetic dentistry, misdiagnosis, child neglect, dental neglect as well as record keeping and consent.

Ms Lo has successfully treated an extensive number of patients who have complex facial deformity, skeletal discrepancy, impacted teeth, hypodontia (missing teeth), obstructive sleep apnoea and medically compromised.

Since appointed as a Consultant Orthodontist in 2006, Ms Lo has regularly provided dental reports for solicitors acting on behalf of defence and prosecution teams.

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# Paying the Price for Expert Shopping: Burke v Imperial Healthcare [2019] EWHC 3719 (QB)

*David Sanderson successfully appeals against a case management order inadvertently permitting expert shopping.*

The judgment of Tipples J serves as a sharp reminder to parties who seek permission to change experts that they will be expected to notify the other party of their intention in advance of the hearing. Failure to do so will impose on them a duty to make full and frank disclosure and to ensure that all material information, both as to the law and the facts, is placed before the court. It is necessary to remind the court of the general rule that a party who seeks to change experts will be permitted to do so only on condition it discloses all the written evidence obtained from the former expert. To displace this general rule, the court will need to be satisfied that there is no hint of expert shopping and no attempt to withhold relevant information.

## Background

This appeal is born out of a claim of clinical negligence in connection with a partial nephrectomy performed on 10 February 2015. At the first CCMC, no directions were given for expert evidence as mediation was anticipated. Mediation failed and, at the second CCMC, the Master gave the defendant permission to adduce expert urology evidence from Mr Mark Sullivan, in place of Mr Christian Brown, who had been named in the Defendant's Directions Questionnaire. No condition was imposed requiring Mr Brown's reports to be disclosed, because the Master was satisfied, on the basis of defendant counsel's submissions, that there had been no expert shopping.

## Grounds of Appeal

David Sanderson for the claimant was given permission to appeal by Mr Justice Stewart on two grounds:

- 1, The decision of the Master to permit the defendant to allow the expert urological evidence of Mr Mark Sullivan in place of that of Mr Christian Brown was unjust because it was made in response to an oral without notice application, unsupported by evidence, and without hearing full legal argument;
- 2, The master was wrong to refuse to require the defendant to disclose all written expert evidence obtained from Mr Christian Brown as a condition of being granted permission to rely upon the expert urological evidence of Mr Mark Sullivan.

## The Facts

The Claimant underwent an open partial nephrectomy in February 2015. During the surgery his bowel was perforated by the operating surgeon. The injury went unrecognised at the time and for a week

following the operation. After significant pain and abdominal distension, the Claimant underwent an emergency laparotomy to remove the damaged section of bowel and to carry out a defunctioning ileostomy, forming a stoma in the abdomen. The Claimant wore a one piece stoma system for 3.5 months after which the ileostomy was reversed in a further operation. Thereafter, the Claimant developed a complex incisional hernia that required a further surgery to fit a mesh, and he has continuing intrusive symptoms that have prevented a return to work and greatly reduced his quality of life. His allegations are three-fold:

- 1, The surgery was poorly performed leading to the perforation of the bowel;
- 2, The post-operative care was poor which led to a delayed discovery of the perforation and unnecessary pain and suffering
- 3, The Claimant was not properly consented for the partial nephrectomy because the alternative minimal access surgery (robotic partial nephrectomy) was not discussed.

The Defendant (i) denies the first allegation, and contends the Claimant was advised as to the risk of a bowel perforation; (ii) admits that post-operative care was poor; and (iii) admits that the alternative surgery was not offered, but denies breach, in that minimal access surgery was not an option because the only suitably qualified member of staff was unwilling to perform the operation in view of the location of the tumour.

## The Legal Principles

Tipples J set out the basic principles about which any court hearing an application on a without notice basis should be informed. These can be broken down as follows:

- ◆ Per *Coyne v Morgan* (2016) HHJ David Grant, the court has a wide and general power to exercise its discretion whether to impose terms when granting a party permission to adduce expert opinion;
- ◆ Per *Edwards-Tubb v JD Weatherspoon PLC* [2011] EWCA Civ 136 that a power to impose a condition of disclosure of an earlier report is available where the change of expert occurs pre-issue as it is when it occurs post-issue. It is a matter of discretion which should usually be exercised where the first expert reported after the parties engaged with each other in the process of the claim;

◆ Per *Vilca v Xstrata Ltd* [2017] EWHC 1582 (QB), the object of imposing a condition that reports of previous experts should be disclosed is to prevent expert shopping and to ensure that full information is available. If there is a hint of undesirable expert shopping, or that significant relevant material is being withheld, the imposition of the condition will be the usual order.

The principal issue in the case was then whether or not the court should depart from the usual order and allow the change of expert without an order for disclosure of the original expert's reports. That being so, Tipples J gave the following guidance:

◆ In line with *Coyne*, the court's discretion as to whether to impose a term when giving permission to a party to adduce expert opinion evidence arises irrespective of the occurrence of expert shopping;

◆ When the court chooses not to impose a condition giving permission to adduce expert evidence, the court must understand why it has departed from the general rule and the factual basis for that. Without a full explanation from the applicant making clear there is no expert shopping, there will always be a suggestion of expert shopping which is itself sufficient to give rise to the imposition of a condition requiring disclosure of the previous expert's report;

◆ Any application to change experts should be notified to the other party in advance, so that party has the requisite opportunity to consider the proposed application and respond appropriately.

◆ Where a party does not put the other side on notice and seeks to make an application for the first time at a CMC, that party is under a duty of full and frank disclosure. For the purposes of this appeal, that duty extended to all matters necessary to show the court that there was no hint of expert shopping, nor withholding of relevant information.

It was common ground that, on appeal against a case management decision, the appeal court cannot interfere unless the decision is plainly wrong. Per Lord Neuberger in *Prince Abdul Aziz* in the Supreme Court [2014] UK SC64, it must be shown that the decision was outside the generous ambit where reasonable decision makers would agree. The Claimant did not dispute that the defendant should be entitled to instruct a second expert in place of the expert originally instructed, the only dispute was as to the terms on which the defendant should be permitted to do so.

### **The Chronology**

Tipples J produced a procedural chronology which focusses on the extent of the Defendant's relationship with Mr Brown. The judge made explicit reference to each point at which the Defendants sought the expert advice of Mr Brown. These were:

◆ 19 October 2016 – to respond to the original letter of claim;

◆ 18 April 2018 – to respond to the second letter before claim;

◆ 29 November 2018 – to prepare the Defence. Thereafter the following dates were relevant for the same purpose:

◆ 14 December 2018 – the Defendant completed and served the directions questionnaire. It answered the question 'have you already copied any expert report(s) to the other parties?' by ticking the 'no' box. Mr Brown is then identified in section E of the form as the expert urologist;

◆ 21 December 2019 – the Defendant's cost budget included costs relating to an expert urology report;

◆ 14 January 2019 – the first CCMC produced an order expressly stating that, if mediation fails, the next CCMC would be on 30 July 2019;

◆ 21 June 2019 – the Defendant held a conference with counsel and Mr Brown at which Mr Brown confirmed he had very limited experience of robotic partial nephrectomy as a consultant;

◆ 24 June 2019 – Mediation failed;

◆ 24 July 2019 – the Claimant's solicitors sent draft directions to the Defendant's solicitors;

◆ 25 July 2019 – The Defendant's solicitors replied to the extent that they cannot agree the directions and will revert with further draft directions. The Claimant's solicitors responded that they were surprised that Defendant could not agree areas of dispute and informed that they intended to rely upon an expert histopathologist;

◆ 30 July 2019 – the second CCMC took place, at which, towards the end of the hearing, the Defendant for the first time gave no notice that they wished to instruct Mr Sullivan in place of Mr Brown. The Defendant's counsel assured the Master that "there is no issue of expert shopping, this matter is simply beyond his expertise and he cannot assist the court. His current report is not Part 35 compliant." The Master accepted these submissions and did not impose a condition that Mr Brown's report be disclosed.

### **The Judgment**

Tipples J highlighted that:

1, The Defendants had provided no substantive response to the Claimant's draft directions before the hearing;

2, The Defendant had not informed the Claimant that it no longer wished to instruct Mr Brown as a urology expert at trial, but wished to instruct Mr Sullivan, although it knew of this intention before the hearing.

The judge was satisfied that the information provided to the Master by Defendant's counsel was "incomplete, wrong and, as a consequence, misleading": The Defendant's counsel told the Master that: 1, Mr Brown was not sufficiently experienced to prepare a part 35 liability report that would provide useful expert evidence to the court;

2, Mr Brown's involvement was very limited and only at a very early stage of proceedings "in responding to the letter of claim";

3, Mr Brown's involvement added nothing to the case.

The true extent of Mr Brown's expertise and his involvement in providing expert evidence to the Defendant contradicted these submissions. The evidence before Tipples J revealed that: (i) in the five year period before February 2015, Mr Brown performed over 250 radical and partial nephrectomies and over 800 robotic operations (albeit no robotic partial nephrectomies as a consultant); (ii) Mr Brown's urological colleague at Guy's Hospital, Mr Ben Challacombe, is the highest volume surgeon for robotic partial nephrectomies; (iii) Mr Brown had attended hundreds of multi-disciplinary team meetings with Mr Challacombe and gained much experience relating to the appropriateness of robotic surgery for particular kidney tumours.

Tipples J held that the Master had been misled into making an order which was wrong. Allowing the appeal she held that there was "more than a hint of expert shopping", and that the court should impose the usual condition requiring disclosure of all the written evidence produced by Mr Brown, as a condition of being permitted to rely on the evidence of Mr Sullivan.

Final Judgement can be found here;  
[//www.12kbw.co.uk/wp-content/uploads/2020/02/Burke-v-Imperial-Healthcare-2019-EWHC-3719.pdf](http://www.12kbw.co.uk/wp-content/uploads/2020/02/Burke-v-Imperial-Healthcare-2019-EWHC-3719.pdf)

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Dr Harriss has served in a variety of NHS, charitable, and private roles, including Medical Director of Queen Elizabeth's Foundation for Disabled People and Clinical Lead Consultant in Rehabilitation Medicine at King's College Hospital London and Honorary Senior Lecturer at KCL. He was until 2016 Clinical Lead in Rehabilitation Medicine at the Lane Fox Clinic, St Thomas Hospital.

Dr Harriss offers medico-legal assessments and clinical leadership for multi-disciplinary evaluations and treatments, including focal and systemic spasticity treatment with botulinum toxin. He provides medico-legal evaluations for public and private health insurers and expert testimony, and ongoing Clinical Leadership. Assessments are conducted either in his clinic at Harley St or if preferred domiciliary.

Dr Harriss also is a board/expert panel member of the Independent Neurorehabilitation Providers' Alliance (INPA), UK Acquired Brain Injury Forum (UKABIF) and the British Polio Fellowship, and he serves on the Executive Board of the British Society of Rehabilitation Medicine.

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# Can Defendants Rely on Life Expectancy Expert Evidence Following Dodds?

by *Lea Brocklebank and David Williams at DAC Beachcroft*

The question of whether a Defendant can rely on expert evidence on life expectancy in a high value personal injury claim has been considered by the Courts in recent judgments. On 8 November 2019, the High Court considered this question in *Russell v Davies*.

The Claimant pursued a claim for personal injuries following a road traffic accident on 6 May 2015 in which he suffered a severe head injury. The Defendant applied for permission to adduce expert evidence on life expectancy from a physician, albeit the report was based on statistics, contending that a number of factors affected the Claimant's life expectancy and that the expert evidence was reasonably required to resolve the proceedings. The Claimant opposed the application, asserting that the expert evidence of the medical experts dealt with the questions of life expectancy and that a combination of their expert evidence and the Ogden Tables was sufficient to enable the Court to resolve the claim without further expert evidence.

The factors to be considered by the Court in deciding whether expert evidence in an additional discipline should be allowed, whether the expert evidence is reasonably required to resolve the proceedings, as set out in *British Airways plc v Spencer* and others and the recent High Court decision in *Dodds v Arif* and *Aviva Insurance* were reviewed by Her Honour Judge Walden-Smith.

In *Dodds* the Master refused the Defendant permission to rely on expert evidence on life expectancy and set out the proposition that permission to rely on expert evidence in this field should not be given where the injury in the claim has not impacted on life expectancy unless the Claimant is atypical, that where the injury has impacted on life expectancy the normal route is for the medical experts to give expert evidence on life expectancy, and that permission to rely on bespoke life expectancy expert evidence will not normally be given unless the medical experts cannot offer an opinion at all or state that they require specific input from a life expectancy expert.

Granting permission to the Defendant to rely on expert evidence on life expectancy in *Russell*, the judge concluded that it would be of considerable assistance to the Court in this matter. The medical experts had caveated their opinions and the Claimant's history of ADHD, smoking and illegal drug use in combination with the increase in his risk of developing epilepsy as a consequence of his injuries meant that the Claimant was atypical and fell outside the cohort on which the Ogden Tables are based.

This judgment should be taken into account alongside *Dodds* when considering whether expert evidence on life expectancy should be sought, and demonstrates that, in appropriate cases, permission will be granted by the Court.

**DAC Beachcroft** represent the Defendant in this matter.

Our Complex Injury team deal with a wide variety of cases on a daily basis. For more information or advice, please feel free to contact one of our legal specialists.

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To view the original article please see,  
<https://bit.ly/2XizqVW>

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# RCOphth Receives Funding Boost to Improve Patient Outcomes

*The Royal College of Ophthalmologists is delighted to announce it has received more funding to support the National Ophthalmology Database (NOD), in a move that will continue to improve patient outcomes and reduce surgical errors.*

The sum of £80,000 a year for 3 years comes from Alcon, a leading Surgical and Vision Care Ophthalmology manufacturer, signifying an effective partnership between industry and the RCOphth to use real world data to improve outcomes for patients undergoing cataract surgery.

“Alcon is delighted to be partnering with the National Ophthalmology Database and Royal College of Ophthalmologists. As the global leader in eye care we are committed to ensuring that we continue to develop innovative technologies and solutions with patient outcomes and health system specific benefits at the centre of what we are trying to achieve. This partnership is a great opportunity to future-proof the ability of the NHS to measure these outcomes through objective means, both now and in the future.” Mike Turner Surgical Business Unit Head UK & Ireland

Further funding has also been committed by Bausch + Lomb in a one-off sum of £10,000. This investment will ensure the highest standards of quality assurance and improvement, helping to facilitate cutting edge research that will maximize the efficiency of NOD data.

Since its inception, NOD has demonstrated significant clinical and economic benefits, including:

- ◆ A 38% overall reduction in PCR complications since 2010
- ◆ In the 2017-18 only 1.2% of operations were affected by PCR
- ◆ A 37% overall reduction in visual acuity (VA) loss since 2010
- ◆ Reduction in PCR complications since 2010 equates to 3,400 fewer complications annually across the NHS
- ◆ Cost saving from avoided PCR complications of £2 million per annum
- ◆ Close to 100% data completeness for PCR outcomes, currently a compulsory field in Electronic Medical Records

Alongside the support of industry, RCOphth’s lobbying has resulted in NODs potential being recognised at the highest levels of government and the health service. In a letter to RCOphth President Mike Burdon, Nadine Dorries, Minister for Health praised the ‘striking’ economic and clinical benefits offered by NOD, having the potential to eradicate variation in cataract surgery and reduce surgical errors.

Reacting to the announcement, Mike Burdon, President of RCOphth said: “This investment by Alcon demonstrates how crucial partnerships between industry the college and are in sustaining projects that make a real difference.”

“With NOD being at the forefront of reducing complications, achieving high data completeness and resulting in considerable savings for a stretched health service, contributions by Alcon and Bausch + Long will allow us to continue and improve an already high performing service.”

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## Mr Kim Hakin

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# New Imaging Technique Unlocks Secrets of the Zebrafish Heart

*Scientists develop a new type of 3D microscopy to capture the growing hearts of zebrafish embryos for the first time, which could also teach us more about how the human heart develops, grows and heals. This is according to research part-funded by us and published in Nature Communications.*

The development of the zebrafish heart begins in a similar way to humans, making them very useful for heart research. In the zebrafish the heart beats several times every second. It is this constant motion that tends to create blurry images, making it difficult to study the images in depth.

Researchers at the University of Glasgow and University of Edinburgh have developed a way to gather many images of the heart into a 3D image layer-by-layer over 24 hours to produce a time-lapse video. The computer program is able to control exactly when to fire lasers for imaging, which means that the growing and dividing cells in the beating heart can be viewed with great detail for the first time.

Dr Jonathan Taylor, lead researcher at the University of Glasgow, said: "This lets us watch continuously as the heart forms over the course of a whole day, without causing any harm to the fish. It's pulled back the veil on processes such as cell division within the heart which we just didn't have any way to visualise before."

## From imaging to future treatments

Dr Martin Denvir, co-author at the University of Edinburgh, said: "There are two very promising potential applications of this new technique. Firstly, now that we can see detailed images of the growth of the heart on a cellular level, we hope to be able to apply that new knowledge to develop treatments for abnormal heart formation in the future.

"Secondly, we've been able to observe immune cells travelling to injured areas of the heart, which could help us guide the modification of immune response to more effectively treat cardiac inflammation and heart disease."

The research was also funded by the Engineering and Physical Sciences Research Council and the Royal Society of Edinburgh.



**Prof Saul Myerson**  
Consultant Cardiologist  
MB ChB MD FRCP FESC

Consultant Cardiologist, Associate Professor of Cardiovascular Medicine, and Clinical Lead for cardiac imaging in Oxford, with specific expertise in diagnostic testing, including all forms of cardiac imaging and functional cardiac assessment.

Professor Myerson is based in the internationally-renowned cardiac MRI department in Oxford and provides expert advice on all areas of cardiology including cardiomyopathy, coronary disease, heart valve disease and aortic disease.

He produces around 50 expert reports a year, for both claimant and defence teams, including many national solicitors, the Medical Protection Society and Medical Defence Union, and is also an expert witness for the GMC. His experience includes the High Court and employment tribunals, as well as criminal cases and for the Court of Protection. Professor Myerson also holds a Cardiff University Bond-Solon expert witness certificate in civil law.



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## Dr Duncan Dymond

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Dr Duncan S Dymond has been a consultant cardiologist at St Bartholomew's Hospital, now a part of Barts Health NHS Trust since 1987.

He has been undertaking expert witness and medicolegal work for more than 5 years and has completed his Cardiff University Bond Solon expert Witness course.

Dr Dymond currently completes 1-2 medicolegal reports per week, for personal injury and medical negligence, with roughly a 60/40% split claimant/defendant.

He has also completed expert witness work for the General Medical Council, the Medical Defence Union and the Crown Prosecution Service as well as accepting private instructions directly for solicitors. He has also provided medicolegal opinions for cases in Singapore.

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# New Guidance for Therapists with Clients Taking Prescribed Drugs

*New guidance from the BPS and its partners, published today, gives psychological therapists the information they need to help clients struggling with side effects and withdrawal issues which have resulted from an increase in the prescription of psychiatric drugs.*

**Guidance for Psychological Therapists:** Enabling conversations with clients taking or withdrawing from prescribed psychiatric drugs was produced following Public Health England's acknowledgment of the growing problem of prescribed drug dependency and withdrawal in its recent ground-breaking report.

The guidance means clients will be better supported to understand the difference between emotional distress, relapse and the side and withdrawal effects of psychiatric drugs.

A 2019 survey of psychological therapists revealed that most work with clients who have taken, or are taking, psychiatric drugs. Fewer than one in ten felt their training equipped them to deal adequately with client's questions on this topic.

Our chief executive Sarb Bajwa said: "We strongly recommend this guidance to psychological therapists. Our members have continually

told us they need more support to work confidently with clients taking or withdrawing from prescribed drugs.

"The evidence reviewed in this guidance provides an up-to-date summary of the main effects, adverse consequences and possible withdrawal reactions of psychiatric drugs."

The guidance, facilitated by the All-Party Parliamentary Group for Prescribed Drug Dependence in the last parliament, has been steered and endorsed by the four psychological therapy organisations that represent 80,000 of the UK's psychological therapists, and by senior clinicians and researchers in the field.

They are the British Psychological Society, UK Council for Psychotherapy, British Association for Counselling and Psychotherapy and National Counselling Society. The National Survivor User Network has also endorsed the guidance.

## Dr Maurice Pye

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### Consultant Cardiologist



I am a Consultant Cardiologist with more than 15 years experience. I have a wide experience in all aspects of cardiology, particularly ischaemic heart disease (angina, heart attacks), interventional Cardiology (balloon angioplasty /stents), heart rhythm disorders and pacemakers.

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# New Research Aims to Improve Healthcare for Cancer Patients with Heart Disease

A new study led by cardiologists at Keele University could have a significant impact on treatment procedures for people with both cancer and heart disease after a major analysis revealed significantly worse health outcomes for patients with both of these conditions.

The study, led by members of Keele's Cardiovascular Research Group alongside international colleagues, looked at data from 6.5 million patients in the USA who were treated for a heart attack as well as having a current or historical diagnosis of cancer.

The aim of the research was to determine whether patients with heart disease who had also received a cancer diagnosis had significantly worse health outcomes than those who hadn't, looking at differences in their treatment and the types of cancer they were diagnosed with.

The results, which have been published in the European Heart Journal, showed that those patients who had received a cancer diagnosis suffered from significantly worse health outcomes following a subsequent heart attack than those who hadn't previously received a cancer diagnosis, with lead author Professor Mamas Mamas saying that the variations in

treatment plans between these groups could be a contributing factor.

Professor Mamas suggests that cardiologists may have been reluctant to treat the heart attack in cancer patients using invasive methods involving coronary stents due to concerns about safety, but argues that these findings present a compelling case for considering these treatment options in the future.

Professor Mamas said: "Our analysis suggests that one in ten patients presenting with a heart attack will have a history of current or historical cancer and yet we have little data about how best to treat these patients.

"Our work shows that cancer patients are treated less invasively with coronary stents following a heart attack, and so their clinical outcomes are much worse, depending on both the type and stage of cancer. Our findings suggest that cancer patients with a heart attack who are treated with stents do much better than those without.

"This work will raise awareness of the suboptimal care received by cancer patients and provide clinicians with more data to give the best possible treatment to patients."

## Dr Mark A Walsh Consultant Cardiologist

MB, MRCPI, MRCPCH (Lon)



As a medical expert witness in paediatric cardiology, Dr. Walsh can provide medicolegal reports in selected cases. He is able to provide opinions and testimony based on his experience as a congenital cardiologist and arrhythmia specialist.

His expert witness services support the medicolegal process in all its phases, including evaluating whether the standard of care was met or breached, testifying in court, or assessing damages based on causation and presumed longevity.

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- Pacemakers (adult and paediatric)
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# Court of Appeals to Review New Expert-Testimony Requirement for Medical Malpractice Defendants Asserting ‘Empty Chair’ Defense

by Derek M. Stikeleather and Sean Gugerty at Goodell, DeVries, Leech & Dann, LLP

Although it is well-established Maryland law that a medical negligence plaintiff must support her claim with expert testimony, the Court of Special Appeals recently issued the first Maryland appellate decision to hold that defendants have the same obligation when asserting an "empty chair" defense. *Reiss v. Am. Radiology Servs., LLC*, 241 Md. App. 316 (2019). The well-established "empty chair" defense asserts that a non-party's negligence caused the alleged injury.[i] Under *Reiss*, those asserting the defense now must elicit "expert testimony, to a reasonable degree of medical probability, that the non-party breached the standard of care." [ii]

Although the rule announced in *Reiss* is relatively straightforward, the holding's full implications remain unclear for litigants in medical negligence cases. The Court of Appeals may address these issues on February 6 at oral argument in *Reiss*. The court can resolve an important unanswered question: Can defendants elicit the testimony from a properly qualified plaintiff's expert? The Court of Special Appeals' reasoning in *Reiss* and existing Maryland law should allow it.

## The "Empty Chair" Defense in a Multi-Defendant Case

Medical malpractice plaintiffs often bring claims against multiple defendants and have long been required to certify expert opinions that each defendant was negligent. But trial strategy can fundamentally shift if plaintiffs settle with or voluntarily dismiss one or more defendants on the eve of trial. After a partial dismissal, plaintiffs would want to downplay the fact that their expert had certified (and presumably explained in detailed sworn deposition testimony) that the dismissed defendant was negligent and a cause of the injury at issue. The remaining defendant would naturally want to present its now-mandatory expert opinion supporting its empty-chair defense at trial from the plaintiff's own expert(s), who has already committed to that position. It should be allowed to do so during the plaintiff's case-in-chief when it cross-examines the expert.

## Facts and Procedural Background of *Reiss*

Plaintiff Martin Reiss's medical malpractice complaint alleged that his doctors failed to detect and treat his cancer. He named several defendants, including a urological surgeon (and his practice) who

removed plaintiff's cancerous kidney in 2011—without removing (or biopsying) a cancerous lymph node—and the radiologists (and their practice) who interpreted the subsequent CT scans looking for any signs of cancer in the lymph node.[iii] Before trial, Reiss dismissed his claims against the urological surgeon and his practice.[iv]

At trial, Reiss presented expert testimony that, if the radiologists had detected the cancer in the lymph node between 2011 and 2014 (and prompted its surgical removal), his cancer would have been cured.[v] The radiologist defendants were not allowed to elicit from the plaintiff's surgical expert any testimony critical of the urological surgeon.[vi] Ultimately, no expert witness testified for the defense that, to a reasonable degree of medical probability, the urological surgeon or the oncologists were negligent in failing to biopsy and/or resect the lymph node. Yet, the radiologists still argued the issue of non-party negligence in closing arguments, and the verdict sheet asked whether any non-party was negligent.[vii]

After deliberations, jurors found no breach of the standard of care by the radiologist defendants, which should have ended their deliberations. But they continued answering questions on the verdict sheet and found that "a negligent act or acts" by non-party physicians had caused Reiss's injuries and awarded him \$4.8 million in damages.[viii] After the trial court informed the jury that it had reached an inconsistent verdict, the jurors deliberated again, this time finding no standard of care breach by the defendants and answering no other questions. Reiss noted his appeal.

## Holding in *Reiss*

The Court of Special Appeals characterized the central issue on appeal as "whether there was any admissible evidence of non-party medical negligence in the record" to allow the question of non-party negligence to go to the jury.[ix] It noted that, in prior cases where defendants had asserted non-party negligence, they had supported that defense at trial with expert testimony that the non-party defendant had breached the standard of care. But the court found that these cases had not clearly established whether such testimony was necessary for the jury to consider the defense. Addressing that question, the court held that expert testimony was required for the defense.

It explained that the underlying logic behind requiring expert testimony, namely that “the subject matter is beyond the understanding of ordinary lay jurors,” applies no matter which party is making the argument.[x] In other words, the “subject matter [i.e., whether the standard of care was breached] does not become any more comprehensible to lay jurors merely because it is presented as a defense to a claim of malpractice, and not as the basis for a claim of malpractice.”[xi] Accordingly, the court reversed and remanded to the trial court.

### The Unresolved Implications of Reiss for Multi-Defendant Cases

The implications of Reiss are straightforward when a defendant has evidence to support an “empty chair” defense against a provider who was never a defendant in the case. The Court of Special Appeals’ 2013 Martinez decision provides an instructive example.[xii] In Martinez, the defendant hospital asserted an “empty chair” defense to contest claims that its obstetrical staff negligently managed the plaintiff’s labor and delivery. It argued that the non-party midwife, who was never sued despite negligently treating the expectant mother before sending her to the defendant hospital, was the sole cause of injury.[xiii] After Reiss, medical malpractice defendants in a Martinez scenario should know that they need competent expert testimony to assert an “empty chair” defense.

Although not squarely addressed by the Court of Special Appeals in Reiss, in cases where a defendant has been dismissed, courts should allow defendants to rely on the opinions of the plaintiff’s own experts during cross-examination. It would satisfy Reiss—and do so efficiently. Courts recognize that “great latitude is often accorded professionals, including medical experts, who have been summoned to testify. It is not uncommon, as a courtesy to these professionals, for a court to structure the order of testimony around their schedules.”[xiv] It would be inefficient and wasteful of an expert’s (not to mention the court’s, parties’, and jury’s) time to force the expert to return to the stand several days later to give opinions that could easily be elicited in a few additional minutes of cross-examination during the plaintiff’s case.

Eliciting such testimony on cross-examination is also permissible under the Maryland Rules because it goes to the expert’s credibility. Cross examination is generally “limited to the subject matter of the direct examination and matters affecting the credibility of the witness[.]” Yet, a “cross-examiner must be given latitude to cross-examine a witness concerning any bias or interest the witness may have that would lead the witness to shade his testimony, whether consciously or not, in favor of or against a party.”[xv] The fact that the plaintiff’s expert holds opinions that another provider was negligent (or that he or she is now trying to retreat from those sworn opinions) sat-

isfies Reiss and would also be important information for the jury in assessing the credibility of the expert’s opinions against the remaining defendant.[xvi]

### References

- [i] See *Copsey v. Park*, 453 Md. 141, 156-57 (2017); *Martinez ex rel. Fielding v. John Hopkins Hosp.*, 212 Md. App. 634, 661-66 (2013).
- [ii] 241 Md. App. at 342.
- [iii] *Id.* at 322.
- [iv] *Id.*
- [v] *Id.* at 322-23.
- [vi] *Id.* at 325 n.1.
- [vii] *Id.* at 324-26.
- [viii] *Id.* at 327.
- [ix] *Id.* at 333.
- [x] *Reiss*, 241 Md. App. at 341.
- [xi] *Id.*
- [xii] *Martinez ex rel. Fielding v. Johns Hopkins Hosp.*, 212 Md. App. 634 (2013).
- [xiii] *Id.* at 644.
- [xiv] *Braxton v. Faber*, 91 Md. App. 391, 397 (1992).
- [xv] Maryland Rule 5-611(b).
- [xvi] See *Wrobleski v. de Lara*, 353 Md. 509, 517 (1999) (internal citations omitted).

This post originally appeared on the Maryland Appellate Blog, the blog of the Maryland State Bar Association Litigation Section.

Many thanks to Goodell, DeVries, Leech & Dann, LLP for permission to re-produce this article.

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# Witness Evidence in the TCC: Reform is on the way

by Oliver Pearson, Associate - BCLP London

January is undoubtedly the most popular time of year for new year resolutions, but the Business & Property Courts (B&PCs) got a head start on all of us by publishing their 2020 resolutions in early December.

As many of you will be aware, in 2018 the B&PCs set up a Witness Evidence Working Group, consisting of B&PC judges (including Waksman J of the TCC), barristers, solicitors and in-house counsel, to consider whether factual witness statements in the High Court are fit for purpose. The working group has now published a set of recommended reforms that will be relevant for anyone practising in the TCC.

## Problems with the current system

The judiciary perceive a number of shortcomings with the current system.

One is that witness statements are “over-lawyered” and that they don’t reflect the witness’s own words. The complaint is that they are subject to multiple drafts, finessed by lawyers to support their client’s case, and do not accurately reflect what the witness can truly recollect.

Another is that statements are too long, contain material of questionable relevance, spend unnecessary space exhibiting or – worse – reciting documents verbatim, and sometimes even stray into legal argument.

Thankfully no such shortcomings have yet been levelled at the Practical Law construction blog.

While the working group focused on views in the B&PCs generally, rather than looking at specific courts, one wonders whether these issues are particularly prevalent in the TCC, where witnesses of fact are often engineers, architects and surveyors. Solicitors, in seeking to help their witness articulate complex, technical matters in layman’s terms, risk distorting the language that the witnesses themselves may use and the nuance that might come with that. Similarly, they commonly include detailed background about an overall project to help the court understand the context of a narrower dispute about a variation, extension of time or defect.

Judicial criticism of expert evidence has ramped up over the past couple of years, as the courts grow increasingly tired of partisan experts. But the judge’s criticism of some of the factual witness evidence in the recent judgment in *Bates v Post Office* highlights why existing practices in this area are ripe for change.

## The survey

In an online survey of solicitors and barristers with close to 1,000 respondents, just six percent thought that the current system presents the best evidence possible and 45 percent felt that it did so only partly or not at all, citing the same reasons as those held by the working group.

While there was widespread desire for improvement, the responses suggested an appetite for evolution, not revolution. A substantial majority also said they would welcome stricter enforcement of the current rules. The more radical reforms put forward by the working group were rejected. These included adopting US-style depositions, dropping written statements completely in favour of oral evidence-in-chief and permitting a lawyer from the other side to be in the room when proofing a witness.

A number of proposals garnered favour with respondents, and these are reflected in the reforms recommended by the working group.

## Best practice

The first proposal is a new statement of best practice as to how to go about preparing witness evidence. That has to be a good thing. While the guidance has not yet been drafted, the working group has recommended that:

- ❖ A statement should reflect what a witness would say if asked open, non-leading questions about their recollection of events.
- ❖ Lawyers may add clarity and brevity, but should not change meaning or emphasis, and the witness’s words should not be “spun” to support the client’s case.
- ❖ Lawyers should be careful about “corrupting” a witness’s memory, by drafting and re-drafting and getting the witness to tell the same story over and over again.

## Statement of truth and certificates of compliance

The second proposal is to widen the ambit of the statement of truth, making it more akin to the statements currently seen in expert reports, so that the witness confirms that they understand the objective of a statement and appropriate practice in relation to the drafting. While the statement of truth in its current form is certainly a powerful weapon, this should add further gravity to the act of a witness signing a statement, and amounts to the witness acknowledging that the statement is in their own words, which is a positive development.

The third is a proposal to include a “certification of compliance” from the solicitor that drafted the statement, confirming that the relevant Court Guide has been complied with, with the solicitor at risk of judicial criticism if that’s found not to be the case. While that might set alarm bells ringing among junior solicitors who are often tasked with drafting statements, it would go a long way to improving transparency and accountability, and might even be more effective than the court’s usual toolkit of cost sanctions.

## Pre-trial statements of fact

The working group recommends that the individual

courts (including the TCC) consider introducing “pre-trial statements of fact” setting out each sides’ factual narrative and, crucially, drawing together what each side considers to be the key documents.

At present, parties aren’t able to set out their full documentary narrative until the pre-trial opening submissions, and as a result solicitors sometimes end up using witness statements as a vehicle for presenting the documents. Without wanting to offend anyone, construction lawyers used to practising in adjudication, where the approach is more common, might be particularly to blame for this growing trend.

Construction cases often turn on the documents rather than witness evidence, so not having an opportunity to draw them all together pre-trial is a little unsatisfactory, and possibly even a barrier to early settlement. While that has been addressed in part by the introduction of “Initial Disclosure” in the Disclosure Pilot Scheme (under which parties can disclose up to 200 key documents with their statements of case), the proposal for a standalone “statement of facts”, to be issued post-disclosure would be welcome. It would also help narrow the scope of the witness evidence. Even if it just results in the transfer of content from one document to another, that could still have efficiencies further down the track, for example if it results in more focused cross-examination at trial, or if it means that delay experts can narrow the scope of their reports by cross-referring to their clients’ statements of facts.

#### **Examination-in-chief**

While not a reform as such, the working group clearly considers that the court should encourage parties to supplement their written witness statements with oral evidence-in-chief at trial. A number of the judges think that this will result in better quality evidence that is more genuine and more reliable, and avoids putting witnesses immediately on the defensive in cross-examination. In construction disputes the documents might not “speak for themselves” in the way that they might in, say, a shareholder dispute. So it might be particularly helpful to have a witness educate the court on complex engineering concepts or the interrelationship of construction activities, or to talk the judge through a set of architectural drawings.

The working group has asked for evidence-in-chief to be considered at the CMC, but whether this will be taken up in practice remains to be seen. Litigators whose witnesses are reasonable, informed, articulate and self-assured might welcome a non-combative way to convey that to a judge, particularly as it might not come across during cross-examination.

There is also the question as to where the time would come from. The courts are stretched as it is, so they are unlikely to extend the trial timetable – they are more likely to reduce the time available for cross-examination.

#### **Page limits**

The working group has also proposed harmonising the Court Guides for the different B&PCs. This raises the question: what of the dreaded page limit currently imposed on witness statements in the Commercial Court (30 pages, unless directed otherwise)?

#### **Will it make its way to the TCC?**

The working group said that the “TCC might usefully consider whether to introduce a limit at least in some cases”. That will cause some trepidation among readers who know that even the most “straightforward” delay and disruption claim can require substantial witness evidence. Similarly, given that most of the simpler construction cases are now resolved by adjudication, it is predominantly the really complicated or multi-faceted ones that make it to the TCC these days, often involving a “wrap-up” of 10, 20 or sometimes even more individual claims. Query whether a page limit would really be suitable for this sort of dispute.

#### **Concluding thoughts**

Witness statements in their current form do a useful job of setting out, pre-trial, each party’s factual case and are an important aide to early settlement. The act of putting something in writing can help witnesses structure and clarify their thinking. Pure examination-in-chief, without written statements, might lead to muddled answers, particularly in technically difficult construction cases. So it is welcome that the working group are not proposing to “throw the baby out with the bath water” and return to the pre-statement era of the early 1980s.

But there is clearly a very real issue with witness statements not presenting evidence as well as they might. The threat of page limits aside, the reforms proposed by the working group are designed to re-purpose statements back to what they were intended to be: the witness’s own words, not the client’s best case. And that has to be a step in the right direction.

A version of this blog was published in the Practical Law construction blog on 15 January 2020.  
Many thanks to Oliver for permission to reprint.

### **Dr Andrew Logan**

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# The Assessment of Personal Injury Compensation

by Paul Fretwell. Partner & Head of Personal Injury at George Ide LLP

## How do our Courts assess compensation for personal injury and loss?

It is a common misapprehension that people with devastating life changing injuries are entitled to £1 million- plus awards for the injuries alone. Sadly, awards in England and Wales are not generous, although our Courts have for very many years wrestled with the question of how one truly compensates for pain suffering and loss of amenity (reduced quality of life). It is extremely challenging to put a £ to something as subjective as pain. It is however vitally important that compensation truly recognises the devastating impact of life changing injuries.

Our Judges award compensation for injuries according to the latest-end of 2019- edition of the Judicial College Guidelines. By way of example, the following are the highest awards to be made for particular injuries (the guide covers, essentially, all parts of the body/ injury types);

- Tetraplegia i.e. loss of use of all 4 limbs, £380,000
- Paraplegia i.e. loss of use of legs/ function from the waist down, £267,000
- The most severe brain damage, £380,000
- Moderate brain damage, rendering a person unfit to work, £205,000
- Severe spinal fracture with immobility of the neck and loss of use of 1 or more limbs, £123,000
- Above knee amputation, £129,000
- The most serious knee injury, £90,000
- Knee fractures with serious constant pain, £65,500

Injuries are valued by reference to expert opinions, for instance from orthopaedic surgeons, neurologists, neuropsychologists, psychiatrists, and these experts are independent and are reporting to the Court i.e.

they owe a duty of impartiality. Defendants/ insurance companies tend to obtain their own opinions, particularly in cases of serious/ life changing injury.

The reason a serious/ disabling knee injury claim, for example, can end up with a total award in excess of £1 million, is that, with the right legal/ expert team, all aspects of lifelong loss can be fully investigated and costed. For instance, a 20-year-old may face 50 years' loss of earnings at say £30,000 per year (less any residual earnings), may need lifelong (70 years') paid help and support at say £200 per week, and may need a bungalow i.e. to avoid stairs.

Financial loss claims tend to be supported by a range of experts such as employment, accountancy, pensions, housing, care, occupational therapy/aids and equipment, transport, footwear etc., to ensure that reliable lifelong costs are considered.

A recent case of ours, involving a leg injury, was settled in negotiations in 2019 for almost £850,000. More important than pure money, however, was that we enabled our client to have peace of mind as to loss of earnings, potential future surgery costs etc., safe in the knowledge that they would always be able to undertake their leisure pursuits, because necessary/ disability adaptations were all factored in.

The purpose of compensation is, so far as possible, to put the injured person back in the same position they would have been in had the accident/injuries not occurred. It is all about helping people to get their lives back and to restore peace of mind.

For further information about claims for personal injury please contact us on 01243 786668 or at [info@georgeide.co.uk](mailto:info@georgeide.co.uk) - [www.georgeide.co.uk](http://www.georgeide.co.uk)

**Paul Fretwell.**

Partner & Head of Personal Injury

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# English and Welsh Courts Fight Back Against Fraudulent Holiday Sickness Claims

by Noelle Donnelly

In recent years, the travel industry has experienced a surge in claims for gastric illness contracted during package holidays; commonly known as ‘holiday sickness’ claims. Those who make fraudulent claims to court risk prosecution - and now, thanks to a landmark case, false claims made before the case even goes to court also face penalties.

In the recent case of *Jet 2 Holidays Limited v Hughes & Anor* [2019] EWCA Civ 1858 the Court of Appeal in England & Wales held that a witness statement made pre-action in support of a fraudulent sickness claim, could give rise to contempt of court. This decision demonstrates that fraud at any stage of a claim may give rise to serious consequences for claimants. But, how did we get here? It is useful to look at the evolution of holiday sickness claims and the way in which fraud in this area has been managed.

## Holiday sickness epidemic

Between 2013 and 2016, claims against tour operators relating to gastric illnesses contracted during package holidays increased by 500% according to ABTA, the UK’s largest travel association.

However over the same period, the actual number of sickness cases reported in resorts either remained stable or decreased. The fact that this increase in claims is associated only with British holidaymakers adds to the suspicion of fraudulent activity.

ABTA has blamed unscrupulous Claims Management Companies (CMCs) for targeting overseas package holidaymakers. It has been suggested that such CMCs did so because whiplash claims were no longer profitable and holiday sickness claims have been hailed as ‘the new whiplash.’

The problem was perhaps exacerbated by the fact that when the wave of holiday sickness claims first hit, many travel companies opted for early economic settlements in a bid to avoid disproportionate litigation costs. Unfortunately this ‘buy off’ approach unintentionally led to a surge in claims which was encouraged by the knowledge that they were unlikely to be challenged.

The claims were driven in part by touts in holiday resorts, who were targeting and recruiting prospective claimants to bring false sickness claims. ABTA estimates that one in five people have been approached to bring a holiday sickness claim.

With the problem escalating, the Solicitors Regulation Authority in England & Wales issued a series of warning notices targeted at solicitors involved in potentially fraudulent sickness claims, and investigated more than 12 firms.

## Package Claims Protocol

The outbreak of claims was costing the travel industry millions and also tarnishing the reputation of British holiday makers abroad. Boris Johnson, at the time in the post of Foreign Secretary, commented, “If the figures were to be believed, the digestive systems of the British people had become the most delicate in the world.” There was concern that British holidaymakers would be excluded from European resorts or that the costs would significantly increase.

In a bid to quash dubious sickness claims, the government introduced the Pre-action Protocol for Resolution of Package Travel Claims (‘the protocol’) in 2018 for England & Wales.

The protocol applies to claims for gastric illness contracted on package holidays notified after 7 May 2018, which are now subject to fixed costs on the same scale as public liability claims.

The protocol goes some way to combat fraud as claimants are now required to provide evidence at the pre-action stage (if the claim is denied) of medical records, bank statements, receipts for medication, photographs and social media posts during their stay, as well as details of any other package travel claims they have made. It was suspected that repeat claimants were using compensation from one sickness claim to fund their next holiday.

Alongside civil justice reforms, the travel industry has secured many findings of fundamental dishonesty and criminal prosecutions in the fight against fraudulent sickness claims. Thomas Cook’s prosecution of Deborah Briton and Paul Roberts made headlines in October 2017 with the couple being sentenced to nine and 15 months respectively after admitting their sickness claims were fraudulent.

## Consequences of dishonesty

It is well known that claimants who pursue dishonest claims in England and Wales can face custodial sentences for contempt of court, but usually such matters only come into play after the claim is litigated.

The issue of court proceedings is a milestone in a fraudulent claim because the claimant is required to move through a series of procedural steps; each of which carry a risk of prosecution if he/she is not truthful. For example, the fraudulent claimant may sign pleadings and statements containing dishonest facts, give dishonest information to a medical expert, and possibly give false evidence before a judge.

These are all serious misdemeanours which expose a fraudulent claimant to a risk of prosecution for contempt of court.

For a fraudulent claimant, the pre-action phase might appear less risky. They might be tempted to test the waters by sending a letter or two to the proposed defendant in the hope of eliciting a settlement offer and in the (mistaken) belief that should their dishonesty be exposed, they can simply abandon the claim with no repercussions.

### **Jet 2 Holidays Ltd v Hughes & Anor [2019] EWCA Civ 1858**

In this landmark decision, the Court of Appeal held that committal proceedings for contempt of court can be brought for false statements made at the pre-action protocol stage.

The claimants alleged that they had contracted food poisoning during a Jet2 package holiday in Lanzarote. At the pre-action protocol stage, they served witness statements with a signed statement of truth in support of their holiday sickness claims.

Jet2 uncovered various social media postings that undermined the claims, including a 45 minute GoPro video of Mr Hughes enjoying a snorkelling trip during the holiday despite claiming to be ill. Jet2 rejected the claims, which were effectively abandoned as the claimants did not issue proceedings.

However, that was not the end of the matter; Jet2 sought permission to begin committal proceedings against the claimants.

In the first instance decision, the High Court held there was no jurisdiction to find contempt as the witness statements were disclosed when proceedings had not been started under CPR Part 7. The Court of Appeal disagreed and found that the claimants' conduct in making the statements satisfied the stringent requirements for contempt proceedings, and therefore granted Jet2 permission to proceed.

The judges recognised the importance of the pre-action protocols in personal injury, describing them as 'an integral and highly important part of litigation architecture.'

### **What does this mean for other claims in England and Wales?**

The decision is a stern warning to dishonest claimants that there are no 'risk free' stages for pursuing a fraudulent claim; whether it be holiday sickness or otherwise.

Any belief that a claimant has to litigate, before they are exposed to a risk of prosecution, is mistaken. Pre-action fraudsters are equally at risk and can no longer walk away scot-free.



### **About the Author**

#### **Noelle Donnelly - Associate**

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Noelle joined the Insurance and Risk team as an Associate in 2019 to provide English litigation services to clients. She qualified as a solicitor in England and Wales in 2012 and was employed by multi-national law firms to defend liability actions on behalf of global insurers, self-insured corporates and public bodies.

Her specialist areas include industrial disease, EL, PL, professional negligence and insured commercial disputes. She has technical expertise in English civil procedure and Pre-Action Protocols, and defends actions at County Court and High Court level. She has a particular interest in limitation and complex medical causation issues, and has successfully defended numerous actions on these grounds.

Noelle has also undertaken secondments with national insurers to support their claims management services.

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### **Mr R. G. Springall - ChM FRCS Consultant Surgeon**

Mr Roger Springall has been a Consultant General, Gastrointestinal and Colorectal surgeon since 1974.

His main areas of interest are the following:

- gastrointestinal
- colorectal surgery
- general surgery
- small/large bowel resection
- surgery for advanced disease
- IBD
- complicated diverticular disease
- fistula in ano
- fissure
- haemorrhoids
- pilonidal sinus
- pelvic floor disorders
- laparoscopic gallbladder
- laparoscopic appendicectomy
- hernia surgery including repair of complex defects and recurrences.

Mr Springall accepts medicolegal instructions on behalf of both claimant and defendant. He has 20 years experience in medical expert report writing and this includes court appearances. Consultations are held at our practice in London.

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# The Inexorable Rise of Food Hypersensitivity

*We have all heard the media news reports of fatal allergic reactions to food – often takeaways, such as sandwiches, burgers or a curry. In this article, journalist Rosalind Whistance asks leading food safety expert **Dr Belinda Stuart-Moonlight**, who in the article below sets out the reasons why the profile of food hypersensitivity is so high now, what is being done by regulators and the industry and whether we are likely to see an improvement in food safety in this regard over the next few years.*

## **Meet Dr Belinda Stuart-Moonlight**

**RW:** You are an award-winning, sought-after expert witness in food and infectious disease cases. How did you gain experience for this role?

**BSM:** I started out as a regulator, an environmental health officer in local government enforcement before taking up a junior research fellowship at King's College, University of London, where I examined microbial survival on food contact and structural surfaces in food preparation environments. For the last 20 years I have run my own business providing consultancy, training, auditing and expert witness services, mainly in food related sectors. I firmly believe that by continuing to undertake practitioner work, my expert witness work is better informed by current industry practice. As an expert witness, the majority of my instructions focus on food contamination risk and, in the last 18 months they comprise an unprecedented number relating to serious or fatal food allergy.

**RW:** What sort of cases have you undertaken historically as an expert witness?

**BSM:** I've been involved in criminal and civil cases and aim to maintain a 50:50 balance in producing reports for: i) the prosecution / claimant and ii) defence. The majority of my instructions require comprehensive reports and I produce approximately 15 per year. Some notable cases include large infectious disease outbreaks on cruise ships, fatal food poisonings, major pest infestations and the first ever norovirus prosecution under health and safety legislation. Here, I was appointed by the defence, and on receipt of my report, the prosecution was withdrawn (*Exeter City Council v Mitchells & Butlers plc*). Two of the higher profile allergy cases for which I have provided expert reports were *R v Mohammed Khalique Zaman* (re the Indian Garden restaurant in Easingwold, Yorks, heard in Teesside Crown Court), and *R v Mohammed Abdul Kuddus, Harun Rashid and Royal Spice Takeaway Ltd* (Oswaldtwistle, Lancs, heard in Manchester Crown Court). There is discussion and reflection on these cases further in this article.

## Food Hypersensitivity - Consequences Controls and Cases

### 1.0 What are the basic statistics for food hypersensitivity in the UK?

Food hypersensitivity includes food allergy, intolerance and Coeliac disease<sup>1</sup>. Food allergy affects 1 – 2% of adults and 5 – 8% of children in the UK<sup>2</sup>. Currently, it is estimated that approximately 2 million people in the UK live with a diagnosed food allergy and 600,000 (equating to 1 in 100) have Coeliac Disease<sup>1</sup>. Individuals with intolerances add further to the food-hypersensitive population. Year-on-year rates of food hypersensitivity are increasing but the causes are not fully understood<sup>3</sup>.

### 2.0 What is the difference between food allergy, food intolerance and Coeliac disease?

**Food allergy** is where the body's immune system reacts to a seemingly harmless substance – in nearly all cases a protein, in food. Symptoms of food allergy<sup>4</sup> include tingling or itching in the mouth, hives, swelling of the face, mouth, throat and other areas of the body, difficulty swallowing, wheezing, nausea, vomiting, diarrhoea and anaphylaxis. Food allergy can be life-threatening.

**Food intolerance** is an inability to process or digest certain foods, the most common being lactose intolerance, where there is a deficiency in the enzyme lactase to process lactose (sugar present in milk). Symptoms of food intolerance include tummy pain, bloating, wind, diarrhoea, skin rashes and itching. Food intolerance is not life-threatening.

**Coeliac disease** is an autoimmune condition that causes a complex inflammatory reaction following ingestion of gluten. It is not life-threatening but can cause severe weight loss and malnutrition.

Food hypersensitivity therefore encompasses three different types of physiological response to allergens (the proteins that trigger the reactions). In the case of food allergy, reactions tend to be very quick (within seconds or minutes) and in severe cases can be life-threatening. In contrast, food intolerance and Coeliac disease may take some minutes or hours before symptom onset and they are not life-threatening.

### 3.0 What are the risks associated with food allergy?

In rare cases, the allergic reaction becomes severe and causes anaphylaxis that can lead to death. Symptoms of anaphylaxis include swollen tongue, breathing difficulties, tight chest, trouble swallowing or speaking and a drop in blood pressure. Individuals who are severely allergic need to carry epinephrine auto-injectors such as the Epi-Pen, for rapid administration upon experiencing anaphylactic symptoms. Risks include i) not having the auto-injector readily available, ii) not administering the auto-injector properly and iii) receiving too small a dose – all three risks have contributed to recent food allergy fatalities.

### 4.0 To how many foods are people hypersensitive?

There are 14 foods responsible for the majority of reactions in the European food-hypersensitive

population. These foods are considered key allergens that are defined in legislation for provision of specific information; they comprise:

1. **celery** (includes stalks, leaves, seeds, celeriac and celery salt, e.g. used in stocks and soups)
2. cereals containing **gluten** (includes wheat, rye, barley and oats, e.g. used in breads, cakes, couscous, pastry, soup, cereal-dusted products)
3. **crustaceans** (includes crabs, lobsters, prawns, scampi, e.g. shrimp paste)
4. **eggs** (found in a wide variety of products including cakes, mayonnaise, and foods brushed with egg glaze. Egg white is used as a processing aid in cocktails)
5. **fish** (can be unexpected in products such as pizzas, relishes, salad dressings, stock cubes and Worcestershire sauce)
6. **lupin** (includes lupin seeds and flour, and can be found in bread, pastries and pasta)
7. **milk** (found in dairy products including butter, cream, cheese, milk powders, yogurts, sauces, powdered soups and foods glazed with milk)
8. **molluscs** (includes mussels, land snails, squid and whelks and are found in a range of products, such as fish stews and oyster sauce)
9. **mustard** (includes liquid, powder and seeds often used in breads, curries, marinades, meat products, dressings, sauces, soups, etc.)
10. **tree nuts** (includes almond, hazelnut, walnut, cashew, pecan, Brazil, pistachio, macadamia and Queensland nuts, used in a variety of products including breads, biscuits, nut oils, sauces, curries and stir fries)
11. **peanuts** (can be found in a variety of products including biscuits, cakes, curries, desserts, sauces, groundnut oil and peanut flour). NB peanuts are considered separately from tree nuts, as they grow below the ground.
12. **sesame seeds** (can be found in bread, breadstick, hummus, sesame oil, tahini and as a sprinkle on various sweet and savoury products)
13. **soya** (can be found in various products including bean curd, edamame beans, miso paste, texturized soya protein, soya flour, tofu)
14. **sulphur dioxide** (used as a preservative in dried fruit, meat products, soft drinks, vegetables, wine, beer)

The foods that a population in one part of the world are allergic to can differ from those to which a population in a different region of the world is allergic. The list of key allergens requiring specific declaration information in the EU is thus different from that in the US and Australia. As with many aspects of food hypersensitivity, the reasons for this variation are not fully understood.

The most common foods that elicit hypersensitivity reactions in European populations are milk, egg, wheat, fish and nuts<sup>6</sup>.

### 5.0 How do allergens get into food?

Allergens enter food in three ways:

1. as an ingredient
2. as a processing aid (substances used to help achieve qualities in a food product such as sulphur dioxide used as a preservative and antioxidant in dried fruit, soft and alcoholic beverages)
3. through cross contact (formerly known as cross-contamination, where the allergen is inadvertently or accidentally transferred into a food that does not contain it as an ingredient. For instance, the transfer of a sesame seed on a baking tray used firstly for a batch of sesame-containing rolls then, through insufficient cleaning, the remaining sesame seed attaches to a non-sesame-containing batch.)

### 6.0 What are the realities of living with an allergy?

Writing in the Guardian, Sophie Ankle, an allergy sufferer, sums up living with an allergy<sup>7</sup>:

“Living a life with food allergies can feel like you're walking through a minefield. It means having to call up restaurants in advance to see if it's possible to eat there, and then feeling like a nuisance every time you have to grill a stumped waiter about how certain foods are prepared. It means developing a habit of meticulously reading through every single ingredient list, and becoming an expert at studying any allergen guide handed to you. And it means checking, double checking, and then living with the fear that you haven't checked enough and that any oversight can, in severe cases, cost you your life.

“It is a burden people like myself have no choice but to carry, we simply have to learn how to cope. But it's made even harder when people fail to give us relevant information. Take Leon for example, whose co-founder and chief executive John Vincent advised diners with severe allergies to think carefully before choosing to eat at the health-conscious joint. In a blog post, he wrote: ‘the idea that Leon could cause harm to one of its guests is horrifying. And we therefore ask those of you with serious allergies to consider carefully whether to choose to dine with us.’”

The realities of living with an allergy are thus about a lack of choice, being seen as the odd one out and the constant fear that food may be contaminated. From research and analysis of cases, it has been identified that young people (16-24-year-olds) are particularly at risk. This recognition has caused the Food Standards Agency to engage in the ‘Easy to ASK’ campaign, which follows the prompt ‘Always ask about allergies, Speak up, Keep safe’<sup>8</sup>.

### 7.0 What is the regulatory landscape for food hypersensitivity?

#### 7.1 Introduction

The regulatory landscape in respect of allergen control and information has changed significantly in the

last 20 years. For example, prior to 2012, eight foods were required to be identified as allergenic ingredients, whereas the number is currently 14. More recently, change has been gaining pace, particularly following specific incidents such as the death of Natasha Ednan-Laparouse. Natasha consumed a Pret a Manger baguette that contained sesame but was not required to have a label identifying its ingredients because it was prepacked for direct sale, a type of food exempt from such labelling. This exemption is now closing following Foods Standards Agency (FSA) consultation and the Food Information (Amendment) (England) Regulations 2019 (SI 2019 No. 1218) will come in to force on 1st October 2021.

To an expert witness, there is a distinct challenge resulting from the current rapid pace of change. Consumers are much more familiar with allergen issues now because of media coverage. This means that in jury trials, jurors are likely to automatically apply the allergen climate of today (with knowledge of exemptions often unhelpfully referred to as ‘loopholes’, fatalities and lessons learned) when listening to evidence about issues that occurred maybe three years ago, in any event prior to some of the knowledge-giving incidents that have occurred in the interim. Indeed, even three years ago, business systems, expectations and awareness were quite different. This means that jurors may well expect higher standards of food businesses than were the industry norm at the time.

Within general food law there is an overarching requirement that food is not unsafe. Food intended for a food-hypersensitive individual will need to be free from certain ingredients, processing aids or contaminants to avoid a potential reaction. Notwithstanding, given that the 14 key allergens are safe for non-hypersensitive individuals, foods that are safe for some people may be unsafe for others. Food-hypersensitive individuals can identify any of the 14 key allergens in prepacked food by consulting the label, but for non-prepacked foods or those prepacked for direct sale, such as in sandwich bars, the information must be available and easily accessible.

#### 7.2 Mandatory particulars for 14 allergens

**Article 9 1** of Regulation EC 1169/2011<sup>9</sup> requires, inter alia, to provide specific information (termed ‘mandatory particulars’), namely detail of any ingredient or processing aid derived from 14 allergens that are identified within Annex II. These allergens (products and products thereof) are: cereals containing gluten, crustaceans, eggs, fish, peanuts, soybeans, milk, nuts, celery, mustard, sesame, sulphur dioxide, lupin and mollusc (please see section 4 above for further details).

**Article 12 1** of Regulation EC 1169/2011 requires that the mandatory information “shall be available and shall be easily accessible...”

#### 7.3 Prepacked Food – Food inside a wrapper

**Article 12 2** of Regulation EC 1169/2011 requires that the mandatory information in the case of

prepacked food, “shall appear directly on the package or on the label attached thereto.”

The requirements regarding pre-packaged foods are therefore quite straightforward whereby on the label any one of the 14 key allergens, if present as an ingredient or processing aid, is highlighted in a defined way – usually in bold font.

#### **7.4 Non-Prepacked Food – Restaurants, bars, buffets etc**

**Article 12 5** of Regulation EC 1169/2011 indicates that in the case of non-prepacked food, the provisions of Article 44 shall apply.

**Article 44 1** of Regulation EC 1169/2011 indicates that, inter alia, where food is offered for sale to the final consumer without packaging, the mandatory information (14 allergens) must still be available.

Article 44 2 of Regulation EC 1169/2011 indicates that EU Member States may adopt national measures concerning the means through which the mandatory information is to be made available and, where appropriate, their form of expression and presentation.

The UK took up this Article 44 option via The Food Information Regulations 2014<sup>10</sup> in respect of non-prepacked food to specify how compliance might be satisfied within the catering / hospitality sector. It introduced some flexibility in how allergen ingredient information can be provided.

**Regulation 5 (1)** of The Food Information Regulations 2014 enables food business operators to make available the allergenic ingredient information “by any means the operator chooses, including, subject to paragraph (3), orally”.

**Regulation 5 (3)** of The Food Information Regulations 2014 provides that where a food business operator intends to make available the particulars (allergenic ingredient information on the 14 specified allergens) relating to the relevant food orally, the operator must indicate that details of allergenic substance(s) or product(s) can be obtained by asking a member of staff.

**Regulation 5 (4)** of The Food Information Regulations 2014 provides that in instances outlined in 5 (3), the particulars “must be given:

- a) on a label attached to the food, or
  - b) on a notice, menu, ticket or label that is readily discernible by an intending purchaser at the place where the intending purchaser chooses that food”.
- Guidance on the interpretation and practical implementation of the requirements can be found in the FSA document ‘Food allergen labelling and information requirements under the EU Food Information for Consumers Regulations No 1169/2011: Technical Guidance (April 2015)’.<sup>11</sup>

**Paragraph 79** of the Guidance states: “Allergen information for non-prepacked food can be communicated through a variety of means to suit

the business format of the FBO [food business operator]. The requirement is to provide information about the use of allergic ingredients in a food. The provision does not require food businesses to provide a full ingredients list. Where food businesses choose for this information to not be provided upfront in a written format (for example allergen information on the menu or foods sold by a butcher or delicatessen), the food business should use clear signposting to direct the customer to where this information can be found, such as asking members of staff. In such situations there must be a statement that can be found on food menus, chalkboards, food order tickets, food labels or webpages (see Regulation 5 (4) of the Food Information Regulations 2014”.

**Paragraph 81** of the Guidance states: “All mandatory allergen information, on menus or signpost statements to where it could be found, should be easily accessible and visible, and clearly legible to the final consumer regardless of whether they have a food allergy or not.”

The requirements regarding pre-packaged foods are, therefore, that information regarding 14 key allergens when used as ingredients or processing aids must be available and easily accessible. A food business operator can choose how to make the information available but if this is orally, there must be signposting to indicate the availability of the information.

One issue that will be tested in a forthcoming case is the question of who is responsible to initiate a discussion about the allergenic ingredients - the individual ordering food or the business which has the information available but does not place it in front of customers unless asked. The decision will have far reaching implications for the industry should there be no onus on the customer. For instance, pubs and restaurants would have to ask about the allergy needs of every customer every time a food or drink is ordered.

#### **7.5 Food that is Prepacked for Direct Sale (PPDS) – Food that is wrapped on the site of making and sale but does not require a label**

The sandwich purchased by Natasha Ednan-Laparouse falls under the umbrella of non-prepacked foods and, in particular, the classification ‘prepacked for direct sale’ (PPDS). Regulations do not specifically define PPDS. Regulation EC 1169/2011 Article 2 2 (e) defines ‘prepacked’ and states that ‘prepacked food does not cover foods packed on the sales premises at the customer's request or prepacked for direct sale’.

The FSA Technical Guidance<sup>11</sup> provides examples of PPDS foods (at paragraph 74):

“... meals prepacked in a canteen for consumption on or off the premises, cheese or meat sold loose from a delicatessen counter, bread or pies sold at bakeries or meat and meat products at butchers and packed at the consumer's request.”

The Gov.UK website<sup>12</sup> provides a further indication that states:

“...Put simply, PPDS foods are foods that are packed on the same premises from which they are being sold, before they are offered for sale. These might include a packaged salad or baguette from a shop that was made by staff earlier in the day, packaged in the kitchen and then placed on a shelf for customers to purchase.”

PPDS foods therefore are sold in a wrapper that does not require a label with ingredient information. Incidents have happened where, for instance, the consumer assumed that the absence of a label meant the absence of risk (on the basis that there was no allergen information). In another case, the customer followed the label signpost and asked for ingredient information, but the wrong information was provided despite the business having all relevant staff training and competence systems in place. Given the tragic outcomes of such situations, the exemption of PPDS from the requirement to label will cease next year in England, Wales and Northern Ireland when full labelling will be required. Scotland is taking longer to consider the impact of alternatives.

#### **7.6 Cross contact (inadvertent contamination) and precautionary labelling**

Other than general food law requirements, there are no specific legal provisions for precautionary labelling in prepacked or non-prepacked foods. Historically, some manufacturers used ‘may contain’ indiscriminately as a form of disclaimer but nowadays, through risk analysis, it is feasible to identify the risk of cross contact, minimise it and then provide the customer with products that have integrity of precautionary labelling. In practice, despite the theory of risk analysis being sound, threshold levels are the current challenge. Most allergy experts consider a threshold should be no lower than ED01 (Eliciting Dose 1%); this is the amount of an allergenic substance in mg of protein below which adverse reactions are unlikely in the majority of the allergic population. Some may ask why tolerate any risk at all? If manufacturers were required to work to an even more stringent level, the risk may not exist, the allergic population would have a significantly reduced availability of goods and warnings would arguably be devalued. There is therefore a tension and some data uncertainty around thresholds.

Caterers also have a particular challenge in respect of precautionary labelling. While larger catering and hospitality businesses are getting to grips with allergen matrices that identify ingredients and possible contaminants in dishes and beverages, smaller businesses are at a significant technical disadvantage.

#### **8.0 Allergens not amongst the 14 key allergens**

There are approximately 200 different food substances to which people are allergic aside from the 14 key allergens; for instance tomatoes, kiwi and strawberries. In theory, the presence of one of these allergens in a food offered to an allergy sufferer

would be unsafe, particularly if they were likely to suffer a severe reaction. General food law requires that food is safe and of the nature, substance and quality demanded by the customer. Notwithstanding, if a restaurant were to receive an enquiry / request regarding the need for the absence of a particular ingredient not among the familiar 14 key allergens, they may not realise the gravity of such enquiry / request and that a person’s life may depend upon it. I am aware of just such a situation that occurred recently in relation to a lemon, where the customer was hospitalised. Thankfully they made a full recovery.

Currently, there is no specific legislation or comprehensive guidance in this part of the allergy arena. It will be interesting to see whether in the future it, too, becomes subject to stricter control as awareness is raised of the magnitude of the impact of such customer demands.

#### **9.0 How are regulators managing to assess risk and prioritise inspections and interventions?**

Regulator interventions are defined in and guided by Food Law Codes of Practice and Practice Guidance. These set out a framework for inspections, the frequency of which are conducted on a risk-based basis. Unfortunately, the presence of allergens in food falls into two different fields of inspection, which are often conducted by two different regulators, depending on location. The question of ingredient information is dealt with as a food standards matter and, in most areas, regulated by Trading Standards Officers. The question of cross contact and inadvertent contamination by poor practices is dealt with as a food hygiene matter and is regulated by Environmental Health and Food Safety Officers. This means that in areas with county and district/borough/city councils, a food business may be inspected by two different council bodies at different times, looking at different aspects of allergen management. In unitary authorities, London Boroughs and Metropolitan Boroughs, one regulator, namely environmental health departments, usually conducts both inspections.

In practice, this has sometimes meant that businesses (and even regulators) are confused as to which authority and regulator is responsible for interventions over which aspects of allergen management – ingredient information or ingredient control.

There is a wide variation in approach to regulatory inspections in respect to allergens. Some environmental health departments use checklists to assist in examining risk, whereas others do not. Some conduct separate allergen compliance inspections, whilst others include allergen management within the food standards or food hygiene inspection. Some take an educative approach with businesses that are struggling to manage allergens effectively, whereas others take a harder line of enforcement.

Based upon what is evident within criminal allergen case instructions, plus what I have learned from providing workshops for regulators and industry, the

somewhat disparate regulatory approach to allergen management results in businesses with similar histories and compliance standards experiencing a wide variety of interventions.

## Case Studies

### **R v Mohammed Khaliq Zaman, Teesside Crown Court**

Zaman was found guilty of gross negligence manslaughter and was given a six-year prison sentence after selling a takeaway curry containing peanuts to Mr Paul Wilson, who was known to be severely allergic to peanuts since the age of seven. The conviction and sentence were subsequently found to be safe at appeal.

Zaman was the owner of a chain of five curry houses in the north Yorkshire area. Financially, the business was struggling. It had an overdraft of £200,000 at the start of 2013 that rose to £300,000 by the end of the year. Zaman was under pressure to cut outgoing costs. It was found that this was likely to have been the reason that he chose to substitute ground peanut for the more expensive ground almond used in curry sauces in the restaurant.

When he changed his customary order from almond to peanut powders his wholesale supplier warned him to make clear the change of nut to his customers. However, this was not done and just three weeks before Paul Wilson died another customer, Ruby Scott, suffered an allergic reaction from food bought from one of his other restaurants. Her reaction had been communicated to Zaman so he was aware of the problem, but peanut-contaminated meals continued to be served.

Zaman's defence was that he wasn't present in the restaurant on the evening when Mr Wilson had bought his takeaway meal; that he'd taken reasonable steps, and that he had been let down by his staff and by his supplier. Both the waiter who took the order and the chef, who was an illegal citizen, absconded before trial, making the examination of some evidence related to communication during the transaction difficult.

Paul Wilson died at home, alone, on 30th January 2014. Evidence presented at trial included the fact that he must have asked for a peanut-free dish because a carton lid in which the meal had been served bore the indication 'no nuts'. Results from stomach contents and leftover takeaway elements confirmed that he had consumed considerable peanut protein in the tikka masala curry sauce.

Zaman was found guilty of manslaughter and six charges of contravening food safety requirements including selling unsafe food (Article 14 EC178/2002) and selling food not of the substance demanded by the customer (Section 14 Food Safety Act 1990). In addition, he was found guilty of employing individuals subject to immigration control and perverting the course of justice.

### **R v Harun Rashid and Mohammed Abdul Kuddus and the Royal Spice Takeaway, Manchester Crown Court**

Megan Lee, 15, died after eating a takeaway from the Royal Spice Takeaway ordered from the Just Eat website on 30th December 2016. A mixed order was placed for her and her friend's different dishes and a note was included on the website order made at the time that referred to 'prawns and nuts'. Unfortunately, the system was unsophisticated and not fool-proof, there was no clarification call from the restaurant, and on delivery no indication, such as a note on relevant packaging, as to which dishes contained nuts or prawns.

On eating, Megan had a slight reaction and took the antihistamine Piriton, but three hours later had a severe asthma attack. She was put on life support but died two days later, on 1st January 2017.

Environmental Health and Trading Standards Officers visited the Royal Spice and observed poor practices, including no system for recording or managing allergen requests, and because there was no evidence from the meal she consumed, asked the business to make replica dishes to those ordered by Megan Lee. The replica meal contained peanut protein present through cross contact due to poor practices.

### **Reflections from the two cases**

The two cases are interesting to compare on a number of levels. Paul Wilson's allergy was severe: he had an autoinjector. Megan Lee's was mild, she did not have an autoinjector. They had both taken precautions in specifying their needs yet did not receive safe food. Judge Higginbottom said of Zaman of the Indian Garden that his negligence was "gross" and behaviour "appalling", while Mrs Justice Yipp in the Royal Spice case marked the two men as "incompetent" and "not bad men". The conviction of Kuddus was later quashed. Another difference was in the regulatory approach to the two events; the Indian Garden was not immediately closed by regulators, while the Royal Spice was. Common threads include that both were small businesses, they lacked understanding of food safety systems and staff training. Staff did not understand the importance of allergen information requests and were not competent at managing to produce food free from allergens when such requests were made.

If one were to carry out a root cause analysis of the two incidents, it is likely that the majority of contributory factors in both cases are still present today in a significant number of smaller catering and take away food businesses. For this reason, it is my view that these will not be the last gross negligence manslaughter cases for food allergen incidents.

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### Dr Belinda Stuart-Moonlight

Dr Belinda Stuart-Moonlight is a Chartered Environmental Health Practitioner and specialises in food safety. She holds fellowships of the Chartered Institute of Environmental Health, the Royal Society for Public Health and the Institute of Food Science and Technology and is a member of the Academy of Experts. Her early career saw her working as an EHO in local government enforcement before taking up a Junior Research Fellowship at King's College, University of London. Here, she looked at influences on survival of pathogenic bacteria on various food environment surfaces. Her laboratory results were used to comment on the suitability of legislation to control risk in this area.



For the last twenty years Belinda has run her own business providing consultancy, training, auditing and expert witness services. She has a wealth of experience in food safety in the manufacturing, catering and retail sectors and is highly respected in her professional community. As an expert witness, her instructions include food contamination, infectious intestinal disease and increasingly, injury and death from food allergy. She works in the criminal and civil arenas with a split of roughly 50:50 prosecution/claimant to defence.

Belinda's approach is pragmatic and plain speaking. She is regularly commissioned to deliver workshops and presentations to industry and regulators for the Food Standards Agency, Chartered Institute of Environmental Health and ABTA. She is known for her inimitable enthusiasm for food safety and makes technical and scientific concepts accessible.



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# Dr Rob Hendry: Six Reforms Will Make Real Difference to Management of Clinical Negligence Cases

*Dr Rob Hendry, medical director of the Medical Protection Society (MPS), sets out the medical profession's perspective on Mr Justice Charles Meenan's expert group on tort reform and the management of clinical negligence claims.*

In 2018 the State Claims Agency paid out nearly €270 million in compensation following clinical negligence claims – an increase of 7.5 per cent from 2017. A further €39.1 million was paid out for plaintiff legal costs.

High legal fees are the norm in Ireland, in fact they are higher than all the other countries around the world where the Medical Protection Society (MPS) supports members. Significant delays in resolving claims are often responsible for inflating legal costs, and the current court rules can be easily exploited to accommodate delays.

Civil justice reform – particularly in respect of clinical negligence claims – has long been acknowledged as being ripe for reform in Ireland and this is a debate not just about rising costs and how sustainable this is for society. Is it also about how the current process affects those at the heart of it; notably patients and clinicians.

For patients, too many find themselves involved in unnecessarily protracted court cases at a time when they may need financial help to pay their mortgage or access care. They may have to wait many years to achieve closure. For the clinician, at MPS we know too well that it can be an all-consuming process, with negative effects on their health and career.

We need to reduce the delays in resolving claims by creating a more efficient and predictable legal process.

The establishment of an Expert Group, led by Mr Justice Meenan, to review the current framework for managing clinical negligence claims and explore alternative mechanisms to the court process for resolving such claims, was warmly welcomed by MPS.

The ability to resolve claims without going to court would save unnecessary expense and would benefit all parties, particularly patients who could receive compensation at a far earlier stage in the process. Importantly, it could allow some vital funds to be invested back into healthcare.

We have engaged fully with Mr Justice Meenan's evidence gathering and we are championing six reforms that will make a real difference to the way clinical negligence cases are managed – and that can also be implemented swiftly:

## **Formal written offers:**

Parties should be allowed to make formal written offers – similar to other jurisdictions – where they are made in a prescribed form with the aim of encouraging early resolution. In the right type of case, this would serve everyone's interests.

## **Alternative dispute resolution:**

The Mediation Act 2017 was a welcome piece of legislation, aimed at achieving fair but swift resolution in what can be complex disputes between parties. For this Act to have teeth, the court should have the power to impose cost sanctions against any party that unreasonably refuses to engage in the mediation process.

## **E-litigation:**

MPS believes that the increased use of technology, where appropriate, would have a positive impact for all parties involved in court actions and the court system itself. Increased use of e-litigation would reduce the need for parties to travel to court thereby reducing costs, saving time, preventing unnecessary procedural delays and increasing access to justice.

## **Introduction of judicial guidelines:**

The introduction of an equivalent to Judicial College Guidelines – for the Assessment of General Damages in Personal Injury Cases – would be a welcome development. The purpose of the Guidelines is to provide a clear and logical framework for the assessment of damages in personal injury cases, and to achieve consistency.

## **Expert evidence:**

Too often, our efforts to resolve claims early are frustrated by the claimant refusing to disclose expert evidence, or agree to a meeting of the experts, to limit the issues in dispute. MPS wants to see the court taking a proactive approach to determining the appropriateness of expert witness instructions in clinical negligence cases. The court should have the authority to order experts to meet before the trial.

## **Specialist courts with specialist judges:**

We would welcome the introduction of a specialist personal injury/clinical negligence court with specialist judges and procedural rules designed to ensure early engagement of both parties, alongside proper case management. This has proved successful in Scotland, following the introduction of the All-Scotland Personal Injury Court.

We have been encouraged by the Government's proactive approach to resolving the current issues, through the Expert Group. And the Minister for Health Simon Harris' hopes for a mechanism that is more "person-centred and fair to all parties" is promising.

The final conclusions and recommendations of the Expert Group are now eagerly anticipated by all.

Dr Rob Hendry is medical director of the Medical Protection Society (MPS).

[www.medicalprotection.org](http://www.medicalprotection.org)

This blog was originally published in **Irish legal News**.

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## **Mr Nikolaos Giotakis** MD, FRCS (G) **Consultant in Trauma and Orthopaedic Surgery** **(Subspecialty: Complex Trauma and Limb Reconstruction Surgery)**

Mr Nikolaos Giotakis is a fully qualified Consultant Orthopaedic and Trauma surgeon, working at the Liverpool University Hospitals Foundation Trust. He has been heavily involved in complex trauma surgery since 2004.

### **Subspecialty Interest:**

**Acute Trauma Practice:** Management of complex limb trauma. His acute trauma practice takes place at the Aintree hospital which is a Major Trauma Center that admits the majority complex trauma cases in Merseyside. His area of special interest includes managing open fractures, complex lower limb injuries including limb threatening injuries.

**Elective Orthopaedic Practice:** Management of post-traumatic complications such as non unions (fractures that fail to heal), malunions (fractures that healed causing deformity), bone infection and implant related infections, joint contractures, post-traumatic arthritis.

In addition Mr Giotakis is involved in management of general trauma, including soft-tissue injuries.

Mr Giotakis has undertaken formal training in the preparation of medico legal reporting and has been providing a large number of medical reports since 2007.

He provides reports for both personal injury and clinical negligence for both claimant and defendant instructions, aiming to provide fair and unbiased reports and comments within his area of expertise.

He receives instructions on Personal Injury, which includes patients with complex and serious injuries. As a result of his clinical practice dealing regularly with complications of trauma, Mr Giotakis is very comfortable on providing opinion on negligence cases relating to trauma management and its complications.

In order to avoid delays and optimise communication, instructing solicitors have direct access to me via telephone and via email. He also a fast turnaround on average 5 working days from examination to report provision.

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## **Mr Fortune Iwuagwu** **Consultant Plastic, Reconstructive and Hand Surgeon** **MB BS, MSc, FRCS (Glas), FRCS (Ed), FRCS (Plast Surg.)**

**Mr Iwuagwu** has over eighteen years experience in the fields of plastic, cosmetic and reconstructive surgery.

He offers a full range of cosmetic surgery procedures and treatments to enhance your image and boost confidence.

Mr Iwuagwu trained in all aspects of plastic surgery in various internationally acclaimed units in both the UK and USA, gaining extensive expertise and experience in cosmetic, reconstructive and hand surgery

### **Medico-legal Experience:**

Mr Iwuagwu has been preparing medico-legal reports for medico-legal agencies and solicitors for more than 17 years. He prepares approximately 100 medical reports a year. The distribution is approximately claimant (80%) to defendant (20%). From instruction to completion of report is approximately three weeks if the client and medical records are available for examination/review. Mr Iwuagwu has undertaken specialist expert witness training.

Special interests: Scars, burn scars, hand injuries, soft tissue reconstruction, cosmetic surgery

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# Negligence Claim Costs Increasing - Again

*Following a Freedom of Information Act request made by the BBC, it has recently been confirmed that the current bill for outstanding clinical negligence claims is going to be in the region of £4.3 billion. This figure includes “all current unsettled claims and projected estimates of ones in the future.”[1] The “total cost of outstanding compensation claims”, which presumably means legal costs and damages, is estimated to be £83 billion.*

These figures certainly seem very high, but there are various aspects to this news article which do not provide a complete picture and explanation for some of these high costs especially to readers not familiar with clinical negligence work.

It is not unusual for claims often involving serious injury and which have to involve many experts to be defended but which are settled shortly before trial. Had those representing the healthcare providers made a more prompt admission of liability or explored a possible compromise earlier this would result in a significant saving of costs to both sides.

Granted, lawyers can be pedantic, but a genuine question to ask is, what is meant by a ‘current unsettled claim’? Is it a case which has been issued at Court? Is it a case which the Trust has received formal notification of by way of a Letter of Claim? Or is it a request for medical records where only a potential claim has been intimated? Claims that are not supported by the medical records and/or expert evidence quite rightly do not go any further with no costs to the state. Turning to the overall figure of £83 billion, there are other issues to consider. Firstly, cases involving injury to children at birth are often very high value because the child’s entire future has to be considered, along with the care and adaptations they may need to live a full life. Further, these cases often take many years to settle, because certain neurological injuries may not become apparent until the child is older. This figure will encompass costs relating to cases where the negligence took place some years ago, before the NHS brought in various measures to try and improve maternity and obstetric care, such as the Early Notification Scheme for incidents involving brain injury at birth. It is too soon to tell whether these measures will have a positive impact in years to come in bringing down rates of injury at birth and consequential claims for damages.

Crucially, the changes in the discount rate must be taken in to account as part of this figure. The discount rate is the percentage deduction which applies to future losses to take into account the fact that the Claimant would likely invest their compensation, and earn an investment on this sum. It had been set at 2.5% since 2001, however in 2017, it was reduced to -0.75%. As a negative figure, this essentially meant that future loss claims were suddenly inflated by a

large degree. This change in the discount rate accounted for a 33% increase in damages paid out between 2016/2017 and 2017/2018.[2] The discount rate is changed by the Lord Chancellor, over which both Claimant and Defendant solicitors have little or no control.

The principal of proportionality is also key here. The costs of a claim must be proportionate to the value of the case, otherwise serious penalties are likely to be imposed upon Claimant solicitors. This is why so many lawyers have stopped taking on low value claims, because the costs involved cannot be justified. If cases are on a No Win No Fee Agreement, the lawyer takes on a significant risk that the case won’t be successful and that all of their work will be written off. This is also why so much risk assessing goes into cases right from the beginning, and at each and every stage. The cases that are incurring costs are cases where there has been negligence and deserve to be settled.

The NHS has taken strides in the right direction; changing its name from NHS Litigation Authority to NHS Resolution in 2017, and having a permanent mediation scheme in place since 2016. Unfortunately, change in the culture away from litigation has only been a recent thing on the part of Defendants, and still seems an alien concept to some. Letters of intention are frequently sent to Defendants very early on before significant costs have been incurred, in cases where there is strong evidence of negligence obtained from an internal Trust enquiry, but all too often these are met with denials until many months further down the line, just as in the case of baby Hayden’s death reported by the BBC. This is the main scandal from this story – how can taking three years to reach a decision on whether there was even negligence in the first place help anybody?

## References

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[2] [www.resolution.nhs.uk](http://www.resolution.nhs.uk) – NHS resolution presses ahead with mediation as litigation decreases but claims costs continue to rise

Author: **Sarah Ratcliffe**

Many thanks to Sarah and Minton Morrill Specialist Solicitors for permission to reprint this article.

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# Researchers Receive £500k for ‘Completely New’ Prostate Cancer Treatment

Researchers from the University of Strathclyde have received a grant worth more than £500,000 to help develop an all-new drug to treat prostate cancer.

The grant has been awarded by Prostate Cancer UK as part of its Research Innovation Awards scheme.

The study, led by Professor Simon Mackay, aims to develop a new type of drug and bring it a step closer to clinical trials. He and his team have spent the last decade developing a chemical which could target a completely different protein in the cancer cell to other treatments.

## Effectiveness

If successful, this new drug has the potential not only to stop the cancer from growing but also to increase the effectiveness of other existing treatments.

Latest figures show that a record 12,000 men have died from prostate cancer in a single year in the UK, highlighting the need for new research to help diagnose and treat the disease. It is the most common cancer in men and kills one man every 45 minutes in the UK.

The study is one of eight projects sharing a total of £2.8 million from Prostate Cancer UK.

Professor Mackay, of Strathclyde Institute of Pharmacy and Biomedical Science, said: “Many existing drugs for men with advanced prostate cancer work in the same way. Although they can be very effective, men are left with few options once their cancer becomes resistant to these drugs.

“That’s why I was so excited when I came across studies by colleagues which showed that men with aggressive prostate cancer had higher levels of a protein called IKK alpha. Our team realised that if we could attack this protein, we could stop prostate cancer from growing and also help men respond to treatments for longer without becoming resistant.

“After years of research and negotiating many hurdles, we now believe we’ve found the chemical that can do this, but we need to do more research to find the best way for this drug to be delivered to men.

Thanks to the funding from Prostate Cancer UK, we now have the chance to bring this treatment one step closer to clinical trials. After all this time, I’d be over the moon if I could make that difference to men affected by prostate cancer.”

Simon Grieveson, Head of Research Funding, at Prostate Cancer UK said: “We know that around

20% of men with prostate cancer are diagnosed at a stage where their cancer has already progressed beyond the prostate and cannot be cured. By funding Professor Mackay’s exciting research to develop a new drug for prostate cancer, we hope it can take us a step closer towards our goal of stopping prostate cancer from being a killer.”

Professor Simon Mackay’s research could have a life-changing impact on men with advanced prostate cancer, such as patient and campaigner Lloyd Pinder.

Lloyd said: “I’ve been through so many different treatments, like hormone therapies and chemotherapy. But they’ve all eventually stopped working for me. It’s hard to stay positive when I know my options are limited, and my time is running out with my family.

“But I know I have to keep going. I have everything to live for. And it’s research into new treatments like Professor Simon Mackay’s that keep me hopeful. I just have to live long enough to be able to tap into them, it’s as simple as that.”

## Mr Roger Plail Consultant Urologist BSc MBBS FRCS MS CUBS



Mr Roger Oliver Plail is a Consultant Urologist at the East Sussex Healthcare Trust, Conquest Hospital Hastings, Eastbourne District General Hospital and Spire Sussex Hospital.

He has extensive general urological experience and surgical practice in both open and laparoscopic procedures. He has particular specialisation in Endoscopic Urology, Urological Oncology, Female Incontinence, Male Erectile Dysfunction and Vasectomy Reversal.

Mr Plail has been in medicolegal practice for approximately 10 years undertaking work for instructing agencies including Premex and Speed Medical but with many other referrals through solicitors direct.

He undertakes litigation work for both the Plaintiff and Defendant on Condition, Causation and Breach of duty.

He has undertaken a large number of Personal Injury cases on behalf of the claimant. These are often complex with associated brain injury and significant spinal and pelvic injuries with consequent upper and lower limb neurological damage and associated damage to bladder, bowel and sexual function.

He also has experience in the criminal court acting for the defendant in cases of allegations of sexual misconduct associated with concomitant alleged sexual dysfunction and has experience in being cross examined.

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# Should Surgeons Use Hernia Mesh? RCS Responds to Questions on Victoria Derbyshire Programme

Responding to the Victoria Derbyshire programme on hernia mesh (aired 15th January 2020), a Royal College of Surgeons spokesperson, said: “It is sadly the case that around one in ten patients experience pain following an inguinal hernia repair. Recent studies suggest the risk of pain following an inguinal hernia repair is similar, regardless of whether the operation uses mesh or the alternative non-mesh operation. If you are one of those affected, it is incredibly distressing, and you should certainly return to your doctor and seek further help.

“The dilemma is that doing nothing also has its risks, such as reduced mobility and/or pain. As surgeons, our duty is to explain the options and risks to patients, so they can weigh them up and decide what the best course of action is for them. Surgeons should always include the option of doing nothing as part of the range of options. However, many patients do want an operation, even knowing the risks. This is because untreated groin hernia can become increasingly painful, especially with sport and exercise or heavy lifting. There is also the possibility of the hernia becoming stuck, or worse, the bowel getting stuck in it, and having its blood supply literally strangled.

“The surgical community is continually working to improve techniques and to better understand the effects of different procedures. There have been a number of scientific studies looking at the use of mesh in hernia repairs. In view of patients’ experiences we are keeping a close eye on emerging evidence and studies, to ensure our guidance and understanding of the risks remains current.

“The Royal College of Surgeons of England is also campaigning to improve regulation and monitoring of new devices and implants. Together with the British Hernia Society, we are calling for a mesh registry to help track and understand the effects of mesh following operations.

“The priority for every surgeon is to alleviate a patient’s symptoms and improve their quality of life, so to hear that patients have experiences poor outcomes, and feel they have not been listened to, is very concerning. Any patient unhappy with the medical care they have received has the right to complain, have their complaint investigated and to receive a full prompt reply. There is more information about making a complaint on the Royal College of Surgeons’ Website and on NHS Choices.”

## Mr Myles J.O. Taylor

*Consultant Obstetrician & Gynaecologist*  
BA (Oxon) MRCGP PhD FRCOG

I am a Consultant Obstetrician and Gynaecologist and a Sub-Specialist in Fetal and Maternal Medicine at the Royal Devon & Exeter NHS Foundation Trust. My sub-speciality training was at Queen Charlottes and Chelsea Hospital, London where I researched monochorionic twins and twin-twin transfusion syndrome in particular. My research culminated in the attainment of a PhD.

I have published widely and am currently President of the British Maternal and Fetal Medicine Society. My expertise is in Obstetrics, Fetal Medicine, twins, including twin-twin transfusion, intrapartum care and general gynaecology.

I have over 15 years experience as an Expert Witness, acting on instructions from both Claimant and Defence solicitors. I have also had considerable Court experience.

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## Mrs Robyn J S Webber

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Consultant Urologist based in Fife, Scotland.

My medicolegal areas of interests are; personal injury, pelvic and genitourinary trauma, clinical negligence in all aspects of urological surgery, including delayed diagnosis and complications related to implanted surgical materials.

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# RCR Launches new Curricula for Clinical and Interventional Radiology

The RCR has unveiled its new curricula for clinical radiology and interventional radiology, based around a small number of high-level learning outcomes that describe the holistic capabilities needed for day-one consultant practice.

The reshaped and enhanced curricula reflect the General Medical Council's Excellence by Design standards for postgraduate curricula. They replace the old extensive and granular lists of knowledge, skills and behaviours with concise outcomes and tables showing the presentations, conditions and procedures that clinical and interventional radiologists need to be proficient in.

The curricula include a requirement to maintain general radiology skills alongside special interest or subspecialty practice, ensuring that all radiologists can meet changing patient and service need. They also include a requirement for trainees to embrace and evaluate emerging techniques and technologies, such as AI and hybrid imaging.

All trainees will transfer to the new curricula by August 2020, except those due to achieve their Certificate of Completion of Training before September 2021.

Dr Stephen Harden, Medical Director for Education and Training in Clinical Radiology at the RCR, said: "Under the new curricula, training activities on the hospital 'shop floor' will not be affected - what is changing is how trainee progress is monitored and how and when training requirements are deemed to be met fully.

"The expectation is that trainees will be able to deliver a broad range of care, as part of maintaining a generalist skill set."

Under the current 2016 curricula, trainees are assessed against long lists of competencies. Under the new 2020 curricula, they will instead be judged against 12 high level capabilities in practice. Six of these describe generic capabilities that apply to all doctors, including areas such as ongoing professional and reflective practice, commitment to quality improvement, leadership and teaching and supervision abilities.

There are six radiology-specific capabilities in practice that describe the unique role of a radiologist, plus two additional capabilities for interventional radiology subspecialty trainees, which focus on the ability to provide high-standard interventional care to emergency and elective patients, and the ability to clinically manage all stages of a patient's admission and treatment.

Assessment of the capabilities is based on intuitive entrustment scales that will support professional judgement and, along with progression grids, provides clear expectations for trainee progress.

Dr Harden continued:

"The idea behind the collated capabilities is that these rounded skills are what are expected of a new clinical or interventional radiologist on day-one of consultant practice. The new curriculum states much more clearly what is expected of – and to be demonstrated by – trainees, and makes clear to the public and the medical community just how broad the role of hospital radiologist is, around and beyond our core function of image interpretation."

"The inclusion of emerging technology and techniques future-proofs the curriculum and ensures that trainees are able to embrace new advances."

The curricula and a package of key documents, implementation tools and supporting information are hosted on a dedicated section of the RCR website.

For more information and support, please contact: [curriculum@rcr.ac.uk](mailto:curriculum@rcr.ac.uk)

## Professor Peter Sullivan

BSc MB ChB (Hons) DRCOG MA (Oxon)  
MD (Manc) FHEA FRCPC FRCP (London)

Consultant Paediatrician,  
Emeritus Professor in Paediatric  
Gastroenterology



Professor Peter B Sullivan holds the academic position of Emeritus Professor in Paediatric Gastroenterology at Oxford University and is a Fellow of Magdalen College, Oxford. Also Associate Dean (Postgraduate Medicine) at the University of Oxford Medical School.

Professor Sullivan has been a practising consultant in Teaching Hospitals for over 26 years. He initiated and developed the paediatric gastroenterology service at the John Radcliffe Hospital in Oxford. Each year this serves around 2000 Outpatients referrals, over 500 inpatients and performs over 200 gastrointestinal endoscopies.

His expert witness expertise covers the full range of gastrointestinal problems in children. With particular expertise as an authority in the gastrointestinal and feeding problems of children with neurodisability especially cerebral palsy in which subject Professor Sullivan is actively engaged in research and on which he has produced numerous scientific papers and textbooks.

Professor Sullivan has produced over 70 medico-legal reports with a mixture of reports for Defendants and Claimants. Increasingly asked to provide Joint Expert Reports. Current ratio: Claimants (41%); Defendants (45%) and joint instructions (14%).

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Oxford University Hospital NHS Trust, Oxford, OX3 9DU

# Patients Living with Crohn's and Colitis to Benefit from £5m Grant for a New Data Research Hub Based in Cambridge

- £5m grant awarded by Health Data Research UK (HDR UK) to establish a health data research hub for inflammatory bowel disease (IBD) following a successful bid led by Eastern AHSN and Cambridge University Health Partners (CUHP)
- The Cambridge based hub will be one of seven hubs set up across the UK to speed up research for new medicines and treatments, support quicker diagnoses and potentially save lives
- The IBD hub, to be known as G.I. Know, will work together with patients, industry, academia and the health service to transform our understanding of inflammatory bowel disease, drive improvements in diagnosis and treatment and deliver a data framework to reproduce in other disease areas

There is an urgent need to better understand why patients with Crohn's disease and ulcerative colitis (collectively known as inflammatory bowel disease or IBD) respond differently to treatments so they can be prescribed the best personalised treatment as early as possible in order to improve outcomes, minimise surgery and reduce costs. Whilst advances in clinical imaging, pathology and particularly genomics have produced remarkable progress in understanding Crohn's disease and ulcerative colitis the power of these technologies cannot be fully realised until their outputs are combined in a secure research resource and made accessible to the whole research community. This project makes that possible.

Mark Avery, Director of Health Informatics at CUHP and Eastern AHSN, who brought the bid team together commented; "This is such an exciting opportunity to be at the forefront of health data research. Working with the NIHR BioResource and patients we will transform our understanding of inflammatory bowel disease, drive improvements in diagnosis and treatment and deliver a data framework that could be used in future for other diseases. At Eastern AHSN we believe that citizens, academia, health services and industry will achieve more working together than they will in isolation. This project exemplifies that, and we are grateful to all our partners on this hub including the NIHR BioResource, Crohn's and Colitis UK, the IBD Registry, Wellcome Sanger, AIMES, Privitar and Microsoft."

Crohn's disease and ulcerative colitis are estimated to affect one in every 130 people in the UK (over 500,000) and costing UK health budgets approximately £1.5 Billion each year. Treatment is with steroids, immunosuppressants and antibody therapies, but results are variable. Over 70% of patients with Crohn's and 15% with colitis require major surgery. There is an urgent need to better understand why patients respond differently to treatments in order to improve outcomes and reduce costs.

Rosanna, Crohn's disease patient commented; "Patients with inflammatory bowel disease need to find the most effective treatment as quickly as possible to limit disease progression – but currently this process can take three or more years of trial and error. This initiative makes the tantalising prospect of personalised medicine real for patients, who for the first time will have the confidence that they have been prescribed the most effective treatment for them from the start."

Patient and public involvement is key to the success of this bid. 25,000 IBD patients across 90+ NHS Trusts have already been recruited to an NIHR BioResource and provided consent for their health records to be used for medical research.

## Dr Gerry George Robins Consultant Gastroenterologist FRCP Lond, MD, MBBS



Dr Gerry Robins is experienced and continues to practice in all aspects of Gastroenterology, including functional bowel disease (incorporating the Irritable Bowel Syndrome), Inflammatory Bowel Disease, dysphagia, dyspepsia, reflux disease, altered bowel habit, investigation of iron deficiency anaemia, coeliac disease, unexplained abdominal pain and abnormal LFTs.

Dr Robins has all necessary accreditation, and extensive experience in, gastroscopy, enteroscopy, flexible sigmoidoscopy and colonoscopy (including therapeutics).

He is experienced in writing Medico-Legal reports, including for (alleged) clinical negligence. He holds twice weekly clinics so can see patients and prepare reports rapidly.

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# Guidance for Healthcare Professionals Acting as Professional Expert Witnesses

The Academy of Medical Royal Colleges has recently published *Acting as a professional expert or witness*. The guidance, which follows a recommendation in Sir Norman Williams' Review of Gross Negligence Manslaughter in Healthcare, has been endorsed by nine healthcare professional bodies on behalf of over 70 healthcare separate professional organisations representing doctors, dentists, nurses, midwives, pharmacists, allied health professionals, optometrists and healthcare scientists (listed below).

Importantly, the General Medical Council, Nursing and Midwifery Council, Health and Care Professions Council, General Pharmaceutical Council, General Dental Council and General Chiropractic Council have all confirmed that the advice set out in this guidance is consistent with their standards and guidance as regulatory bodies.

Whilst the guidance was produced in response to the Williams inquiry recommendation there have been concerns about aspects of the role of expert witnesses for some time. Whilst professional bodies cannot act to regulate professional witnesses this guidance, aimed specifically at clinical professionals who provide an expert opinion or act as professional or expert witnesses in courts or tribunals, clearly states what healthcare professional bodies expect of their members in terms of standards, training and behaviour when acting as a witness.

The guidance reflects good practice set out by other bodies and highlights the legal requirements of witnesses. However the aspects which are original or have been highlighted as specific responsibilities for clinicians include:

- Healthcare professionals giving expert evidence must hold the appropriate licence to practise or registration and be in, or sufficiently recently be in, practice
- Healthcare professionals who act as expert witnesses should undertake specific training and continuing professional development (CPD) for being an expert witness
- The healthcare professional must have a full understanding of the wider context of the care delivery and how it impacts on the case, including the care delivery setting (rural, tertiary care, district general hospital, independent sector, primary care etc) and the historical context and circumstances if relevant.
- Healthcare professionals should be able to describe and explain the range or spectrum of clinical and/or professional opinion on the issue in question and indicate, with sufficient reasoning, where their own opinion fits into that spectrum
- Healthcare professionals acting as expert witnesses should make a self-declaration as to their scope of practice, professional development, training, special interests, areas of expertise both in general and in

relation to the specific case and any conflicts of interest that could impact on their evidence.

- If they are found to have provided misleading information after such a declaration, they could be liable to professional misconduct proceedings in addition to the possibility of any criminal sanction.

Professor Carrie MacEwen, Chair of the Academy of Medical Royal Colleges, said *"Being an expert witness is an important and valuable role. It is essential that clinicians acting in these roles are properly trained, fully up to date and act with complete integrity. Having this guidance endorsed by such a range of professional bodies and supported by professional regulators is a significant step. I believe this guidance will help ensure and maintain the required standards as sought by Sir Norman Williams Review"*

Professor Sir Norman Williams said *"The review which I led into gross negligence manslaughter in healthcare identified problems with the expert evidence provided by healthcare professionals in both criminal and regulatory proceedings. The review recommended the introduction of standards and better training to ensure greater consistency and higher standards in the evidence provided by medical expert witnesses. The important work taken forward by the Academy of Royal Medical Colleges, which has been agreed with organisations across the profession, is a major step forward in delivering this recommendation."*

## Dr. Piers N Plowman

Senior Clinical Oncologist/Radiotherapy  
MA, MD, FRCP, FRCR

Adult and Childhood Cancer.  
Radiotherapy and Chemotherapy for Cancer.  
Author of textbook on complications of therapy.

Over twenty years experience as Expert Witness for above.

Also specialises in delay to diagnosis.

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# New RCOG Women's Voices Lead appointed

*Shaista Gohir OBE has been appointed as the next Women's Voices Lead for the Royal College of Obstetricians and Gynaecologists and will begin her three-year term in June 2020.*

The RCOG's Women's Voices Lead is an honorary lay role with responsibility for leading the College's Women's Voices Panel and influencing the College's patient and public involvement agenda; ensuring women's views and experiences of maternity and gynaecology services are heard.

Shaista has a wealth of experience, with an incredibly varied and rich background in campaigning and advocacy. Among Shaista's achievements is her work with the Muslim Women's Network, a national charity that works to improve social justice and equality for Muslim women and girls. She is currently serving as co-chair of the organisation, which she has spent the last 15 years growing.

Her work with the charity has included conducting research, operating a national helpline and delivering campaigns and policy influencing information.

In recognition of all her work, Shaista was awarded with the MBE in 2008 and OBE in 2016.

Shaista will succeed Kate Brian, who has held the position since 2016, and will spend the next few months working with the College's Patient & Public Involvement team and the many voices that engage with the RCOG. Shaista will begin the role formally in June, following Kate's departure in May.

Commenting on her appointment, Shaista Gohir, said: "I am so delighted to have been appointed as the next RCOG Women's Voices Lead and can't wait to get started in June.

"The College's commitment to ensuring women are at the centre of its work is fantastic. So too is the dedication of the Women's Network and all those who bring their insight and experience to shape O&G education and training, guidance, quality improvement and policy. I'm excited to lead this amazing group and ensure all voices are heard within the College.

"Too often women are forgotten in their own care. Health inequalities persist in the UK that must be addressed and eliminated, and I hope to bring my experience to further enhance the RCOG's drive to achieve these objectives."

Dr Edward Morris, President of the Royal College of Obstetricians and Gynaecologists, said: "We are absolutely thrilled to welcome Shaista whose wealth of knowledge and passion will undoubtedly continue to ensure women's voices are at the heart of everything the College does.

"Shaista's role is key in making sure women are at the centre stage of discussions and decision making at the College, from the development of clinical guidelines, patient information, and training and education, to professional development, quality improvement and policy. We very much look forward to Shaista starting in June.

"We would also like to extend our heartfelt gratitude to Kate Brian, who has worked tirelessly and made tremendous achievements as the first Women's Voices Lead. We wish her all the best in her work to continue to champion the very best in women's health."

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## Mrs Lynne Greenwell Midwife

Msc Medical Ethics and Law (Imperial College, London), Bsc RM,  
Bsc (Hons) Psychology

Lynne Janique Greenwell is an expert in midwifery, based in West Sussex. She has experience in all areas of midwifery including: antenatal clinics, day assessment unit, labour ward, postnatal ward, SCBU. All assessment, planning, evaluation and implementation of individual holistic care, (antenatal, intrapartum and postnatal) to women and their families, reporting deviations from the normal to the appropriate health professionals. Mrs Greenwell has a special interest in infant feeding and has worked for Heinz, Hipp Organic and Mead Johnson as an infant nutrition specialist.

Mrs Greenwell is familiar with the statutory requirements of the UKCC regarding the Midwives code of practise, midwives rules, drug administration and storage, and record keeping, ensuring a safe working environment for mothers, babies and staff members.

Her expertise also includes various nursing duties, e.g. medication, observations, supervision of junior staff. She is also experienced in nutrition and diets, specialising in paediatric feeds advising; midwives, nurse's dieticians, neonatologists and paediatricians.

Mrs Greenwell is a serving Magistrate and Appropriate Adult for Hampshire Police and Portsmouth Council, she also undertakes voluntary work.

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# GP Expert Witness...What's involved?

*“Medico-legal work fits very well within a portfolio career. It adds diversity to your work and improves your clinical practice as you gain a much deeper knowledge of subject matters.”*

**Dr Adrian Rees**

*The expert opinion of experienced GPs is sought after in clinical negligence investigations. It's an intellectually stimulating career choice, is well paid, and can be built up alongside a clinical practice...I think it is incredibly fascinating...*

**Dr Jonathan Moore**

It does, however, require a serious time commitment, often determined by Court timetables. You must have an eye for detail and the ability to communicate clearly in writing as well when speaking.

We asked current experts for their advice to GPs considering this career choice.

You need some time on the clock and experience before starting. I started in earnest 8 years after starting as a full time partner, though I had done my first case after 6 years.

I think you need to feel reasonably confident that you could go up against a more established GP in an experts' meeting and hold your own. You must also be prepared to go to Court.

*Consider whether being cross examined in the witness box for 2.5 hours is something that they are willing to put themselves through!*

You need to have been qualified as a GP for at least 10 years and be a member of the Royal College of GPs (MRCGP). There is no minimum requirement but I think this gives a good basis for expert work.

*There aren't any other specific requirements but it is wise to go on a course to understand the law and report writing.*

Inspire MediLaw provide training and guidance to doctors from the very outset of their medico-legal journey. It's essential that a medical expert fully understands their duty to the Court; the legal tests involved in a clinical negligence investigation; and what's involved in giving an expert opinion – both in writing and under cross examination.

*If you don't have good experts you have a poor level of justice*

**His Honour Judge Charles Harris QC**  
addressing delegates at the Inspire MediLaw  
Summer Conference 2019

The best way to develop your medico-legal expertise is by learning from experienced medical experts and lawyers, and engaging in discussion with your peers. Our two day Expert Witness Training Course is designed and refined by medico-legal experts with an existing clinical negligence practice. It's attended by new and established experts from a whole range of

clinical disciplines, a great forum for meeting and sharing experiences with others. You'll learn key skills, talk about tips and pitfalls, and network over refreshments and meal times. And this is only the beginning!

On successful completion of the course we'll support your medico-legal practice. We can help you finalise your medico-legal CV; provide training on medico-legal practice management; offer opportunities to attend or speak at medico-legal conferences and events to help you raise your profile; and send updates on case law and judicial comment on expert evidence.

## What next?

Read about two of our GP experts below, take a look at the profiles of experts on our Medical Panel, and get in touch with us for a chat if you'd like to find out more.

Follow us on Twitter @InspireMediLaw  
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#InspireExperts #InspireLawyers

## Inspire MediLaw talks to two experienced GP Expert Witnesses...



**Dr Jonathan Moore:** I discovered being an expert witness in my first year as a medical student! One of my colleagues, who is now a female consultant surgeon, had done a degree in medical law on her journey to medical school.

As a junior medical student I read her amazing dissertation on “Clinical Negligence in Obstetrics” and I was totally blown away. I was sure I had chose the wrong career and wanted to retrain as a barrister then and there! However, she told me that I should continue as a doctor and develop my career into an expert witness practice as “then you get the very best of both worlds”!!

It turns out she was absolutely right and it changed my life. So, uniquely, I underwent my entire medical training knowing that this is what I wanted to do, and I started my LLM (Master of Laws) just a month after qualifying as a GP.

I have found it even more rewarding than I could have expected, especially when a case settles in the way you feel it rightfully should, through the power of your own evidence. That and reading a Court judgment in your favour...



**Dr Adrian Rees:** I developed an interest in medico-legal work during my trainee years in hospitals where I was seeing how complaints and medico-legal work was handled. I undertook a Masters in Ethics in Law to improve my knowledge and started undertaking medico-legal work once I had been in practice as a GP for 10 years.

I find the work mentally stimulating and challenging. It is interesting working with other professionals outside of medicine and using my knowledge to translate the mystery of medicine to non-medics.

I find that this role has developed my communication, increased my knowledge of medicine and enabled me to better understand the previous mystery that was The Law!

## Inspire Medilaw online Expert Witness Training courses

The Training Faculty for the online courses are our very experienced and distinguished Expert Witness Training team:  
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## Inspire MediLaw Medicolegal Expert Witness Accreditation Programme Launch 2020

Inspire MediLaw seeks to equip, encourage and inspire medico-legal practitioners, developing your professional skills and practical understanding. We firmly believe that education is vital for the administration of justice in clinical negligence and personal injury cases.

It is our vision to see excellence in medicolegal practice. We are confident that this can be achieved through ongoing training, peer support, and dialogue between medical and legal professionals.

We are delighted to launch our membership and accreditation programmes as we promote the highest standards of medical and legal practice in litigation.

Our membership packages for expert witnesses will enable you to raise your profile, access professional medicolegal support, and benefit from a discount on our CPD training.

Applications for Panel or Full Membership are welcomed from medicolegal experts, regardless of whether you have attended an Inspire MediLaw training course.

Our accreditation programme provides medicolegal experts with a quality mark, an indication of commitment to continued training and development in order to maintain a high standard of expert witness practice.

Delegates who have completed our two day Expert Witness Training are invited to apply for Inspire MediLaw's Expert or Senior Expert accreditation.

For full details of application process and fee, contact Caren Scott, Managing Director.

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## Mr Hazem Alfeky Halexie Health

### Consultant Plastic & Breast Reconstructive Surgery

Mr. Hazem E. Alfeky is a Consultant Plastic and Breast Reconstructive Surgeon at Bedford hospital services. He provides a wide range of plastic surgery procedures including breast reconstruction, microsurgery, hand elective and trauma surgery, laser, skin cancer surgery, limb reconstruction and general plastics surgery. His main area of expertise is breast and limb reconstruction.

#### Mr Alfeky's areas of expertise includes;

- General Plastic Surgery
- Burn management including;
- Upper Extremity including Hand
- Head and Neck
- Acquired Soft tissue injuries
- Aesthetic surgery: Blepharoplasty, Rhinoplasty, Otoplasty
- Lower Extremity
- Skin diseases and soft tissue
- Chest and Breast

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## Mr Jonathon Pleat

BM BCh (Oxon), MA (Oxon), DPhil (Oxon), FRCS (Plast)

Consultant Burn, Plastic and Reconstructive Surgeon;  
 Past Lead for the Bristol Adult and Paediatric Burns Services; Research Director, Restore Burn and Wound Research; Lead, The Scar Team - the UK's first independent scar multidisciplinary team; Scar Expert, The London Scar Clinic; Faculty The Scar Academy



Mr Jonathon Pleat is a Consultant Burn, Plastic and Reconstructive Surgeon; Past Lead for the Bristol Burns Services; Research Director, Restore Burn and Wound Research; Lead, The Scar Team - the UK's first independent scar multidisciplinary team; Scar Expert, The London Scar Clinic.

#### Special interests include:

- Assessment, treatment and prognosis of burns and scars of all causes
- Particular interest in scarring from major burns

His key focus is on the assessment, treatment and prognosis of skin scarring from all causes. A scientific, objective approach that draws on both a current extensive clinical experience in this field, an active research interest and the lead for a multi-professional practice that purely focuses on scars (The Scar Team).

He lectures nationally and internationally on scarring. Mr Pleat is also an English language lead for the international POSAS scoring system of scar outcome. He is a faculty member of The Scar Academy, a European network of scar specialists which focus on education and research.

Mr Pleat has completed formal legal training through Bond Solon; he has received the Cardiff University Bond Solon Civil Expert Certificate.

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#### The Scar Team

The Nuffield Hospital, 3 Clifton Hill, Bristol, BS8 1BN

#### The London Scar Clinic

152 Harley Street, London, W1G 7LH

Area of Work: London, Bristol and UK



# The Medicolegal Challenges of Fibromyalgia

by Dr Chris Jenner, MB BS FRCA, FFPMRCA, Consultant in Pain Medicine

Although fibromyalgia (FM) is now widely accepted, there is still no definitive diagnostic test for the condition and the causes are not yet fully understood. Therefore, the condition presents several challenges in the medicolegal field. These are chiefly focussed around diagnosis, establishing causation and whether the symptoms reported are severe enough to cause significant disablement (1).

## Diagnosis

The major symptom of FM is widespread pain, which occurs in all four quadrants of the body (1,2). Although previous diagnostic criteria also included the presence of a certain number of specific tender points, this measure is no longer used (3). Additional symptoms include fatigue, cognitive dysfunction, mood and sleep disturbance, headache, abdominal pain and depression (1,2,4). Furthermore, there must be no other clinical cause that could account for these symptoms (2,4). However, there is no definitive test to prove the existence of the condition (1). One major issue with diagnosing FM is that several of the symptoms presented are also associated with depression and anxiety, or with other somatic conditions which are medically unexplained, such as myalgias, sleep disturbance and chronic fatigue (2,5). Thus, some doctors remain sceptical that FM is a physical condition, viewing it more as a somatisation disorder, in which psychological distress is manifested as physical symptoms (5,6).

Furthermore, many patients report that their symptoms fluctuate over time which means that some patients may not meet the diagnostic criteria for FM all of the time (1,2). However, in the medicolegal setting the intensity of symptoms relating to impaired function is more relevant than an 'all-or-nothing' diagnosis. As the diagnosis of FM is often not clear-cut, the opinion of a pain specialist is preferable to that of a GP, who may not have the sufficient specialist knowledge or experience of the condition needed to exclude a diagnosis of other similar conditions (1).

## Causal Events

There is no single well-defined cause of FM but many patients attribute their condition to a triggering event, often physical trauma (1,6). However, this can be difficult to demonstrate when an incident has not resulted in any physical damage to the patient. Thus, proving causation is often a central issue in many FM claims, as there may be a number of interacting factors. Aspects to consider include the nature of the triggering event, whether physical or psychological, along with any evidence of predisposition in the claimant (1). There is some indication of a genetic element to FM (1,6), with up to 25% of the blood rel-

atives of a sufferer also receiving a diagnosis (1). It is also important to consider whether any pre-existing conditions might compromise the patient's health and increase their vulnerability to FM. These might include a susceptible psychological status as well as previous adverse life experiences, particularly in childhood, all of which have been shown to be more commonly found in FM sufferers (1,6).

It is often alleged that some form of physical injury, such as a motor vehicle accident (MVA) or work-related incident, triggers the onset of FM although the reason why this occurs has not yet been explained. There is some evidence of over-diagnosis of FM following whiplash injuries, with the number of patients affected dropping from 14% to 8% when tender points in the neck region are excluded. In the UK, pre-collision health-seeking behaviours and somatisation, perceived injury severity, post-collision physical symptoms and older age all predicted new onset of diffuse pain in individuals involved in MVAs. By contrast, in Lithuania, where compensation for disablement is much less common, there were no reported incidences of chronic neck pain following MVA. However, it should be remembered that while it may not be possible to confirm that FM has been caused by an injury, this does not necessarily prove that it cannot be triggered in this way (1).

A recent systematic review (6) considered the evidence for a precipitating physically or psychologically traumatic event in the causation of FM from a total of 51 studies. The majority of studies that considered physical trauma reported that it was significantly associated with the onset of either chronic widespread pain or FM. Furthermore, psychological trauma was consistently more commonly found in FM patients. In addition, several studies indicated that post-traumatic stress disorder may have a mediating effect on FM. However, it should be noted that many of the studies included in this review were of low or very low quality. For ethical reasons, it is not possible to conduct randomised controlled trials, which provide the most robust source of evidence. Instead, data came from retrospective studies which are prone to various sources of bias, in particular issues with patients' recall of events. Variations in the definition of triggering events and outcomes, due in part to the change in diagnostic criteria for FM over time, also make it difficult to compare the results of different studies. Moreover, for physical trauma, the evidence specifically relating to FM comes from a limited number of sources.

Various mechanisms have been suggested to explain the association between physical trauma and FM.

One possibility is that, following spinal cord injury, chronic immune-mediated neuroinflammation then causes FM to develop (7). In the concept of central sensitisation, the central nervous system displays a prolonged or exaggerated reaction to stimuli that should not normally provoke an effect. FM patients are known to be hypersensitive to various stimuli such as pinpricks, pressure and temperature extremes, although it has been suggested that 'central amplification' may be a better description of the type of pain perception experienced in FM (8). Another hypothesis centres around endocrine abnormalities, such as atypical dopamine secretion in response to painful stimuli. These have been demonstrated in FM patients and it is possible that some of the symptoms of FM such as sleep disturbance, fatigue and stress are both a cause and a consequence of these abnormalities (6). Overall, it is difficult to conclusively demonstrate a temporal link between physical trauma and the development of FM because of the emotional response which often follows physical injury, as psychological factors are themselves associated with an increased risk of FM (6). Furthermore, MRI scans have demonstrated an overlap between the regions of the brain that process pain and those that are activated by psychological trauma (9). Observations of abnormal cortisol secretion in FM patients who reported former abuse support the hypothesis that a chronic reaction to ongoing psychological stress can lead to the development of FM and possibly other pain conditions (10). This is further supported by the finding that in post-traumatic stress disorder (PTSD) patients, abnormal cortisol patterns appear to be predictive of widespread pain (11). PTSD has a high prevalence among FM sufferers and when both conditions appear together, an increase in the severity of both has been reported (12).

### Disablement

A further consideration in medicolegal cases involving FM is whether the symptoms reported are severe enough to cause disablement and should therefore be compensated. In this respect, there is often little else to rely on than the claimant's subjective self-report of their own symptoms. However, there is no consistent method to assess the validity of self-reported symptoms and no accurate method of establishing the reliability of subjective reporting. A patient may perceive their symptoms to be considerably more severe than a health care professional believes them to be. It is possible that a patient may indeed be suffering from severe subjective symptoms while outwardly appearing normal. However, there is also evidence that fabricating or exaggerating symptoms is relatively common in claimants alleging disability due to FM, as the disability rates associated with the condition are much higher than those observed for many other chronic illnesses (1), although more recently it has been reported that rates of malingering in FM are low and that compensation rarely results in the resolution of symptoms (6). One key issue in assessing disablement is whether a claimant has achieved the maximal medical improvement, but this can be difficult to determine



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in FM, where the severity of symptoms often fluctuates. Thus, determining the patient's efforts to mitigate their illness through self-motivation and active participation may prove useful (1).

The understanding of FM has changed considerably over recent years and this raises important considerations. The dependence on subjective reports and medical assessments for diagnosis and disability assessment could be exploited by a small number of dishonest claimants. It is important that these individuals are identified, as they serve only to negatively affect legitimate sufferers.


### About the author

**Dr Chris Jenner**, MB BS FRCA, FFPMRCA, Consultant in Pain Medicine, is highly regarded for his extensive experience and skill for all medicolegal cases involving pain. He has 15 years' experience as an expert witness and acts for both claimant and defendant. Please contact us on 0207 118 0650 or [info@medicolegal-partners.com](mailto:info@medicolegal-partners.com) to instruct Dr Jenner or any of our other medical experts.

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Dr Kacker have been providing personal injury medico-legal reports since 2002 under the direct instruction of solicitors. He provides reports that are internally consistent, logical and unequivocal. His reports have been complimented and credited in the past by a number of instructing Solicitors.

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# Denying the Successful Claimant Fixed Costs: A Cautionary Tale

## *Hussain (I) & Begum (II) v Aviva Insurance Limited*

The rule that costs follow the event is very rarely displaced, except in favour of claimants in fast track claims who are protected by the operation of QOCS. However, in some circumstances, where the Claimant (or the Claimant's solicitors) have prepared a claim so badly that it affects the level of the damages awarded or the smooth running of the trial, a DJ can (by operation of the general discretion as to costs – see CPR 44) refuse to award fixed costs at all.

In a recent claim, 2 claimants brought claims for whiplash type injuries arising from the same incident. The first claimant required the services of an interpreter, but had not properly certified the translation of the Particulars of Claim. This issue was raised as a positive point in the Defence, but was not dealt with. I raised this as a preliminary point on the morning of trial, and, there being no good reason for the problem still remaining live, the claim was struck out without further ado.

The trial proceeded with only one claimant. Although there were inconsistencies and problems with the evidence as between the various documents in support of the claim, this was mainly down to the in-

eptitude of the Claimant's solicitors in obtaining proper medical evidence and preparing the bundle. The claimant himself was not dishonest, and liability had been admitted. The DJ awarded a modest sum for general damages, just above the threshold for the Fast Track.

However, on costs, the situation was quite different. In respect of the costs relating to C1, whose claim had been struck out, the DJ accepted my submission that the solicitors should have to show cause as to why they should not be personally liable for D's costs (a "wasted costs order"). On C2's claim, bearing in mind that he had been successful, the DJ made an order for "no order as to costs" save for the court fees. C's solicitors therefore recovered NO costs at all in respect of either claim, and may well have to pay a wasted costs order to D. Mere success at trial is therefore no guarantee that an inadequate solicitor will recover their costs.

Francesca was instructed by **DAC Beachcroft**.  
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### Dr Mark Rosenthal

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Dr Mark Rosenthal is a consultant respiratory paediatrician at the Royal Brompton Hospital London.

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- Relationship of housing environment to the onset and exacerbation of respiratory symptoms in children.
- Food allergies in children.
- Diagnosis of rare lung diseases.
- Issues over home ventilation of children with chronic lung disease.
- Condition and prognosis in relation to neurodevelopmental problems especially cerebral palsy.
- Risks of choking hazard with children's toys etc.
- Deaths from asthma.

Dr Rosenthal is formerly Honorary Consultant Respiratory Paediatrician to the Royal Marsden, Epsom, Wellhouse, Hemel Hempstead, Watford, Worthing, Central Middlesex, Frimley, Mayday and Waltham Forest NHS trusts. Honorary Senior Lecturer to the National Heart and Lung Institute, London. He is also a visiting Consultant in Paediatrics in the Ukraine, Greece and Qatar.

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# Non-Delegable Duty and Vicarious Liability in the Healthcare Sector



by Dr Jock Mackenzie  
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My attention was recently drawn to this interesting case, *Neema Ramdhean v (1) Alfredo Agedo (2) The Forum Dental Practice Limited* [unreported][1]. It is only a County Court judgment regarding dental care, but it is pertinent because it provides another indication of the direction that the courts appear to be taking with regard to the issues of non-delegable duty and vicarious liability in cases involving healthcare.

## The issues are relatively straightforward.

The Claimant (“C”) claimed damages for personal injuries and losses as a result of alleged negligent dental treatment provided by the First Defendant (“D1”). D1 did not take part in the proceedings and his whereabouts was/is unknown. The dental care provided by D1 was in fulfilment of obligations of the Second Defendant (“D2”) under an Intermediate Minor Oral Surgery Contract (the “IMOS”) with Doncaster Primary Care Trust (the “PCT”). The case was before the court because of an order for a split trial with the preliminary issues to be determined of (1) whether D2 owed C a non-delegable duty of care (“NDD”) in relation to the advice and treatment provided to C by D1; and, (2) whether D2 was to be held vicariously liable (“VL”) for any such negligence as C may subsequently prove in her claim against D1.

## The facts are also relatively straightforward.

C was referred by her General Dental Practitioner (“GDP”) to D2 for a wisdom tooth extraction. This took place at The Flying Scotsman Centre owned by the PCT and the treatment was administered by D1. C’s case is that D1 failed to remove the roots. Her GDP referred her back to D1 at The Flying Scotsman Centre, where he told her that all the roots had come out, although subsequent x-rays showed that some had been left behind and required removal. This took place at a different dental hospital; C has been left with some consequential sensory loss around her left lip, chin and tongue.

With respect to insurance, D1 had professional indemnity cover with Dental Protection, a mutual society that runs discretionary indemnification. However, he did not notify his indemnifiers of a possible claim by C. The indemnifiers refused to provide cover, therefore (which they were entitled to do under the terms of the cover) and stated they had no interest in the proceedings. D2 had public liability insurance. Dr Keith Jackson, a fully qualified dental practitioner and orthodontist, was the managing director and majority shareholder of D2, a limited company, and he was employed by D2. He had

personal medical indemnity cover for himself but not for associates of the practice (such as D1). Dr Jackson claimed that D2’s responsibility to C was with respect only to the referral for treatment; with regard to the treatment of C, she was D1’s patient as D1 was the only person in the practice who could carry out the specialist wisdom tooth extraction work. Dr Jackson asserted that D1 was a “fully qualified, self-employed, individually indemnified, independent dental professional”. He also asserted that D2 was simply an administrative centre and D1 took all the clinical responsibility.

The judge (HHJ Belcher) made it clear early on in her judgment that the potential impact of her decision on the wider dental profession was not a relevant consideration. Similarly, she determined that the fact that C could only obtain redress by bringing a claim against D2 was also not a relevant consideration. Additionally, she was not willing to take into consideration that C had discontinued proceedings against the PCT and NHS England.

She then turned her attention to the NDD. She referenced Woodland[2] and Lord Sumption’s five “defining features” of: (1) vulnerability: C is a patient, a child, vulnerable or dependent on D’s protection against risk of injury; (2) antecedent relationship: between C and D which places C in the custody, charge or care of D and from which there is the imputation of a positive duty on D to protect C from harm; (3) lack of control: C has no control over how D performs his obligations; (4) delegation: D has delegated to a third party some function which is an integral part of D’s positive duty and that third party is exercising D’s custody or care; and, (5) negligence: the third party has been negligent in the performance of the very function delegated to him by D.

There was then consideration of Farraj[3]. Although on the particular facts of that case the court held that the defendant NHS Trust did not have a NDD, on the basis that they had delegated the performance of genetic testing to an apparently competent independent contractor external laboratory, the case was being relied upon by C for the assumption (rather than determination) that a hospital does indeed owe a NDD. Dyson LJ noted in Farraj that the concept of a personal NDD substituted for “the duty to take reasonable care” a more stringent “duty to ensure that reasonable care is taken” and must be justified on policy grounds. There were no such grounds in that particular case, however.

On that background, the judge considered Lord Sumption's five factors, not as a test but as defining features of the facts in this particular case:

(1) Vulnerability: the judge concluded that D2 had accepted C as a patient. She did not accept Dr Jackson's assertion that D2 performed a solely administrative function. D2 also asserted that C was the PCT's patient and not D2's, as the PCT had contracted D2 to provide dental services, but the judge rejected this.

(2) Antecedent relationship: D2 argued that the only such relationship was that D2 arranged for C to be examined by D1; it was the latter's decision whether to treat C and C was, therefore, in the care of D1. The judge considered that the question to be answered was whether C was in the care of D2, not D1: she concluded that D2 had undertaken to care for C, with the IMOS permitting that to be by way of employing or engaging the services of D1. The judge further concluded that, whilst D2 had no control over the treatment decisions made by D1, D2 had "control" in the sense that it was up to D2 to refer C to D1. As C had asserted, she was not a patient only of D1: C's GDP could not refer her directly to D1; it had to be through D2.

(3) Lack of control: D2 sought to argue that C could have declined treatment by D1, but the judge concluded that such an assertion missed the point: the question was whether C had control over how D2 chose to perform its obligations, i.e. personally, by employees or by third parties, and C had no such control.

(4) Delegation: D2 unsurprisingly asserted that it had no positive duty and its role was only administrative. The judge rejected this, concluding that D2 had delegated the care of C to D1 and D1's function (to treat C) was an integral part of D2's positive duty.

(5) Negligence: no findings had yet been made regarding whether D1 had been negligent but the allegations made were clearly not collateral and related to the performance by D1 of the very function delegated to him by D2.

The judge concluded that it was fair, just and reasonable to impose a NDD: D2 would accept a referral as a patient of the practice with attached obligations to provide such patient with relevant dental services for which it made commercial profit.

Although the judge did not need to determine the issue of VL, she was conscious that her judgment might be appealed and so she did address the issue. She referred to the Barclays Bank[4] appeal, judgment which is pending from the Supreme Court, and the decisions made in the line of cases leading up that appeal[5]. The starting point was Lord Phillip's five criteria identified in the Christian Brothers case for the imposing of VL:

(1) Means to compensate: the employer is more likely to have the means to compensate the victim than the employee;

(2) Activity on behalf of employer: the tort has been committed as a result of activity by the employee on behalf of the employer;

(3) Business activity: the employee's activity is likely to be part of the employer's business activities;

(4) Creation of risk: the employer has created the risk to the victim by employing the employee to carry on the activity; and,

(5) Control: the employee will have been under the control of the employer, to a greater or lesser degree.

The judge referenced Lord Reed saying that the five factors were not all equally significant and that the fact of a defendant with deeper pockets is not in and of itself a reason to impose VL. With respect to the fifth factor, the judge concluded there was a sufficient degree of control, even though D2 could not tell D1 how to treat C; it was sufficient that D1 was treating C only because of D2. The three remaining factors were inter-related. The judge concluded that C's treatment was part of D2's business activity and D1 was carrying out that activity on behalf of D2's obligations under the IMOS; D2 had created the risk, therefore. The judge rejected D2's invitation to rely on Whetstone[6], a similar case factually but one which was a first instance decision determined before Cox and Mohamud, regarding whether the associate agreement under which D1 was "employed" by D2 was a relationship "akin to employment" or an independent subcontract, deciding that it took her no further in determining the VL issue.

She concluded that D2 was vicariously liable for any negligence which C may subsequently prove in her claim against D1.

This is an interesting decision. It might, of course, be appealed, given the judge's conclusion notwithstanding that it is a County Court decision. To some extent, evolution in this area may of course depend upon the outcome of the Barclays Bank Supreme Court appeal, whatever that outcome may be, and the ultimate reasoning for it; however, this judgment demonstrates that the issues of NDD and VL in a healthcare context are live and the law appears to be on the move. Given the backdrop of some recent high profile cases, such as that of Mr Ian Paterson, it might not be that surprising if the traditional model of independent contractor was soon to be eroded and the private healthcare sector has to come to terms with a shake-up of who ends up being liable for what, with the consequential impact on insurance and indemnity arrangements.

## References

- [1] My sincere thanks to Richard Booth QC for drawing the case to my attention
- [2] Woodland v Swimming Teachers Association & Others [2013] UKSC 66
- [3] Farraj v King's Healthcare NHS Trust [2009] EWCA Civ 1203
- [4] Barclays Bank plc v Various Claimants [2018] EWCA Civ 1670
- [5] The Catholic Child Welfare Society v The Institute of the Brothers of the Christian Schools [2012] UKSC 56; Cox v Ministry of Justice [2016] UKSC 10; Mohamud v WM Morrison Supermarkets PLC [2016] UKSC 11; and Armes v Nottinghamshire County Council [2017] UKSC 60.
- [6] Whetstone v MPS [2014] 1024 QB

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\*Disclaimer: The information on the Anthony Gold website is for general information only and reflects the position at the date of publication. It does not constitute legal advice and should not be treated as such. It is provided without any representations or warranties, express or implied.\*

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I am a Consultant Otolaryngologist with specialist interest in Otology, Hearing Implantation including Cochlear Implantation and Lateral Skull Base Surgery with a paediatric and adult practice. I sit on the British Society of Otology Council. I have authored over 40 academic papers in peer reviewed journals and 10 book chapters. I regularly present at both a national and international level.

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Mr Matthew Smith is a Consultant Orthopaedic Surgeon at The Royal Liverpool and Broadgreen University Hospitals NHS Trust and has been since September 2009.

He is the Associate Clinical Director for the department with responsibility for Upper Limb Surgery. His primary role is as a subspecialist shoulder and elbow surgeon.

He has a wealth of experience including experience of procedures that are practiced by a limited number of appropriately skilled surgeons across the country such as The Arthroscopic Latarjet or "Arthrolatarjet" and the fixation of complex shoulder fractures.

He has a large arthroplasty (shoulder replacement) practice and is leading the way with innovative techniques such as CT scan navigated shoulder replacements. In addition to this ultra complex work he undertakes all aspects of routine shoulder surgery and most aspects of routine elbow surgery.

Mr Smith undertakes medico-legal work and has been preparing medico-legal reports for over eleven years. He undertakes reports for claimant and defendant solicitors alike for both personal injury and medical negligence matters. He aims to provide fair unbiased reports for the assistance of the court, and parties involved, in all cases.

He almost exclusively provides reports dealing with shoulder and elbow problems over and above the remit of a non-specialist shoulder and elbow expert. Overall his practice is roughly 50% claimant and 50% defendant. He provides a bespoke personalised service with all instructing parties having direct access to him via email or mobile phone facilitating Expert - Solicitor communication which is essential, especially in complex cases.

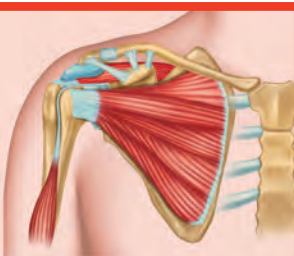
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I also provide clinical negligence related reports in my specialist area of practice concerning hip and knee replacements, revision surgery, and trauma including pelvic-acetabular fractures.

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# Why Continued Professional Development is Important to MedCo



*Continuous training and development is a vital part of any medical career, especially when training and development can open up new opportunities for work. Dr Dan Bunstone is the lead GP of a practice in a high growth area of Warrington, as well as the Chief Medical Officer and key member of the Clinical Advisory Board at Speed Medical.. Following his recent article about the NHS crisis, Dr Bunstone explores the need to stay on top of Continued Professional Development (CPD) in order to maintain MedCo accreditation.*

## **Meeting training deadlines**

The MedCo CPD training cycle is now over halfway through for this year, giving us until the end of May 2020 to ensure we've kept ourselves up to date and able to produce high quality, compliant medical reports.

There's a minimum of six hours of training required per year for Continued Professional Development, with much of the training being available online. MedCo has supplied 12 hours of online learning through their portal, which is effectively good enough for two years worth of accreditation. However, I'm not suggesting to stick to the minimum requirement. Keeping ourselves up to date is a vital task for any medical expert, and now there is the added incentive of not being allowed to continue with your MedCo registration unless the training is complete. If you've not started the training yet, I'd suggest making a start as soon as you can.

## **Maintaining MedCo accreditation**

The format on the MedCo site is different as it is mainly video-based coupled with transcripts and reference material. It's intuitive, interesting and focused on the work you'll be undertaking as an expert. This will support you in making those difficult decisions that sometimes come to us as medical experts.

To stay registered with MedCo and continue working as a MedCo-accredited expert, you must complete the minimum of six hours of CPD. While there are only four months remaining to get this done, it couldn't be any easier to do, especially as everything you need is on the MedCo website.

I'd encourage you to go further with the training. Consider completing all of the online modules plus at least one face-to-face meeting per year. This will put you in the best possible position to be offering high-quality medicolegal reports.

By taking the time to complete training, especially before the end of the MedCo training cycle, you are able to maintain your registration and accreditation - allowing you to keep working on cases and providing high-quality, impartial reports. Training should be a constant part of your role as a medical expert -

not only does it help you maintain access to professional bodies like MedCo, but it also keeps you at the forefront of your profession and striving to be the best you can be.

## **About the Author**

**Dr Dan Bunstone**  
**Chief Medical Officer**

Dr Bunstone has significant experience in both the Public and Private Sector from working in a variety of very senior roles. Acting as Chairman of the Warrington Clinical Commissioning Group (CCG) since 2015 and a board member prior to that, he has over 8 years' experience with the CCG. In his position as Chairman, he has the overall responsibility of ensuring the £275 million budget is spent in the most efficient ways to obtain the highest possible quality of care for the residents of Warrington.

The work he undertakes for Spire in the role of Educational Advisor, overseeing the GP Education Programme, allows Dr Bunstone to continuously gain additional experience in his field. He also sits on the Medical Advisory Committee for Spire Cheshire Hospital where he uses his vast experience to ensure the delivery of best practice.

Dr Bunstone has worked closely with the team at Speed Medical since 2015 in his role as Chief Medical Officer and has been instrumental in maintaining a high quality of experts on the panel. Leading the regular audit of reports, he is able to feedback to experts about what is working well, and what needs improving. He is also responsible for identifying experts that may not be meeting the very high standards that Speed Medical demands and supporting experts who may have received unreasonable requests.

As Chief Medical Officer at Speed Medical, Dr Bunstone plays a pivotal role in supporting the direction of the Clinical Advisory Board, a new addition to the clinical support team.

# In the Case of Clinical Negligence...

by Dr Diyari Abdah

A very well-known and excellent clinician friend asked me a while ago for an 'informal' opinion regarding a letter he received from a solicitor firm accusing him of potential clinical negligence based on a patient's point of view at the time.

Clearly, I could not make any comments in a legal capacity, nevertheless, the language that was used in the latter was very discriminatory and very much reminded me of the language occasionally used in some governmental correspondence (we know which ones) designed to cause intimidation and sleepless nights.

This academic and clinician friend is one of the best we have in the his clinical field, and yes sometimes unexpected problems could happen to all clinicians, but I know how thorough and methodical he is, in addition to the fact that he is a very talented and gifted clinician, and yet all the sudden was vilified by this firm.

Without going into much details, the case against him did not go any further, when all parties realised that he did everything by the book and the results were more than satisfactory, but maybe not exactly what the patient has envisioned, which in itself is not a 'clinical negligence' case, and maybe an expectation management case.

To make matters worse, he received no apologies from anyone, especially the firm which left him wondering what this world has come to.

This made me also wonder, why so-called professional solicitor firms use this kind of language? Is it to bully and intimidate? Just couldn't see the need for it, because facts are facts, and as an expert witness I learnt that we look at facts without any prejudice or emotions or any other form of speculations.

Every doctor, dentist, and other professionals including solicitors can receive letters of complaint regarding some aspect of the way they carry out their service, and the question is, does it have to be in a threatening and speculative language, especially if the letter is asking simply for clinical records, meaning they have only heard one side of the story yet, but still assumed this is a clinical negligence case.

The words clinical negligence is used so lightly nowadays unfortunately. It is on most patient's tongues and some firms love to run with it and keep digging.

When he asked, what was he accused of, they told him they do not know yet, but they are looking into the clinical records. That is a "Fishing Expedition" in my opinion.

Is this the norm that these firms conduct their so-called professional services? Because to me that is bullying and intimidation.

We all know about the No-win No-fee practices, and it is true that maybe this kind of practice itself is not unprofessional in itself, but what it represents and how, that is the problem in my opinion.

No health professional wants to cause harm to their patients, but if problems occur, the easiest way to get everyone on board and getting to the bottom of the issue, is by professional dialogue and if part of that is asking for records or making the clinician aware that he has been targeted by a client or patient, and I am sure there are many better ways to communicate this instead of a degrading and threatening language from the outset.

As an expert witness, I learnt very early what cases I want to be involved in, and these are the ones that my report can be neutral without influence from the firm.

We all hear stories of firms pressurising experts in one way or another, which goes against what we are supposed to be doing, having an impartial, balanced but highly professional view regarding the cases we deal with.

I am only hoping that professional firms change their tactics and the language they use when communicating with highly respected and intelligent people like health care professionals or other professionals. After all it is not their job or up to them to decide who has committed clinical negligence, as everyone is innocent until proven otherwise.



## Dr Diyari Abdah Dento-Legal Expert

DDS, DDS, MSc (Implant Dentistry), MBA, CUBS  
Adjunct Clinical Assistant Professor

Dr Diyari Abdah has over 30 years of general experience (25 years in Dental Implants), with special interest in reconstructive and implant dentistry.

Dr Abdah has placed hundreds of implants and is highly experienced in advanced implant techniques and complex mouth reconstruction.

Areas of extensive expertise include:

- Dental Implants / Bone and Sinus Augmentations
- General Dentistry (Including Prosthodontic, Periodontics)
- Restorative Dentistry
- Laser Dentistry
- Piezo-dentistry
- Full Mouth Rehabilitation
- Aesthetic Dentistry

Dr Abdah undertakes instructions as an expert witness, including the preparation of medico legal reports, in cases involving dental injuries. He offers a fast track service for the legal community in cases of clinical negligence.

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# The IFAB Agrees to Implement Substitution Trials to Address Concussion Incidents

The International Football Association Board (The IFAB) at its 134th Annual General Meeting (AGM), held in Belfast, Northern Ireland agreed to draw up protocols to be used in trials for substitutions in cases of concussion.

Following feedback from the recent meeting of the Concussion Expert Group (CEG), The IFAB also agreed that more research data is required before proposing possible changes to the Laws of the Game. FIFA indicated a strong interest in having trials at the Men's and Women's Olympic Games football tournament in July 2020, with other competitions also being able to take part in the trials.

The AGM agreed to consultation with all the relevant stakeholders, including The IFAB Technical Advisory Panel (TAP) and the Football Advisory Panel (FAP), to review the offside Law to foster the spirit of attacking play.

The IFAB will continue to look at measures within the Laws of the Game to tackle mobbing of match officials and confrontations between players which should have no place in the game.

Members were updated on the use of video assistant referees (VARs) around the world, highlighting the success of this innovation, while also considering fu-

ture developments, including improving communication and potential technological advances.

The meeting also agreed on the importance of finding solutions to allow competitions with restricted budgets to be able to access and use VARs, with such solutions being led by the working group for innovation excellence that has been established by FIFA.

The AGM reviewed the changes to the 2019/20 Laws of the Game and noted their positive impact on the way the game is played and the image of the game. The AGM also approved clarifications to several existing Laws to the 2020/21 Laws of the Game. These changes relate to Law 10 (yellow cards are not carried forward into kicks from the penalty mark), Law 12 (handball, to differentiate more clearly between the arm and shoulder) and other clarifications.

The meeting was chaired by the president of the Irish FA, David Martin, and was attended by representatives from FIFA, led by the FIFA President, Gianni Infantino, the FA, the FA of Wales, Scottish FA and The IFAB's administration.

The decisions taken at last year's IFAB AGM are available at: [www.theifab.com/news/133rd\\_annual\\_general\\_meeting](http://www.theifab.com/news/133rd_annual_general_meeting).



## GOOD NEURORADIOLOGY

### Dr Catriona Good

MBChB, FFRad(D), FRCP, PhD

Dr Catriona Good is Consultant in Neuroradiology and Honorary Senior Lecturer at Brighton and Sussex Medical School.

Dr Good is suitably qualified to provide expert opinions on all aspects of brain and spinal neuroimaging. Including: all aspects of diagnostic brain and spine imaging, brain and spinal trauma, brain haemorrhage and stroke, neurodegeneration including dementia, movement disorders, skull base, orbital and ENT imaging, TMJ imaging and Peripheral nerve imaging.

Dr Good has been undertaking medicolegal work for the past 16 years and is a vetted expert for Academy of Experts, Faculty of Experts and APIL (1st tier) She has also obtained the Cardiff University CUBS qualification. Cases include personal injury, clinical negligence, criminal cases and GMC and Irish Medical Council fitness to practice proceedings. She undertakes both Claimant and Defendant work, has civil court experience including hot tubbing and has been instructed as a Single Joint expert.

Dr Good has attended Coroner's Court on four occasions and an Irish Medical Council hearing. Medical Report turnaround time is usually 2-3 weeks but she can provide reports in 5 working days in urgent situations.

Dr Good can also supply Screening Reports.



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Consultant Neurologist - Dr. med., MRCP, PhD

Dr Anke Hensiek is a Consultant Neurologist at Addenbrookes Hospital, Cambridge; the Spire Cambridge Lea Hospital, Cambridge; and BMI The Sandringham Hospital, King's Lynn.

Dr Hensiek has a strong academic background and a broad range of knowledge in general neurology. Her experience lies in assessing general neurology patients; in both an outpatient and inpatient basis and also in intensive care. Dr Hensiek also has significant experience in acute neurology.

Dr Hensiek was awarded a PhD for her work on the genetics of multiple sclerosis. Specialist areas of expertise are; Neurogenetics, including specialist clinics in Neurofibromatosis, Ataxia Telangiectasia and Hereditary Spastic Paraparesis and Motor Neuron Disease.

Dr Hensiek has been undertaking medico-legal work since 2009.

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# What Sort of Expert Witness are You? What Will the Judge say About You?

by Alec Samuels

The claimant was injured in a motor car accident. She successfully sued the driver, and also sought contribution from the hospital for allegedly failing to make a trauma call and for negligent failure properly to care for her as a patient. Eight experts were called, four on each side *ZZZ v Yeovil District Hospital NHS Foundation Trust* [2019] EWHC 1642 (QB), [2019] Med LR 545, paras 53-102. The judge assessed each expert in turn.

**Witness A** - Witness A made three concessions, and amended her evidence accordingly.

**Witness B** - Witness B was careful and consistent.

**Witness C** - Witness C was disingenuous. He missed some fractures, he did not comment upon some relevant matters, he did not correct his report even though the errors were commented upon in the report of one of the other experts, he did not volunteer a correction, only belatedly acknowledging the errors in cross-examination. His analysis was unconvincing.

**Witness D** - Witness D was thorough and careful in his report and did not resile from his position under cross-examination.

**Witness E** - Witness E was impressive. He indicated his expertise and the limitations upon his expertise.

**Witness F** - The deficiencies in the evidence of witness F were numerous and fundamental. He was a thoroughly unsatisfactory witness. It was not safe to rely upon his evidence where it differed from that of

the other witnesses. His expertise was in doubt. He had had no direct experience of the matter for six years. His preferred treatment differed from everybody else. He acknowledged a “silly mistake”, which the judge characterised as “fundamental”. He was incompetent, ignored relevant matters, gave no explanations. He was ignorant of the duty of the hospital towards the patient in a professional negligence claim. His defence of a mental block was palpable nonsense. He repeated the same mistake. He did not appreciate his inadequacies. He was wholly unreliable as a witness.

**Witness G** - Witness G was highly impressive and credible, a very good witness. He referred to the literature and the research and he explained the basis for his opinion.

**Witness H** - Witness H was “quite exceptional”. He had an impressive CV, and he had complete mastery of his subject. He was a clinician of great experience and expertise, and recent experience of the injury. He gave a firm opinion of the cause of the injury.

## Self-assessment

Following your report, and meeting with the other experts and joint report, and giving oral evidence in court under cross-examination, what would and could and should be said of you by the judge?

© Alec Samuels

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Mr Anand has prepared personal injury reports for the court since 2016. He is fully compliant with the CPR rules and has received training in the preparation of medico-legal reports. He receives instructions from Defendants (50%) & Claimants (50%)

### Areas of expertise include,

- Mr Anand is a specialist in Spinal Surgery. He manages all aspects of spinal injuries and disorders (neck, thoracic spine, low back pain)
- All aspects of Orthopaedic trauma & musculoskeletal injuries.
- Mr Anand provides Personal Injury reports for solicitors & insurance companies.

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# André Gomes' Injury is a Reminder of the Perils of Playing Professional Football

*Article written by **Barrington Atkins**, a sports injury lawyer at **Stewarts**. Barrington considers the consequences of serious injury for players at all levels of the game and looks at a recent case in which a player sued for loss of earnings due to an injury sustained as a result of the recklessness of an opponent.*

Saturday 9 November 2019 is a day many football fans will not forget. Supporters of Everton and Tottenham will remember it as the day they saw a footballer suffer a sickening injury that will see him out of action for the foreseeable future.

André Gomes suffered a badly broken ankle in a clash on the ball with Spurs striker Son Heung-min. As the player was stretchered off the pitch, the distress etched on the faces of his fellow players suggested the prognosis was not good.

Thankfully for Gomes and Everton, however, the Portuguese midfielder is expected to make a full recovery and his injury is not thought to be career-ending.

As the media focused on the incident and whether or not the tackle deserved a red card, what fans won't have been aware of was that on that day a staggering 162 Premier League footballers were out of action and undergoing treatment for injuries.

## **Football injuries**

The majority were nursing ankle sprains, torn ligaments or hamstring issues, but some were more serious. Newcastle's Jamaal Lascelles, for example, sustained a knee injury on the same day that will see him missing from the Magpie's line-up until at least February. Bournemouth's Charlie Daniels was even more unfortunate and will sit out the rest of the season with a dislocated kneecap.

Injuries are, of course, a career hazard, with footballers at all levels likely to suffer at least one of the more common injuries at some point in their career. These include hamstring or knee sprains, ankle injuries and at the worst end of the spectrum, cruciate ligament problems.

In an average season, a team with a squad of 25 players can expect at least seven hamstring injuries, and almost half of its squad (40-45 per cent) will suffer some form of leg injury. Other common ailments to befall players are Achilles tendinopathy (an aggravation of the ankle), torn meniscus (which

affects the cartilage in the kneecap), abductor and groin strains, and concussion from head injuries. Thankfully, anterior cruciate ligament tears occur relatively infrequently (25% of injuries), as these are the most common season-ending injuries.

### The cost of injuries to football clubs

The cost to clubs can be significant. Research from insurance brokers Marsh found that the top-flight clubs spent on average £26.3m on injured players in the 2018-19 season. At least teams at the leading clubs have the treatment and rehabilitation facilities necessary to recuperate their stars. Certainly, the smaller teams don't have anywhere near as good treatment facilities as the likes of Manchester City, for example, who send their injured stars to a hospital in Barcelona (the same unit that treats Messrs Messi and Suarez).

At the other end of the English League spectrum, semi-professional players are not so fortunate, and many don't have insurance to cover the expenses and loss of earnings they incur if they get injured. As a result, when they are injured long term, it can affect their livelihood and impact their mental health.

In some situations, legal action is possible. In a recent landmark case, *Welsh v Ossett Town*, Manchester County Court ordered Northern Premier League team Ossett Town to pay £19,000 in damages to a semi-pro player, Reece Welsh, for loss of earnings after deciding the club's player, Sam Akeroyd, was guilty of a reckless challenge against him. The court also ordered Ossett Town to pay costs

of £115,000 to cover Welsh's legal fees.

The club had insurance through their league membership, but not enough to cover such a hefty sum and may be forced to sell off their ground to cover the bill.

**Barrington Atkins**, a specialist sports injury lawyer, says about the case: "The case shows that players can take action if they suffer financial loss as a result of an injury that is not their fault. Players often worry about making a claim against an opponent or a club when they suffer a career-affecting injury. While the claim might nominally be made against another player or a club, the reality is that players and clubs are insured and it is the insurer that runs the defence of any such claims and ultimately pays the compensation. Similarly, in cases where the claim is brought due to the failure of a doctor to diagnose an injury or adequately treat an injury, the doctor will have insurance in place that would meet the claim."

You can find further information regarding our expertise, experience and team on our Football Injuries, Sports Injury and Clinical Negligence pages.

[www.stewartslaw.com/people/barrington-atkins-sports-injury-lawyer/](http://www.stewartslaw.com/people/barrington-atkins-sports-injury-lawyer/)

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- Medico-legal experience of over 15 years. Average instructions annually are 30-40, with 80% claimants and 20% defendants.
- Expert Witness in radiological diagnosis of personal injury and clinical negligence.
- Professional expertise in X ray, ultrasound, CT & MRI scan in musculoskeletal radiology
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ANDREW LODGE  
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## Mr Andrew Lodge

Consultant Orthotist - Dip OTC MBAPO

Andrew Lodge is a highly experienced Consultant Orthotist who has practised extensively in all aspects of Orthotics including service management and development, product evaluation and clinical practice for over 35 years.

He is trained and accredited in many specialist areas of orthotics as well as being highly skilled in the supply of both modern and traditional orthoses.

He has many years' experience in all aspects of orthotic care including the following areas:

Orthotic treatment of traumatic injury, including spinal injuries.

Treatment of neurologically impaired children.

Footwear and footwear modifications.

Calipers including stance control KAFO's

Foot orthoses including the latest 3D printed technology.

He has over 10 years' experience of expert witness work writing over 30 reports each year. His in depth, up to date knowledge enables him to act as a highly effective expert witness, including giving evidence in court. He is able to assist in cases where any level of orthotic intervention, opinion or expertise is required. Reports are prompt and concise with clear explanations of any medical or technical terms.

Andrew is trained in report writing, giving evidence in Court and holds the Bond Solon Civil Procedure Rules Expert Witness Certificate. He also holds the Cardiff University Bond Solon Expert Witness Certificate.

He is able to accept instructions in all aspects of Orthotic care including clinical and professional negligence and trauma.

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Consultations are available in: Elland, West Yorkshire or Sutton, South London. Alternatively on a domiciliary basis nationwide.

# Eye Health Experts call for Urgent Action on Hospital Eyecare to Reduce Delays and Improve Patient Safety

The Association of Optometrists (AOP), The College of Optometrists and The Royal College of Ophthalmologists have joined forces to issue a statement outlining steps to tackle increasing pressure on hospital eye departments in England.

Calling on NHS England leaders, the organisations are urging that new models of eyecare with adequate funding, are introduced in a bid to protect patients from failings that pose a risk to sight.

The call follows recent findings from the Healthcare Safety Investigation Branch (HSIB) and the Getting It Right First Time (GIRFT) Ophthalmology report which highlighted serious inadequacies in eye healthcare and an urgent need for change.

Under existing services, as many as 22 patients a month across the UK suffer severe or permanent sight loss because their follow-up appointments and treatment in hospital do not take place quickly enough.

Clinical Director for the AOP, Dr Peter Hampson said: "Under the current system, things are simply not working. We're regularly hearing stories of patients that are suffering as they live with unnecessary sight loss. National recommendations were made on the referrals process for conditions like glaucoma over a decade ago and yet people continue to experience the same systemic failings. We believe it's time to see a change. Making full use of the skills of other professionals, such as optometrists, could release time for ophthalmologists to manage cases where the patient has more complex needs."

Melanie Hingorani, Chair of Professional Standards at The Royal College of Ophthalmologists and UK Ophthalmology Alliance said: "There is an enormous amount optometrists and ophthalmologists can do to reduce care delays for patients with eye conditions if we work together. However, we need NHS England and Improvement to enable greater collaboration by urgently addressing the many barriers in the current system limiting this."

The College of Optometrists' Director of Policy and Strategy, Dr Sarah Cant, said: "This joint statement is an acknowledgement of the root and branch reform that needs to happen across England to alleviate the pressure that hospital eye health services and patients are experiencing. We know that there are some areas where optometrists' skills are utilised in enhanced services schemes, resulting in patients

being seen quickly and their treatments managed locally. These need to be available across England if we are to tackle the systemic problems now being faced."

In their joint statement, the organisations have set out immediate steps to improve patient eyecare referrals in hospitals in England. The document includes guidance for commissioners, hospital eye departments, individual ophthalmologists and optometrists to better integrate services and pool existing resources. For example, ensuring that only patients whose conditions need secondary care input are seen in hospital will improve capacity for patients with serious and sight-threatening conditions.

**Need an expert fast call our free searchline on 0161 834 0017 or visit [www.expertwitness.co.uk](http://www.expertwitness.co.uk)**

## Philip Jaycock

Consultant Ophthalmologist  
MB ChB, BSc, FRCOPhth, CertLRS, MD

**Mr Philip Jaycock** is a consultant ophthalmic surgeon specialising in cataract, cornea and refractive surgery at Bristol Eye Hospital.

He has over 16 years experience in ophthalmic surgery. Mr Jaycock completed his fellowship in cornea, external disease and refractive surgery at Moorfields Eye Hospital in London. He has been appointed as the external examiner to the University of Ulster.

Mr Jaycock is the Consultant lead for the regional cornea and refractive surgery service at Bristol Eye Hospital, treating patients from the South West of England. The service also provides excellent teaching and training.

He has developed a National profile in the fields of cataract, cornea and refractive surgery through publishing and presenting his innovative research work. He is widely published with 19 peer reviewed papers and has given over 30 International and National presentations.

He has undertaken and completed specialist training in the Bond Solon expert witness training course.

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# What does a Court Want From an Expert Report?

by *Katie Lee* - [www.hardwicke.co.uk](http://www.hardwicke.co.uk)

## **The introduction**

Apart from the usual summary of instructions, it is useful for a report to have a description of the property in question. This should provide a description of the relevant rooms affected by the defects in relation to where they are on the building, what floor they are on etc. Each room should be given a name, which is then referred to continuously throughout the report so there is no confusion. For example, don't call the master bedroom "bedroom 1" and also the master bedroom, as that becomes confusing. If it is possible to provide a plan of the floor or building layout with each room labeled, that is helpful.

## **Standards of Care**

It is useful for the report to set out what the standard of care under the contract is briefly at the beginning of the report. This helps the court to focus on that standard when reading through the specific defects detailed later throughout the report. If the contract specifically requires adherence to relevant British Standards, Building Regulations, manufacturer's instructions etc, set out that provision at this point. However, only set out the relevant part of the relevant British Standard, Building Standards etc applicable to a particular defect when dealing specifically with that defect later in the report.

When moving on to discuss specific defects, have a separate sub-heading and section for each defect, or related group of defects. If the employer's requirements, contractor's proposals or contract specification provides specific requirements for a particular piece of workmanship or product, set this out at the beginning so that the court is aware of what was required to be done/constructed. This is also the place to refer to the relevant part of the relevant British Standard, Building Regulation, or manufacturer's instructions applicable. The point of setting this out here is to explain to the court what ought to have been built and to what standard. This sets up the court's expectation for what is good workmanship.

Once it has been set out what the contract and/or workmanship requests are for the relevant work, the report should then explain what the defect on site is. This should include a description of what has been done, and an explanation of how this does not satisfy the contract requirements, Building Regulation, British Standards etc. The point of this section is to explain to the court what has been built, and to explain how this does not achieve the relevant standard of work. It should include an explanation of whether the way the work has been constructed poses a risk of further damage, poses a health and safety issue, with an explanation of why.

Even where the contract does not require specific compliance with Building Regulations, British Standards or manufacturer's instructions, this does not mean these standards are irrelevant to considerations of whether workmanship has been done properly/with reasonable care and skill. My view is that if there is a relevant standard etc, reference to it and how it has not been complied with should be made where workmanship or design is an issue and it is relevant. In addition, I have seen many experts' reports state that certain work "falls below the standard of reasonable workmanship" without giving any explanation of why. I have also seen reference to something "not complying with Building Regulations", but then failing to explain which Regulation or why the work does not comply with it. This does little to assist the court and prevents an early analysis of the strength of the client's case.

I have read expert's reports where the expert has failed to provide the express summary conclusion in relation to the relevant standard of care following all the above explanation, which is that, in the expert's opinion, the workmanship which has been undertaken, or the design provided, "therefore" demonstrates a lack of reasonable care and skill or falls below the relevant standard required in contract. I would be wary of an expert stating that something has been "negligent", which is more of a legal conclusion, but the court would expect the expert to refer expressly to an opinion that the relevant standard of care has not been met.

The expert should avoid straying into areas which are properly the realm of lawyers in their report. Although many experts sit as adjudicators, arbitrators etc (and thus have a fantastic understanding of the law), when acting as an expert witness legal conclusions and observations are best avoided. If there is a dispute about what standard applies or what terms apply, then the expert should state that they have prepared their report on the assumption that those terms apply, but make it clear the expert understands those are issues in dispute and that they provide no opinion on their applicability. This prevents the expert from being accused of "overstepping their role" or trying to advocate for their client.

## **Causation**

It is also important for a report to explain causation fully. When discussing the defective work, the expert should explain how failing to construct or build in a particular specified way has caused, or is likely to cause, any damage. The expert should never just assume that the court will understand how defective workmanship resulted in any subsequent damage or

the risk of any subsequent damage. The best way to approach this is to assume the judge in question is not familiar with the particular construction in question, and to explain the cause of the loss as if to a layperson. If the judge is familiar with the construction/technical issue, then this will serve only to confirm their understanding is correct. If they do not then they will be able to understand all they need to from the report.

### Remedial Works

It is important to remember that, in many cases concerning defective works, a Scott Schedule may be required, whether by the legal representative pleading the case, or later in the proceedings by the court (perhaps at a costs and case management conference (CCMC)). One of the purposes of a Scott Schedule is to highlight the specific remedial works and its associated cost right next to a particular item of defective work. This allows the court to more easily rule on each item of defective work, determine whether liability has been established in relation to each individual defective item, and then calculate the judgment sum more easily on those defects which the court considers have been proved against those it considers have not.

Bearing this level of specificity in mind is useful when preparing an expert's report. Things to also bear in mind when setting out a remedial scheme in an expert's report are:

- ◆ **Betterment.** The remedial works should simply remedy the defective work, and not provide for a better item of work than would have been delivered under the original contract.
- ◆ **A breakdown of how the remedial scheme is costed.** At the very least, the cost should indicate how much constitutes labour, and how much materials.
- ◆ **Particulars.** The description of the remedial scheme should be as full as is possible in the circumstances.

### Formalities

Even a draft expert report should try and ensure it conforms as much as possible with the formal requirements of expert's reports set out in Part 35 of the CPR and also section 13 of the TCC Guide.

This article was originally published on Practical Law on 17/12/2019.

### About the author

**Katie Lee** is a commercial barrister with particular expertise in construction, engineering, energy and technology-related law. Known as a hard-working and reliable junior, she is highly regarded for attention to technical detail and commercial awareness, as well as for her cross examination and trial work. She acts and has acted for employers, developers, contractors and construction professionals.

As well as working in large teams with senior counsel, Katie is regularly instructed as sole counsel to act and advise in relation to both High Court and County Court disputes. For example, her most recent multi-track appearances involved a three day trial in relation to agricultural fixtures and field drainage and an application for security for costs in the London TCC (High Court) on a final account dispute, where the judgment was reported.

Katie is currently a co-editor of the Construction, Engineering and Energy Law Journal of Ireland and regularly writes articles and case updates. She has been published a number of times in the Construction Law Journal and the Construction and Engineering Law Journal of Ireland.

Katie was also a contributing editor to the first supplement to the leading text on 'Delay and Disruption in Construction Contracts' (Burr 2016), and a contributor to the leading text, 'Construction Professional Indemnity Insurance' (Reed 2018). She regularly contributes to the Practical Law Construction Blog, and has appeared in a number of video blogs on various litigation topics.

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Mr Rick Linforth has expertise in; Breast Surgery and Oncology, Breast Cancer Treatment, Medico-legal reports on Breach of Duty, Causation, Condition and Prognosis, Delayed diagnosis, Tumour Doubling Times and Informed Consent-Montgomery compliance.

Rick Linforth has undertaken medico-legal cases since 2014, writing expert witness reports for the court which include liability and causation reports. He has received over 40 instructions this year; with a 60/40 split defence/claimant. He has attended court with appearances at; Civil (1) Coroners (1), and Criminal (1).

His areas of speciality also include;

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Annual Surveillance Mammography

Reconstructive Onco-plastic Surgery

Breast Symptom Assessment

Implant checks

Breast Cancer Treatment

Breast Lumps

Breast cancer diagnosis

Ultrasound



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# Horse Related Accidents An Experts View on Litigation

by Peta Roberts

*Unless someone is involved with horses, and has years of experience and training, there are many important points that can be missed in horse related accidents or equine valuations.*

Horses are flight animals, and have an uncanny knack of getting into trouble. Moving up to 40mph, and weighing up to a tonne horses can cause a great deal of damage very quickly. These accidents can happen anywhere, and, in the past I have dealt with accidents in a variety of places: riding schools, private yards, roads, yard open days to name but a few. The variety of accidents can also be surprising, as there are accidents caused when handling, transporting, riding, or viewing horses. Riding school accidents frequently involve a customer who has fallen off and feels the instructor was negligent. However, accidents on private yards or at competitions may involve riders, handlers, judges, stewards, or members of the public.

Some cases involve substantial compensation as people can have life changing injuries around horses. There is also the possibility of substantial compensation if a competition horse is injured or killed as the top racehorses or competition horses can be worth millions of pounds.

Whilst some cases are relatively straightforward, most are quite complicated. Success or failure can hinge on seemingly unimportant information. Some of this includes: whether the correct horse handling methods were used, correct equipment having been used, a systematic approach used in a lesson, with records of risk assessments, correct build up to the exercises used, as well as a sensible approach if the chosen exercise does not work. I often spend a considerable amount of time at a riding school perusing their accident book, to see if the horse has done the same thing before, or the instructor has a poor track record.

One case I did that involved travelling a horse was finally settled out of court, because the owner had used the wrong type of headcollar to travel the horse. I have done several cases where an accident was caused by equipment failure, and it takes a specialist eye to spot these problems.

An equestrian expert is usually needed if there is a dispute over the value of a horse, and valuing a horse is much more complicated than valuing a car – there is no Glass's Guide. A horse is only worth what some-

one is prepared to pay for it, and proving the value of a horse, especially if it is injured or dead, can be tricky.

A site visit is often necessary, and it is best done as soon as possible after the accident, as fences, hedges, surfaces, and horses, can change dramatically over a period of time. Often horses involved in big claims have unfortunate accidents and die before the case goes to court. One case I did involved horses that had escaped from a field three years before the site visit, and the field had been re fenced. This made it very difficult to assess where and how they could have got out.

My advice would be, if it involves horses, seek an expert early on. A good expert will save money, hasten the conclusion of the case, and help bring about a satisfactory result.



**Mrs Peta Roberts** FBHS  
**Equestrian Consultant, Trainer and Expert Witness**

Peta Roberts is a very experienced horsewoman, she is also a BHS Chief Examiner, an NVQ assessor, and a Side Saddle Association instructor & judge. She has worked as an equestrian expert witness for approximately 25 years, and is used by solicitors, insurance companies, and private clients.

Her experience covers; Horse riding accidents, Horse valuations, Sales, Description of horses, Horse handling, Personal injury, Accidents, Horse and vehicle accidents, Carriage driving, Horse behaviour, Riding positions (side saddle, astride), Equine health & safety, Show Jumping, Stables, Training, Transportation and Welfare.

Peta is an experienced equestrian expert and has been trained as a Single Joint Expert. She has provided expert witness reports for solicitors all over the country on behalf of either the Claimant, Defendant or as a single joint expert. She has given evidence in court on many occasions; County Court, High Court and for a criminal case, she has also provided evidence involving Trading Standards.

Peta is prepared to travel anywhere in the British Isles, is aware of the need to meet deadlines and of the rules and responsibilities of an Expert Witness. Her reports are clear, balanced and concise and she will make site visits, or prepare 'armchair' reports, as required. Peta has undertaken Bond Solon Single Joint Expert training.

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# Fertility Treatment: An Issue Ripe for Legal Challenges

by Michelle Last, *Employment & Immigration - Keystone Law*

The number of people undergoing fertility treatment in the UK increases steadily each year. The vast majority of these cases still involve heterosexual couples but new trends are emerging. According to a report from the Human Fertilisation and Embryology Authority, more same-sex couples, single women and surrogates are taking advantage of improving fertility treatments than ever before. In 2017, more than 54,000 patients underwent around 75,000 fertility treatments in the UK. This trend means it is increasingly likely that employers will be faced with requests for time off work from employees seeking to undergo fertility treatment. It is important, therefore, for employers to understand their obligations and how to handle requests sensitively.

## **Fertility treatment**

According to Fertility Network UK, a whopping one in six couples experience infertility. It is therefore a common issue faced by employees, whether or not employers are aware of it.

The phrase ‘fertility treatment’ covers a myriad of treatments available to enable a person to have a child. A summary of the main fertility treatments currently available in the UK is set out in the box on p18. Whether an individual is entitled to free fertility treatment is something of a postcode lottery: in 2017, 62% of treatment cycles were NHS-funded in Scotland, 50% in Northern Ireland, 39% in Wales and only 35% in England.

The fastest-growing fertility treatment in the UK is egg freezing, which rose from fewer than 300 cycles in 2010 to 1,463 cycles in 2017.

Reports that tech giants such as Apple, Facebook and Google are offering free egg freezing may lead cynics to suspect they want their female staff to delay giving birth so they can put work first. However, it can also be argued that the policy indicates a growing awareness, at least by some employers, that fertility issues are a concern for employees.

Employees undergoing fertility treatment may feel stressed and emotional about issues such as the underlying cause of their infertility, financial concerns about the cost of private treatment and whether the treatment will be successful. They may also feel incredibly unwell owing to the treatment. These issues can be exacerbated by concerns about the ability to take time off work. Some employees may feel uncomfortable talking to their manager about the fact they are undergoing fertility treatment and may instead apply to take annual leave. I have had numerous clients say to me they want to conceal the fact

they are having fertility treatment from their employer due to concerns they may be discriminated against.

## **Time off for fertility treatment**

More confident employees (both female and male) may specifically request time off for fertility treatment. The starting position is that there is no statutory entitlement to time off to undergo such treatment. The right to take time off for antenatal appointments, for example, does not apply unless an employee is actually pregnant.

If an employee requires time off for fertility treatment, they will usually need to take annual leave, unless the employer agrees to grant special or unpaid leave. Alternatively, if the employee is unwell as a result of fertility treatment, she may be able to take sick leave. In such cases, the employee will be required to comply with the relevant sickness absence reporting requirements to qualify for company and statutory sick pay (as appropriate).

## **Dealing with requests for special leave**

I would advise employers to encourage employees to be open about requests for time off for fertility treatment, so they can offer support and plan around the treatment. Employers should also consider any requests carefully and not dismiss them outright. Many employers are now developing ‘special leave’ policies to deal with requests for such absences. In the June 2019 edition of *Employment Law Journal*, I set out some considerations for preparing such a policy (‘Create or update a special leave policy’, ELJ201).

Employers can deal with requests for time off to attend fertility treatment in the same way as requests for other medical appointments. If they have a special leave policy, they can note that medical appointments should be taken outside office hours where practicable. An employee undergoing fertility treatment may require multiple appointments, but these can be treated in the same way as multiple medical appointments. An employee who is off sick as a result of fertility treatment should be treated in the same way as an employee on sickness absence.

## **Main fertility treatments in the UK**

### **Medicines**

There are a range of drugs available to help with fertility, especially medicines to help women ovulate to improve the prospects of pregnancy. The most commonly used medicines are Clomifene and Tamoxifen. Some medicines may cause side effects, such as nausea, vomiting, headaches and hot flushes.

### **Surgical procedures**

Various procedures are available, which are typically performed to counter some physical obstruction to pregnancy. These include surgery to:

- ◆ repair blocked or scarred fallopian tubes;
- ◆ treat endometriosis (to remove parts of the womb lining growing outside the womb);
- ◆ remove fibroids (small growths in the womb);
- ◆ destroy part of the ovaries for women with polycystic ovaries syndrome (cysts on the ovaries); and
- ◆ treat epididymal blockage and retrieve sperm (essentially, where there is an issue with the normal ejaculation of sperm).

### **Assisted conception**

This is what people typically refer to as ‘fertility treatment’ or ‘IVF’. However, there are a range of treatments available, including:

- ◆ intrauterine insemination or artificial insemination (IUI) – this involves inserting sperm into the womb via a fine plastic tube passed through the cervix;
- ◆ in vitro fertilisation (IVF) – the woman takes fertility medication to encourage her ovaries to produce more eggs than usual, which are removed and fertilised with sperm in a laboratory before a fertilised egg (the embryo) is inserted into the womb; and
- ◆ egg and sperm donation or freezing – a woman may undergo surgery to remove her eggs to donate to someone in need, to harvest for a surrogate or to save for a future date. Men may also act as a sperm donor or freeze their sperm for a future date.

### **Protection against pregnancy discrimination**

A woman who is pregnant is protected by law from being discriminated against because of her pregnancy. Pregnancy and maternity is one of nine ‘protected characteristics’ covered by s4 of the Equality Act 2010 (EqA). There is no actual definition of pregnancy and maternity in the EqA. However, it is apparent from the legislation that a woman must be pregnant to be protected against pregnancy discrimination and this has now been confirmed by case law (see below).

Pursuant to s18 of the EqA, it is unlawful for an employer to discriminate by treating a woman unfavourably during the protected period (from the beginning of pregnancy to the end of maternity leave) because of her pregnancy or a pregnancy-related illness.

Unfavourable treatment due to pregnancy is expressly not direct sex discrimination (s18(7) of the EqA). However, a woman may still be able to claim direct discrimination on the grounds of pregnancy and maternity. In essence, this provision seeks to clarify that cases involving alleged pregnancy discrimination should be brought as a pregnancy discrimination claim and not a sex discrimination claim.

Furthermore, pregnancy and maternity are excluded from the indirect discrimination provisions contained in s19 of the EqA.

### **At what point is a woman deemed pregnant?**

A woman undergoing fertility treatment is only protected against pregnancy discrimination once she is deemed to be pregnant. However, an employer may not know when an employee is pregnant and therefore it is advisable to be cautious if the employer is aware or suspects the employee may be undergoing fertility treatment.

The European Court of Justice (ECJ) determined in *Mayr v Bäckerei und Konditorei Gerhard Flöckner OHG* [2008] that a woman undergoing fertility treatment is deemed to be pregnant when her eggs are harvested and fertilised prior to the embryo being transferred into her uterus. The protected period therefore begins shortly before the embryo is placed into the woman’s womb. Typically, this is a few days before. The ECJ was clear the protected period does not start at the point eggs are frozen, if that occurs. The embryo may continue to grow into a healthy baby or it may fail but, in either case, the woman is deemed to be pregnant at least by the time the fertilised eggs are planted in her body.

Furthermore, if a female employee is on sick leave as a result of fertility treatment (defined in *Mayr* as follicular puncture followed by immediate implantation of an embryo), this leave arises because she is a woman. In such circumstances, if an employer dismisses her because of her sickness absence, this could be sex discrimination. The Employment Appeal Tribunal has endorsed this approach in *Sahota v Home Office* [2009], holding that the ‘important’ stage is ‘between the follicular puncture and the immediate transfer of the in vitro fertilised ova’ (ie the embryo).

This has been reinforced via the Equality and Human Rights Commission’s Employment Statutory Code of Practice, which provides that:

- ◆ a woman undergoing IVF is protected from the point the embryo is implanted, when she is deemed ‘pregnant’; and
- ◆ if implantation fails, the protected period ends two weeks later in accordance with s18(6) of the EqA. Therefore, even if the IVF treatment is unsuccessful, the woman is still deemed ‘pregnant’ for a period of time.

In *Karavadra v BJ Cheese Packaging Ltd* [2019], an employment tribunal held that where an employee was dismissed following time off for successful fertility treatment, the dismissal was because of her pregnancy. This case highlights the fact that if an employer dismisses an employee after granting time off for fertility treatment, a tribunal is likely to take a dim view of this in the absence of any fair reason for dismissal.

In practice, an employee is not obliged to inform the employer of the nature of her fertility treatment. The employer may therefore not know when she is deemed ‘pregnant’ and so should take care to avoid pregnancy discrimination. One area which is ripe for

clarification by the courts is whether an employee whose IVF fails and who is dismissed on returning to work is deemed to be discriminated against on grounds of pregnancy, even if the protected period as defined in the Code of Practice is over. Alternatively, it is possible that she may have a claim for sex discrimination.

### Surrogacy

As things stand in the UK, 'commissioning mothers' – women having a baby through a surrogate – are not entitled to protection against pregnancy and maternity discrimination.

The ECJ in *CD v ST* [2014] and *Z v A Government Department* [2014] determined that:

- ◆ the Pregnant Workers Directive is only intended to protect the health of women who have gone through pregnancy;
- ◆ commissioning mothers are not entitled to maternity leave, so refusing to grant them this will not amount to sex discrimination; and
- ◆ denying commissioning mothers maternity leave is not disability discrimination – infertility is
- ◆ not a disability because it is not a hindrance to the woman's personal life.

Employers have some freedom, therefore, to determine not to allow a woman to take maternity leave after the birth of her child through a surrogacy arrangement, even though she may be breastfeeding and caring for the child. However, in many cases, employers will grant leave on a discretionary basis.

The Law Commission and the Scottish Law Commission have published a consultation paper on

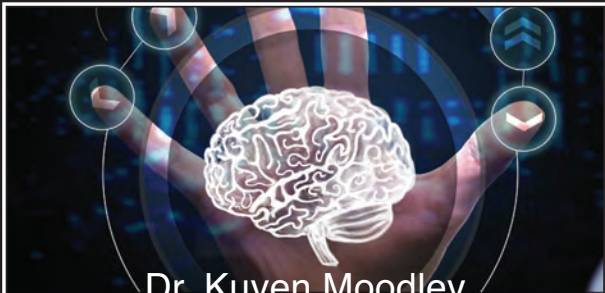
potential reforms to employment law relating to surrogacy arrangements, including the possibility of maternity leave for commissioning mothers. The consultation closed in September 2019. It is possible therefore that commissioning mothers may soon benefit from leave. However, it is likely that they would still not benefit from protection against pregnancy discrimination because they do not become pregnant.

### How to minimise the risk of claims

There are a range of treatments that an employee undergoing 'fertility treatment' may be having. The employee will not be entitled to paid time off to undertake treatment, but they should be treated in the same manner as other employees. Likewise, if an employee is unwell owing to fertility treatment, they are entitled to time off as sick leave. An employer who is on notice that a female employee is undergoing fertility treatment would be well advised to treat her as though she is already entitled to protection against pregnancy discrimination. Where an employer has concerns about time off, conduct or performance, it is better to address this with the employee when the issue arises. Employers who dismiss pregnant employees often say there were performance issues pre-dating the pregnancy. However, if the employer fails to document these, it may ultimately face a sceptical employment tribunal.

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Dr Kuven Kirendren Moodley is a Consultant Neurologist based in London. He has expertise in: general neurology, rapid access neurology (urgent neurology) and the cognitive disorders, including dementia and cognitive deficits arising following stroke, encephalitis and traumatic brain injury.

He attended the Bond Solon excellence in report writing course on the 12th of November 2018. In the year since, he has completed more than 20 medicolegal reports relating to medical negligence, personal injury also acting as a single joint expert.

The medical negligence portion of the work has been roughly split 50:50 between plaintiff and claimant with particular focus on cases involving cognitive impairment and iatrogenic/post-traumatic peripheral nerve injury.

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As well as being a full-time clinician I have also held positions as director for my unit and board positions for the operational delivery network for neonatology in NW London. I currently hold the position of Associate Medical Director for Clinical Informatics and Transformation at Chelsea and Westminster Hospital and I am a Medical Director for the UK Resuscitation Council Newborn Life Support course.

My clinical practice covers all areas of neonatal medicine, including the medical care of babies with surgical problems and premature infants.

I have recently become a Member of the Academy of Experts and have been awarded the Bond Solon Cardiff University Certificate in Civil Law

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# BAUS presents FutUrology – A Collaboration with ITN Productions Industry News

*The British Association of Urological Surgeons (BAUS) and ITN Productions Industry News are co-producing FutUrology, a current affairs style programme, raising awareness and understanding of the challenges and opportunities that affect the area of urology within the health sector.*

Urological emergencies account for approximately 25% of all acute surgical admissions to hospital, and approximately 30% of all GP consultations have some urological component, so urologists work closely with other specialists and departments to treat patients. Futurology will focus on the importance of the role of urological professionals, explore the many areas of the specialty across healthcare and highlight the support BAUS provides its members through professional development and information sharing.

Anchored by an ITN Productions newsreader, the programme will also showcase the latest techniques in research and innovation, mobilising change within the industry, from advances in surgical instruments to transformational technologies such as robotics and AI.

Launching at the BAUS Annual Meeting 15-17 June at the ICC Birmingham, the programme will form part of an extensive communications campaign featuring BAUS members and professional partners, as well as journalists, writers, bloggers and relevant government departments.

Duncan Summerton, President of the British Association of Urological Surgeons said: " BAUS is delighted to be working with ITN Productions on this programme in order to increase public awareness of urology and urological conditions and how they are treated. It is 75 years since BAUS was founded so we also want to celebrate all that is good about our specialty ... "

Elizabeth Fisher-Robins, Head of ITN Productions Industry News said: " We're delighted to be partnering with the British Association of Urological Surgeons to produce a programme highlighting the challenges within the field of urology, and the work being done across the UK to improve patient outcomes. We hope the films will provide a platform to stimulate discussion and advance solutions ... "

For more information, or to participate in the programme, please contact Georgia Gerstein, Programming Director, Industry News at ITN Productions on 0207 430 4165 or by email.

## **About ITN Productions Industry News**

ITN Productions Industry News produces bespoke creative and commercial content for broadcasters, businesses, brands, rights holders and digital channels. Industry News forms part of this offering and is a communications tool for leading industry bodies and national associations produced in a broadcast news-style programme format, including interviews, news items and sponsored editorial profiles.

## **About the British Association of Urological Surgeons**

BAUS is a registered charity which exists to promote the highest standard in the practice of urology for the benefit of patients by fostering education, research and clinical excellence. Our vision is that all those involved in urology are supported to deliver excellent care. BAUS is a membership association and 93% of consultant urologists working across the



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# Less Filler, Less Killer: Regulation of the Beauty Industry

by Graeme Watson, Partner and Megan Lafferty, Associate at Clyde and Co.

The Scottish Government has launched a consultation on the regulation of non-surgical cosmetic procedures.

The number of non-surgical cosmetic treatments carried out across Scotland and the UK has risen considerably over the years and continues to do so. At present, these procedures are largely unregulated. Independent clinics run by a doctor, nurse, dentist, dental nurse, midwife or dental care professional are now regulated by Health Improvement Scotland. However, the procedures themselves are not currently regulated, which effectively means that anyone, anywhere, can carry out lip enhancements, dermal fillers and many other procedures without having to be registered with anyone, and without their premises being regulated.

A number of pharmacists have now entered the cosmetic procedure field. However, unlike doctors, nurses or dentists the pharmacists do not currently need to be registered with HIS.

The consultation seeks views on the need for regulation, the need for non-qualified healthcare professions to be licensed and the regulation of pharmacists providing these services. Responses are due by 30 April 2020. The full consultation paper can be viewed [here](#).

## Comment

This is a good first step by the Scottish Government. At present, self-proclaimed beauticians, or anyone else, can go on a brief training course and start providing these treatments, wherever, whenever.

Celebrities and social media may minimise or downplay the gravity of non-surgical cosmetic procedures.

But things can, and do, go wrong. The reported risks of procedures such as dermal fillers include infection, blocked arteries, necrosis, blindness and stroke. Under-trained – or entirely untrained – individuals may fail to explain the risks. They may fail to get informed consent. They may fail to carry out acceptable treatment. And they may have failed to have appropriate insurance.

We have dealt with cases where seemingly straightforward procedures have gone wrong. Regulation of this field will ultimately benefit everyone involved – the patients, the practitioners, and their insurers.

At present, claims for these types of procedures performed by non-medical practitioners are largely dealt with under public liability insurance policies. Regulation will hopefully enable more specific policies to be developed and offered to practitioners, whilst at the same time improving patient safety.

This is a welcome step towards filling the regulatory void in this growing industry.

## Authors

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Graeme specialises in clinical negligence and healthcare and education regulatory. He heads the Scottish healthcare team. He also leads the historic abuse practice. Graeme is a solicitor advocate.

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Dr Tracey Jean Bell is a qualified dentist and aesthetics expert, with over 26 years of experience in dentistry and 18 years in aesthetic medicine.

Dr Bell has a wide range of knowledge of clinical standards is capable of identifying risk and has a good understanding of the law and its implications in dental and aesthetic medical practice.

Dr Bell recently became one of the first dentists in the UK to be awarded a Masters in Dental Law and Ethics from Bedfordshire University. Dr Bell has also completed a Bond Solon Expert Witness Course, demonstrating excellence in report writing. She also possesses courtroom skills, experience of giving expert testimony under cross examination, and knowledge of civil law and criminal law and procedures.

Dr Bell offers a comprehensive expert witness service, providing clarity, impartiality and expertise when dealing with even the most complex of cases. Having completed her General Diploma in Law with BPP with commendation, she is now a Clinical Lead for the Postgraduate Course in non-surgical facial aesthetics teaching doctors, dentist, surgeons and other medics on the core competence including consent, complication and applications of dermatology, Botulinum Toxin, facial fillers and cosmetic lasers at Salford University.



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# Dermal Fillers: Lack of Regulation Poses a Real Threat to Patient Safety

by Dr MJ Rowland-Warmann

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Non-surgical treatments such as Botox and fillers account for nine out of 10  
procedures and are worth £2.7billion [1].*

Whilst cosmetic surgery numbers are static, there has been an explosive increase in the UK's non-surgical treatment market, with Botox and Filler treatments becoming ever more popular. This has coincided with the rise of social media and many younger patients are now seeking non-surgical procedures, seeing these as inexpensive and quick fixes added to their beauty regimes. Botox and dermal fillers have become the social norm and whilst a wide range of ages are seeking treatment, there are serious risks to patients due to the almost completely unregulated nature of the non-surgical aesthetic industry [2].

The main problems in aesthetic medicine leading to litigation include failure to adequately consent the patient including warning the patient of the possible risks, dissatisfaction with the cosmetic outcome, and complications arising from treatment [3]. However, due to lax regulations surrounding the type of practitioner who can inject, in addition to the broad range of products on the UK market today, patients are at increasing risk of coming to harm.

## **Regulation in the UK**

The HEE and Keogh reports into non-surgical cosmetic practice found that in 5 key areas, namely Botulinum toxin, dermal fillers, peels, laser and IPL there is almost no regulation, leaving patients vulnerable, but also that there has been varying standards of care in key elements such as practitioner competence, consenting and complication management in cosmetic treatments [2, 4]. Figure 1 illustrates the various procedures. Neither product, practitioner nor premises have a requirement to be proven safe.

Reform has been suggested. Public opinion is that non-surgical procedures must be less dangerous, but serious complications can occur in either surgical and non-surgical treatments, and current legislation is not protecting patients effectively as it is based largely on guidance rather than concrete regulation [2].

There are worrying parallels between the state of the regulation with regard to non-surgical treatments using dermal filler products and the PIP scandal. This brought to light concerns about how the cosmetic surgery industry is regulated, but unfortunately at a stage when many thousands of patients had already suffered injury. Approximately 47,000 women in the UK, and 400,000 worldwide, were affected by faulty breast implants with a rupture rate of around 15.9-33.8% [5, 6]. Post-2000 PIP devices were shown to contain a non-approved industrial-grade silicone and were immediately removed from the market after an MHRA warning. However, their low cost meant they were used long after concerns had been voiced some years earlier [6, 7].

Whilst the MHRA did not advise imminent health risks, women in other countries such as Germany, Netherlands and France were advised PIP implants should be removed. This sparked a debate over cost versus care: some UK surgical providers simply changed their company name or refused to offer assistance to patients, loading the burden of cost onto the NHS [7]. It is most likely no accident that in the UK, with healthcare free at the point of delivery and a corporate veil to protect CEOs, moral and legal responsibility have been largely evaded with corporate preoccupation with profits acting against patient care. With more patients being injured by dermal fillers each year, there are worrying similarities in the



Current Regulation of Cosmetic Interventions 'At a Glance'

	Botulinum toxin (medicine)	Breast implants (devices)	Chemical peel	Dermal filler	Laser treatment	Intense Pulsed Light
<b>Product</b>	Regulated as a prescription Medicine	Regulated as a medical device	Regulated under General Product Safety Directive only if sold direct to consumer	Regulated as device only if it has explicit medical purpose – most don't	Equipment regulated as a medical device	Not regulated as a device. Safety covered by Health and Safety at Work (H&SW) rules
<b>Practitioner</b>	May only be prescribed but can be administered by non-health professional	Must be performed by qualified doctor	Can be performed by anyone	Can be performed by anyone	Can be performed by anyone	Can be performed by anyone
<b>Premises</b>	Anywhere. General H&SW rules apply	CQC registered	Anywhere. General H&SW rules apply	Anywhere. General H&SW rules apply	Anywhere. General H&SW rules apply Some LA's license	Anywhere. General H&SW rules apply Some LA's license
<b>Risks and Complications</b>	Bleeding, unintended muscle weakness, eyelid droop, double vision, speech and breathing difficulties, asymmetry, infection, allergic reaction. Not to be used in pregnancy.	Poor scarring, bleeding, infection, numbness, discomfort, implant palpability, implant visibility, asymmetry, implant rupture, capsular thickening/contracture, failure to achieve aesthetic expectations.	Burns, infection, scarring, changes in pigmentation alteration of skin texture, persistent redness, asymmetry.	Infection, scarring, persistent inflammatory response (redness), thickening, pain, infection, asymmetry, tissue loss, poor aesthetic outcome, visual disturbance, blindness.	Burns, infection, changes in pigmentation scarring, asymmetry, visual disturbance, blindness.	Burns, infection, changes in pigmentation scarring.

Figure 1: Regulation of cosmetic interventions, from [2].

management of complications when these patients attend NHS institutions, with the chasm between privately conducted procedures and state-funded healthcare opening. I am also witnessing a lack of knowledge and helplessness of those working in the NHS in dealing with dermal filler complications they are presented with.

Currently, some dermal fillers are exempt from EU Product Safety Directives as they can be used as part of a professional service and those not claiming a medical purpose are exempt from EU Medical Device Regulations entirely. There are over 250 dermal fillers in the UK market and patients currently rely on the manufacturer's declaration of safety and the practitioner's assessment of the product to ensure treatment success. This in turn results in practitioners often being swayed to purchasing products on the basis of cost, and products that would be deemed unsuitable for use by medical professionals are often seen being used by non-healthcare providers with little knowledge of what makes a good

product safe, or a safe product good. This is clearly dangerous, and it is argued that all cosmetic implants, including dermal fillers, should be reclassified as prescription-only medical devices (POM) and subject to CE marking under the EU Medical Device Directive [2]. The practicalities of this proposal are difficult, with MHRA clearance required for every single product under this scenario and reclassification under POM terms may be a challenge. Prescription medications do not carry VAT, and the cynic in me wonders whether the intransigence towards regulating dermal fillers stems from the millions of pounds the government currently receives in taxes each year from the sale of dermal filler products.

**Complications caused by non-healthcare practitioners are on the rise**

Not a month goes by when there isn't an article in the press or investigative feature on a news programme about non-healthcare practitioners causing harm with dermal fillers.

“Botched dermal fillers” is a common occurrence, with the highest rate of complaints in the 18-25 age group [8]. Whilst all articles highlight the lack of regulation surrounding the provision of non-surgical treatments, very little is done to protect vulnerable patients from dangerously unqualified practitioners.

“Botched” procedures may include instances where filler is placed badly, resulting in an unaesthetic result. However, many more serious complications can be caused by incorrectly placed dermal fillers. Instances of serious infections due to patients having treatment in unclean and unsuitable environments are rising. More worryingly, “dermal filler emergencies” are occurring more frequently. These are potentially catastrophic events such as severe allergic reactions or inadvertent injection of dermal filler into an artery which can lead to tissue necrosis (death of the tissue), blindness or even stroke. It cannot be disputed that non-healthcare practitioners are ill-positioned to identify and treat any medical complications of aesthetic treatment, let alone those that require swift emergency management

Save Face is a national, government approved register of accredited healthcare practitioners who provide non-surgical cosmetic treatments such as dermal fillers and anti-wrinkle injections. According to their Consumer Complaints Audit Report of 2018, 83% of complications that were reported to SaveFace were carried out by non-medical practitioners such as beauticians, hairdressers and laypeople [9]. The figures for 2019 show an alarming 73% increase in the number of complaints received by Save Face in one year, a worrying trend that is getting out of control [10].

The Save Face complications report found that 62% of patients who suffered complications found their practitioner on social media, with a staggering 64% choosing them based on price [9].

33% of complications that arose were treated in a domestic setting, and it is not uncommon, especially when presented with a complication, to be told that the patient in question had their treatment performed at their own home [9].

Both of these statistics illustrate a dysfunctional industry and are a far cry from the well-regulated and safe environments that patients should come to expect when having any medical procedure performed on them.

Due to there being very little legislation governing who should be able to treat patients, and the lack of standards surrounding those that perform non-surgical treatments, complaints against non-healthcare practitioners often remain unresolved. Practitioners who are non-healthcare are not accountable to a professional register, often untraceable and frequently uninsured, leaving the patient with no opportunity for redress when something has gone wrong – and in almost a quarter of the complaints received by Save Face the patients were ignored by the person who treated them [9].

The increase in the rate of referrals for complications that I have seen in my practice is astonishing. Whilst I received around 2-3 referrals of poorly placed lip fillers per year when I set up in practice in 2013, by the end of 2019 I was receiving 2-3 enquiries per day. It is not only the rate of complications from dermal fillers that is increasing, but also the severity. More than three-quarters of the complications that I see that require intervention to resolve have been caused by non-healthcare practitioners who often refuse their patients help after being informed of the complication. Unable due to lacking medical education – or unwilling – to help those they have injured by poorly performed aesthetic procedures, these patients end up shouldering additional costs to have problems with their treatments corrected by medical professionals, or burdening the already overloaded National Health Service.

### **Ability to obtain products**

Obtaining products for use in non-surgical procedures in the UK is as easy as shopping on Amazon. A Google search reveals that purchasing dermal fillers online is not only simple, but also requires nothing in the way of certification in order to complete the transaction and receive the products directly to your door.

A myriad of products, most of which I have never heard of (or would dare to use) greets me on one of the major sites. Some of the prices advertised for “genuine” products seem too good to be true.

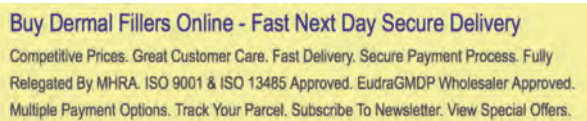
Likely, this is because they are.

I am spammed daily on social media by accounts touting products for non-surgical rejuvenation. My inbox sometimes looks more like a bazaar than the direct messages of a medical professional. I am offered “low cost” dermal filler “genuine dermal filler products”, promising me “top brands at rock bottom prices”. Often the accounts are based overseas, offering me apparently reputable products at prices that I would never get here in the UK. It is easy to see how those with limited medical knowledge or insight would be attracted by these proposals.

As at 2018, the MHRA had seized over £10.9 million in counterfeit drugs and made close to 900 arrests [11]. Counterfeit products, those that are designed to deceive the purchaser into thinking they are buying an original product, are different from fake products, which are often differently named yet claiming to be similar in terms of efficacy, purity and use [12]. Many counterfeit products originate in Asia, and their potency may be varied, some being wholly ineffective but others possessing dangerously high quantities of potentially harmful ingredients, such as has been found in cases of counterfeit Botulinum Toxin [13]. The danger to patients is vast.

These websites are not aimed at responsible medical professionals who source their dermal filler products from pharmacies or the manufacturers direct. These online sellers prey on the fact that reputable pharmacies will not sell to non-healthcare providers but

due to the government leaving open this loophole whereby non-healthcare practitioners are legally allowed to inject, inferior quality, counterfeit and fake products are flooding the market and being used on unsuspecting patients.



**Figure 2: Copy of a Google advert. The glaring error on line three gives a clear indication of the level of care that goes into the industry distributing filler to non-medical professionals.**

It is not only poor quality and counterfeit products being sold to practitioners in the UK. Products like botulinum toxins, a POM, are often obtained by beauticians and other non-healthcare providers through a legal loophole that enables them to practice in the “grey zone”, sourcing them from registered medical practitioners acting as their “prescriber”. The law dictates that a POM must be prescribed by a qualified and licensed medical practitioner after a consultation with the patient to assess their need and suitability for the treatment. Whilst this in theory should mean that all patients who receive botulinum toxin have been seen by a medical professional, in practice this is vastly different. An overwhelming proportion of patients who have botulinum toxin treatment by beauticians report never to have seen a prescribing doctor, dentist or nurse for the initial consultation, are rarely informed of the risks and benefits involved in the procedure, and are never subjected to anything that could be interpreted as a consent process. This is a clear breach of the law and potentially puts patients at significant risk.

### Current Regulation in Practice

In the eyes of Keogh, “fillers are a crisis waiting to happen” and the outcomes of several reports in the PIP aftermath included assessment of product safety, practitioner training, public information and options for redress as key elements, highlighting them for improvement in safety in cosmetic procedures [2, 4, 14].

### Products and Practitioners

With the exception of Botulinum Toxin which is a POM, non-surgical cosmetic interventions can be performed by anyone, and anyone can set up training courses. There are no guidelines regarding what constitutes adequate training or verification of courses at present. The responsibility is the practitioners to decide whether they are performing safely and to a high standard following training which, itself is of a varied standard and usually short (hours or a day), leaving practitioners ill-equipped to deal with adverse events [2].

Worryingly, training courses for beauticians are often poorly structured, lack specific aims or learning outcomes, and are conducted by unqualified persons. Researching for a report some months ago, I found

a well-advertised and popular training academy for non-medical providers of dermal fillers. The “trainers” were a motley crew of an ex-boxer with no medical qualifications and a doctor who was erased from the General Medical Council register in 2014. Considering medical professionals are subject to stringent regulation often not only in their professional lives but also have their personal lives examined by regulators, it is difficult to see how current regulations are adequately protecting the public from rogue practitioners without any medical knowledge.

Anyone can buy dermal fillers and practise on patients, without any training in anatomy, physiology, complication management or risk awareness. Often these practitioners use misleading titles which can further confuse the public, such as “aesthetic therapist”, which mean very little. Non-healthcare providers are endangering the public by practising singularly without support from clinicians and without the knowledge to diagnose or treat the patient if something were to go awry [2].

Currently there is no specialty register for cosmetic surgery, meaning surgeons are often not directly qualified in the cosmetic field. It is expected that a practitioner should act within their competence, which will increase with experience. It is however the luxury of experience that defines competence and the knowledge of when to refer that currently affords this, rather than a set of rules followed by surgical and non-surgical cosmetic practitioners. Many surgical teams do not perform procedures often enough to be competent and some consultations are not carried out by surgeons, inhibiting successful outcomes [15]. Regulators have attempted to improve standards by introducing revalidation (GMC) and CPD records (GDC) but the standards set for cosmetic practice are often vague and undefined [2]. This is all well and good when we are talking about cosmetic procedures that require medical professionals and a controlled surgical environment to carry out. However, it seems that the problem in non-surgical practice is out of control, dangerous and the government are legislating the wrong providers, focusing their efforts on registered medical practitioners rather than those with a propensity to cause serious damage.

Regulation of non-surgical practice has been attempted by government initiatives such as IHAS (Treatments You Can Trust) and companies such as Save Face; they are optional and have contributed little to eliminating the thousands of unqualified practitioners treating patients. The nature of this self-regulatory industry means that subscription is low, and it is only those who are already performing at an acceptable level who sign up, not those under performing in all aspects outlined in the Keogh report and who would arguably need it most [2]. Regulation of the most dangerous group performing dermal fillers – beauticians and other non-healthcare practitioners – is entirely absent.

### **Informed public**

Consent is a process rather than just a document and patients must be consented adequately in order to consider their options and information available to them. Often patients have little understanding of the procedure, or the product they are being treated with and this makes it very difficult to make an informed choice [2].

Marketing messages are confusing patients. Marketing is rarely honest or responsible, with financial inducements, discounts and time-limited deals being used to coerce patients into treatments, whilst misleading statements about practitioners and clinics and unrealistic claims about surgery outcome are equally reprehensible [14]. Many practices advertise prescription-only medicine, which is illegal and may conflict with the health needs of the patient. Compliance with advertising standards is poor, at only 41% [16], and is leaving vulnerable patients exposed to ruthless marketing tactics [16, 17]. Enforcing advertising guidelines has been reactive, with offenders only occasionally getting a slap on the wrist and legislation being produced in a piecemeal fashion.

On January 31st 2020 the Advertising Standards Agency (ASA) and Medicines and Healthcare products Regulatory Agency (MHRA) issued an enforcement notice relating to the advertisement of botulinum toxin. Although it is already illegal to advertise prescription-only medicines in the UK, recent rises in breaches of this law by companies on social media resulted in a clamp-down on paid-for advertisements, non-paid for posts and influencer marketing which has seen an explosive increase [18]. Whilst it is a step in the right direction and in favour of tighter regulation in non-surgical cosmetic treatments, non-healthcare practitioners are not accountable to a regulator and despite the recent threat of enforcement action have changed very little about their advertising strategies of botulinum toxin on social media. Once more tighter regulation has been applied to the lower risk groups with the high-risk providers of treatment being allowed to carry on as before.

### **Accessible solution and redress**

Due to substandard regulation, non-surgical providers are not necessarily location-bound, do not need complaints procedures, and are ill-equipped for emergencies. For non-healthcare providers, there is no requirement for insurance. Professional bodies require indemnity for registration to protect both patients and practitioners and non-healthcare practitioners seem to fly below the radar [2, 17]. It is unacceptable to conduct medical procedures at home, such as at "Botox parties", which display a total disregard for patient safety in venues that are incompatible with standards set down by any regulator – yet they are still commonplace [14].

A key issue is the provision of emergency care - often the provider contracts out of care when things go wrong, letting the NHS foot the bill or simply expecting the patient to carry additional financial

responsibility [4, 14]. NHS hospitals are often not the site of private interventions in surgery yet are used to shoulder the cost when re-admission is necessary [15].

### **The way forward.**

A regulatory framework that is realistic, achievable and appropriate is needed. Products must be safe, practitioners have appropriate skills, and treat patients with respect. It is important that expectations of the service users are met, in terms of outcome and the process by which the treatment is conducted, and for there to be continuity of care [2].

A regulator that ensures accountability of practitioners for surgical and non-surgical interventions should be established to ensure the necessary knowledge, skills and values of the providers.

Non-healthcare providers conducting medical procedures is subject of much debate. Most clinicians including me would welcome the withdrawal of privileges from these individuals by means of legislation. However, in the absence of this, non-healthcare providers should be supervised by a clinical professional. This should include being professionally accountable and holding an indemnity and a complaints procedure in place; whilst de rigueur for those from a healthcare background, this must be enforced for other providers. A register of indemnified practitioners would further improve patient awareness [2].

Safe premises mean that infection control and patient welfare is of paramount importance in order to be equipped to deal with adverse event management and medical emergencies. Whilst already regulating surgical practices, non-surgical providers should be required to register with the CQC and be subject to more stringent regulation. Whether dermal fillers become POMs or not, a mandatory registration for non-surgical providers with the CQC would subtract a lot of the rogue operators from the industry whilst simultaneously raising funds for the Department of Health with registration subscriptions.

In line with ethical marketing, time-limited deals and financial inducements should be banned and the advertising of POM should be restricted. This is currently not enforced widely enough. Regulators are not perceived to take a tough enough stance on breaches in the law, fines being limited and often not being sufficiently punitive to change the behavior of those in contravention of the laws.

Legislation has developed in a reactive fashion. Both minor and major interventions are not well regulated and self-regulation has failed due to the diverse nature of the industry and optional compliance, especially in non-surgical practice. Voluntary codes do not regulate unscrupulous practitioners [15]. Patients wrongly assume that because they are committing to a medical procedure it must be adequately regulated [2, 17].

The Keogh report, HEE document and the RCS Standards for Cosmetic Practice have illustrated grave problems in the way that the cosmetic industry operates. Legislation does not seem to adequately protect the public, especially with regard to non-healthcare providers conducting medical procedures without clear licensing.

The pillars of these reports are Competency, Consent and Complications. Competency is the training and the appropriateness of the service, taking into consideration the practitioner and products. Consent is a process, including the agreement to treat but also the information needed to make this decision. Complication management is essential, both when things go wrong in the immediate and long term, affected by the method of complaint resolution and the level of practitioner indemnity. In a well-functioning responsible practice, these key elements are a matter of routine.

Cosmetic interventions are an evolution of medicine in line with the needs of the patient population. Even though elective, it does not mean that cosmetic medicine needs to be any less regulated and attempts must be made to regulate it for the protection of its users.

There has been repeated failures in protecting patients despite a history of well-documented problems - first Meme, then PIP, and possibly soon to be dermal fillers [7]. Regulatory processes have failed patients and the system cannot be fixed without a complete overhaul. There is a discord between device regulation and the regulation of professionals. Without consistent professional standards, product safety improvements and patient care safeguards in a clearly structured manner, the dangers to the public will not be remedied and will have serious consequences.

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Dr MJ Rowland-Warmann (MJ) is the founder of Smileworks, a multidisciplinary dental and medical aesthetics practice based in Liverpool. She is the lead clinician and her practice is limited to Medical Aesthetics and Orthodontics.

She has a particular interest in Medical (facial) aesthetics, including dermal fillers and toxin treatments, silhouette soft, plasma treatment including non-surgical eye lifting, scar treatment and skin tightening, peels and skincare. Dr Rowland-Warmann has extensive experience of rejuvenation techniques in dermal filler treatment and the management of dermal filler complications. For the latter she is involved in improving methods for the early recognition and treatment of vascular dermal filler complication in addition to standardising techniques for their treatment for the aesthetic profession. She is an ambassador for Save Face, the voluntary regulator for the aesthetic industry, and raises awareness for the improvement in legislation and standards for professional conduct of practitioners.

She is a regular contributor to Aesthetics Magazine and has been featured by ITV, Save Face, Daily Mail, BDA and Dentistry Magazine.

As an expert witness, she is able to accept instructions for cases involving her field of practice in Aesthetic Medicine in medical negligence and personal injury. She holds the Cardiff University Bond Solon (CUBS) Expert Witness Training Certificate.

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# The History of Plastic Surgery

*The history of plastic surgery – from BC, through the 1400s and world wars, to the present day*

Although the development of plastic surgery is popularly believed to have taken place over the past 20 years or so, the origins of plastic surgery are very old.

## **Plastic surgery (and nose jobs) in the 1400s – by Antonio Branca**

The nose received the most attention from early plastic surgeons. One of the first procedures for reconstructing the nose, a primitive precursor to the 'nose job', is attributed to a surgeon called Antonio Branca and is described by the slippery-named Heinrich von Pfolsepeundt in his seminal 1460 work 'Buch der Bündth-Ertznei'. Von Pfolsepeundt described the technique in the following stages:

1. A model of the nose is constructed from parchment or leather.
2. This model is then laid on the forearm and a line drawn around it.
3. The marked area is then cut around and separated from the underlying layers in such a way that the bottom of the nose-flap remains attached to the arm.
4. The arm is then raised to the head with the nose-flap positioned on the face and stitched to the defect.
5. The arm is then bound to the head to hold it in place (see below).
6. After 8-10 (uncomfortable) days, when the skin has healed to the tissue of the defect, the lower part of the skin flap is cut, freeing the arm and allowing reconstruction of the nostrils.

The procedure may sound frightening now but it was cutting-edge at the time (no pun intended).

Unfortunately for Antonio though, It was not until nearly a century later, after his demise, when Gasparo Tagliacozzi wrote his seminal work 'De Curtorum Chirurgia per Insitionem Libri Duo' (on the surgery of defects by implantation), that the technique achieved widespread fame among European surgeons.

## **Much later: the 1800s – plastic surgeons turn to ancient India for inspiration**

Plastic surgery had to wait until the late 18th century for the next significant advance in the history of plastic surgery – the skin graft. And ironically the breakthrough came from rediscovering a procedure developed in ancient India.

The severe-looking skin graft procedure (see below) was rediscovered in an ancient book called the 'Sushruta Samhita' - dating back to 8th century BC. Lurking in a corner of the book's 184 chapters was a technique using a leaf-shaped flap from the forehead to reconstruct the nose.

The technique (shown below) was published in the 'Gentleman's Magazine of Calcutta' in October 1794 and it soon became widely used; known as the 'Indian Method'.



Following the use of this skin grafting technique, Felix Jean Casimir Guyon of Paris and Jacques Reverdin of Geneva started to develop more advanced skin grafts in their practice in 1869; the type that are still more or less used today.

## **Plastic surgery during the war: early before and after photos**

Perhaps the most significant improvements in the history of plastic surgery occurred in the last century, where several plastic surgery techniques were introduced during the world wars. Pioneering skin grafting techniques such as the 'tubed pedicled graft', were developed during World War I and refined by

## **Mr Tim Burge**

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Burns  
Scars  
Hand trauma  
Breast surgery  
Facial injuries



Cosmetic surgery  
Adults and children  
Reconstruction  
Personal injury  
Clinical negligence

Mr Burge has been a Consultant Plastic Surgeon since 1996 and has a broad experience having worked in the Army, the NHS and the Private Sector. He has over 20 years of experience writing reports and receives about 200 instructions per year. He has been instructed by Claimants, Defendants, and as a Joint Expert. He is aware of the Part 35 requirements of an Expert Witness and has obtained Part 1 of the Certificate of Medical Reporting (Bond Solon). He has experience appearing in court as an expert witness. Appointments are available in Bristol, London, Cardiff, Birmingham and Leeds. All reports are produced within agreed timescales, usually four weeks, which can be expedited.

### **Areas of work**

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leading plastic surgeons Archibald McIndoe and Harold Gilles who used the techniques to treat severe facial burns.

These staged procedures differed from earlier plastic surgery because they relied on the growth and development of a blood supply from the recipient bed into the grafted tissue over many weeks or months.

Before and after plastic surgery photos are shown below, and they show the amazing progress that these techniques had on World War patients afflicted by the horrors of war.



#### 1942: Plastic surgery finally meets the mainstream

In 1942, following the Battle of Britain, Gillies and McIndoe performed their pioneering operations on burnt airmen at the Queen Victoria Hospital with the media in attendance, pushing plastic surgery into the public eye.

The "Guinea Pig" club was formed by the airmen who had been operated on and was the first patient support group for burns disfigurement. It is still going strong today.

### Mr Roderick T A Chalmers Consultant Vascular Surgeon MB, ChB, FRCSEd, MD, FRCS (Gen)

Mr Chalmers is a teaching hospital consultant vascular surgeon with a wide range of expertise in arterial and venous surgery, including; thoraco-abdominal aortic aneurysm, abdominal aortic aneurysm, carotid artery surgery, hand arm vibration syndrome (HAVS) all aspects of lower limb ischaemia, varicose vein disease, lower limb ulceration and thoroscopic sympathectomy. Mr Chalmers has some experience in the management of vascular trauma.

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Mr Kim provides a broad spectrum of treatments from simple procedures, such as removal of minor skin lesions, to some of the most advanced cosmetic and plastic surgery procedures provided anywhere. His expertise includes a complete range of facial surgeries, (including oculoplastic eyelid procedures), breast surgeries, body contouring, and microsurgical reconstructions.

Given both his broad and specialist training, Mr Kim is happy to see and manage the full range of Plastic & Reconstructive problems.

Mr Kim welcomes instructions for medicolegal reports, both in the areas of Personal injury and Clinical Negligence. He undertakes Expert Witness work in Plastic Surgery, Hand Surgery and Cosmetic Surgery. These often involve cases of scarring, burns, hand injuries and lower limb injuries. He also accepts all clinical medical negligence instructions in the field of Plastic and cosmetic surgery.

#### Areas covered include:

Personal injury                      Road traffic accident victims  
Industrial accidents                Skin cancer  
Cosmetic surgery negligence      Clinical & Medical negligence  
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His Medical / Clinical negligence work is currently split 95% claimant 5% defendant. High quality reports produced within 1-2 weeks. Multiple appointment venues around the UK.

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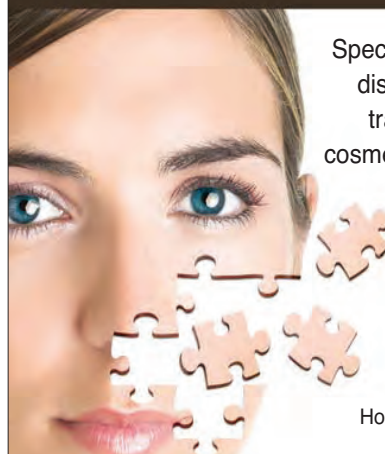
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# Third Party Costs Order for Medical Expert Deemed ‘Not Generally Competent as an Expert’: *Thimmaya v Lancashire NHS Foundation Trust*.

by *Bethan Davies (Pupil), Parklane Plowden Chambers*

Sitting at Manchester County Court, HHJ Evans took the path less trodden and ordered a consultant spinal surgeon, acting as the Claimant’s expert witness in clinical negligence proceedings, to pay £88,800 to cover the costs wasted as a result of his input.

In making her decision, HHJ Evans stated the witness was ‘not generally competent as an expert’ and not fit to be giving evidence at all:

‘[The expert] was wholly unable to articulate the test to be applied in determining breach of duty in a clinical negligence case. He was given a number of opportunities to explain it; he was asked the question in different ways; that did not assist him. In the end, he stated that he did not know the test to be applied.’

The expert’s failings led to the Claimant discontinuing her claim, his being the only medical evidence upon which the claim relied:

‘The consequence for the claimant was that she lost her entitlement to have her case tried on its merits. A considerable amount of court time has been wasted. And there were significant consequences to the NHS in terms of costs.’

In explaining his failings, the expert referred to recent mental health problems which had not affected him when initially asked by the Claimant’s solicitors to confirm his suitability. The Defendant submitted that by virtue of GMC Guidance on Good Medical Practice, and the expert’s overriding duty pursuant to CPR 35, the expert should have ceased his involvement in the claim when his health concerns became apparent.

HHJ Evans concluded:

‘On the balance of probabilities, the reason that [the expert] could not answer the questions in cross-examination as to the test for breach of duty was because he did not know, was unable to recall, or could not apply the legal test, perhaps because of his general cognitive difficulties caused by his mental health problems.’ [11]

The expert’s conduct was found to be unreasonable to the degree the Court’s jurisdiction under CPR 46.2 to make a third-party costs order was engaged. The Privy Council case of *Dymocks Franchise Systems (NSW) Pty Ltd v Todd and others* [2004] UKPC 39 provides the starting point for the exercise of the Court’s discretion, providing that such orders should be made in ‘exceptional’ cases; those ‘outside the

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Medico-legal assessments for suspected or known brain injury and/or brain dysfunction in Personal Injury and Medical Negligence claims

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- Stroke
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**Clinical services:** neurorehabilitation services.

Dr Monaci has completed the Cardiff University Bond Solon Expert Witness Certificates.

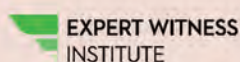
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ordinary run of cases where parties pursue or defend claims for their own benefit and at their own expense.’ [25]

HHJ Evans made clear the order made under CPR 46.2 did not serve as punishment, it is essential that ‘experts should all understand the importance of their duties to the court and the potential consequences if they fail in them.’ [19]

As to the extent of the order, HHJ Evans ordered the expert pay all of the Defendant’s incurred costs from November 2017, the same being the date he had commenced sick leave in regards to his clinical practice. [21]

### Comment

This is not a case of an expert simply providing evidence that was not favoured by the judge, or evidence that was not persuasive; rather an expert who could not properly provide evidence at all. There is a marked difference between a bad witness and the ‘improper unreasonable, or negligent conduct’ of the expert in Thimmaya. [13 and 14]


Yet the case should sound a warning to solicitors and counsel alike; it must be clear that the instructed expert understands, can articulate, and apply the Bolam/Bolitho test, not only in writing but orally. If in any doubt, this understanding can easily be tested in conference.

The case further raises questions as to whether medical experts should require some form of kitemark. Whilst medical professionals invariably have a range of professional memberships, the giving of expert evidence is a wholly different kind of beast. This issue was recently discussed at the Clinical Negligence

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Debate 2020, with members of the legal profession expressing concern as to the standard of expert evidence in the face of its growing use.

Many thanks to **Bethan Davies**, Pupil Barrister at Parklane Plowden Chambers. For permission to reproduce this article  
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# Considerations When Working with People who are Deaf

*by Dr Elizabeth Wakeland, Senior Forensic and Clinical Psychologist, Forensic Psychology Practice Ltd and Lauren Teasel, Assistant Psychologist, Forensic Psychology Practice Ltd.*

The term 'deaf' refers to profound hearing loss, implying little or no functional hearing. There are four categories of hearing loss; mild, moderate, severe and profound, with 900,000 people estimated to be severely or profoundly deaf in the UK. Those who are hard of hearing generally have hearing loss ranging from mild to severe and can benefit from an auditory device, such as a hearing aid or a cochlear implant. The individual's level of hearing loss, including when they acquired their hearing loss, will impact on their ability to participate in legal proceedings, whether criminal, family or civil. It is important to note that it is not the deafness itself that presents the problem. Being deaf does not inherently mean you cannot participate in proceedings, have a lower intellect or cannot understand English. The focus on the ability to hear, and working in a system catered for hearing individuals, presents barriers for those people who are deaf, and this limits their full participation in some areas if adequate adjustments are not made.

Many deaf people, usually those born deaf, or acquire deafness before they develop language (termed 'prelingual' deafness), do not view themselves as disabled, but members of a cultural and linguistic minority. These individuals have usually relied on methods of communication that do not require speech or hearing, and as such, associate with the deaf community. The acquisition of deafness later in life may mean the individual has relied on spoken language, and thus associates with the hearing community. These differences will influence the adaptations required to fully participate in proceedings. For example, it might be assumed that an individual who use BSL as their first, and main, language can understand written language, or engaging them in proceedings is simply about translating information from English to BSL, but this is not necessarily the case.

The assumption may be that all deaf people can or should use some form of hearing aid, however they do not provide benefit to many. Each individual will view the use of hearing aids differently, with some identifying the benefits and usefulness, whilst others will not like to utilise them; viewing them as a tool that enables the hearing person to engage more effectively with a deaf person, rather than being a necessity for the deaf person. Deaf people use a variety of methods of communication, including Sign Supported English (SSE), lip-reading, pen and paper, and light-writers to name a few. In the UK, British

Sign Language (BSL) is the most common form of signed communication amongst the deaf community and was formally recognised as a language in 2003. In the 2011 census, it was estimated that 87,000 deaf people use BSL.

As a language, BSL has its own structure, grammar and syntax. It utilises hand movement, shapes and orientation, along with facial expressions and body movement to express the language. Some English words do not have simple translations, and there are expressions in BSL that may not translate simply into English. It does not follow the rules of English word order. This means it is not simple to place BSL into a written format. It is a visual language, and written English would benefit from being translated into a BSL video translation. This would include documentation and orders that are completed as part of the proceedings.

As deaf people can choose from a number of communication methods, identifying their preferred method is key to ensuring the initial barriers are broken down. Their choice of communication will have been determined by many factors to do with their experiences and the degree of their deafness. Lip-reading should not be relied upon, as even the best lip-readers only catch less than half of what is being said to them. For reasons explained above, paper and pen should also not be relied upon, especially for conversations which require rich detail. If the individual uses signed communication, it is important to identify whether this is BSL or another form (as BSL is not international or a universal signed language). They may use Signed Supported English (SSE) or other variations of signed communication. The introduction of a Sign Language Interpreter (SLI) will be required for signed communication, and finding a SLI that specialises in criminal justice, or mental health related matters (if relevant) will be of further benefit for the particular complex nature of the content being interpreted. There may be a need for a Relay Interpreter to work alongside a SLI. A deaf relay interpreter is used for deaf clients with specific or complex language needs. They are language intermediaries for deaf people who may not be fluent in BSL but use signed communication, and act in a similar capacity to SLI's in that their role is to facilitate communication, but do not intervene if they feel the client does not fully understand; for that, a deaf intermediary is required.

In any proceedings, one of the first actions of the deaf person may be to attend a solicitor's office to provide instruction. The question becomes who pays for the interpreter in this instance. Normally solicitors cannot apply for legal aid until they have been instructed, yet the first interview to receive instruction requires an interpreter, and many may not offer one. The Equality Act 2010 protects people from discrimination because of certain 'protected characteristics'; disability (including sensory impairment) being one of these. There are different types of discrimination, but it includes things that are not done when they should be. For example, the failure to make reasonable adjustments for people who are disabled when required. The Equality Act 2010 covers key areas of life such as employment and training; education; goods, facilities and services; premises and transport. Those who are deaf are recognised under the Act and therefore, solicitors / barristers are responsible for the booking and payment of SLIs.

It has historically been assumed that deaf people lack capacity or are unfit to plead due to their English language abilities. A deaf person's understanding goes beyond their communication method, and is rooted in their developmental and educational experiences. Language development is a critical part of a child's development. Access to any form of language, whether spoken or signed, is important in brain development, however there can be a presumption in certain fields that verbal communication is superior to signed. In the first twelve months, babies develop many of the foundations that underpin language development; whether the baby is deaf or hearing. The key is that parents and child have a shared language. Unfortunately, approximately 96% of deaf children are born to hearing families, but only 1 in 10 of those parents will learn sign language to be able to communicate fully with their child. This lack of communication, and access to a language, can have a significant impact on the overall development of the deaf person. For some, they do not acquire a structured language until they attend school.

The Second International Congress on the Education of the Deaf in 1880, that has come to be known as the 'Milan Conference of 1880' banned the use of signed language in schools, and favoured the oralism teaching method, which further oppressed deaf people and laboured the use of speech to communicate. It was not until the late 1960's that sign language began to be introduced into schools once again, although in the current time, some residential and mainstream educational settings continue to teach using the oralism method, with the children only being allowed to use sign language in their own time (e.g. break times).

This means that many of the older generation did not have access to sufficient language in the developmental years. An assessment of their abilities is required to understand what the best support would be for each individual. It is likely that additional support is required, throughout the legal process,

including in court. Language within legal proceedings is extremely sophisticated, if the deaf person has difficulties with abstract language this makes many of the most common aspects of court functioning prove impossible to navigate. A multi-disciplinary approach to working with deaf individuals, which would include specialist SLIs, alongside relay interpreters, deaf professionals (or at the least, those with expert knowledge in the field) and deaf advocates is best practice in order to identify the individuals' additional needs.

For those children who are not able to access stimulating and challenging language environments, with others who can demonstrate, and thus model, such features as abstract thought, negotiation and emotional awareness, are at greater risk of a number of otherwise preventable cognitive deficits (e.g. Theory of Mind, Executive Functioning). These experiences are hypothesised to have an impact on a deaf person's moral reasoning and consequential thinking, increasing their likelihood of engaging in criminal behaviour.

When considering criminal proceedings, in addition to the above, it is also important to consider the multiple barriers that deaf people face when they are involved in the CJS. This includes a multitude of complex factors that are interwoven which includes communication issues (e.g. lack of interpreters, inappropriate use of relatives/ perpetrators), lack of appropriate resources, the professionals' perceptions and knowledge of deafness, and the type/ severity of offence. Often a deaf person's behaviour can be mistaken for aggression, due to the expressive nature of the language. It is important not to make false assumptions and judgements regarding their communicative ability or misunderstand their needs.

Additional considerations relate to sentencing of deaf people who have been convicted of a crime. Research indicates that prison presents a 'double punishment' for deaf people as prisons do not offer any specialist support, resulting in social isolation and an increased vulnerability. They are often unable to access the rehabilitative aspects of a prison environment thus making limited change or learning. The fairest outcome for all involved, including the victim, would be for prisons to provide an accessible service, not dissimilar to the mental health sector.

In the context of family proceedings, there are a number of considerations to address when dealing with a family who have a deaf or hard of hearing family member; and these considerations may change with the family dynamic. For example, a family whose composition is of a deaf child and hearing parents will have differing support needs to a family who are made up of a hearing child and a deaf parent(s).

In the case of a deaf child, it is the duty of the local authority to ensure that their policies and procedures allow them to effectively investigate and manage child protection, which requires effective communication with the child. Without effective provisions in

place, a deaf or hard of hearing child may encounter difficulties with reporting concerns or worries, voicing their wishes, and accessing independent facilitators such as advocacy services. It is important to remember that deaf children are considered to be more vulnerable to abuse victimisation than their hearing counterparts. Therefore, it is crucial to ensure that staff within all areas of family proceedings, including social workers and law enforcement personnel have an awareness of deafness and how it impacts upon a child's development and family functioning, and are adequate in communicating with experienced interpreters to allow a deaf child to communicate as fully as possible within the context of family proceedings.

The required support of deaf parent and a hearing child within family proceedings will differ somewhat to the needs of a deaf child with a hearing parent. When a hearing child is born from a deaf parent, it is likely that the two have a shared sign language, and therefore the barrier to communication between the two is less. However, it is still necessary for the deaf parent to communicate with authorities, social services, Court officials and such like. The tendency may be to use the hearing child to facilitate communication, however this would be ill advised. Their hearing status, and thus ability to act as communicator, should be placed second to their position as a child.

Deafness can have a profound impact upon the mental health of deaf persons, as well as upon their hearing caregivers. With only 10% of hearing parents learning sign language to communicate with a deaf child, children who experience deafness will more often than not encounter barriers to successful and meaningful communication. This lack of communication can lead to feelings of isolation and loneliness, thus adversely affecting the mental wellbeing of the individual. Previous studies have shown that 45-49% of deaf children and adolescents have mental health problems, with social isolation being a significant contributing factor. Also found to be associated with a higher degree of emotional and behavioural problems are poor self-esteem and peer rejection, whilst peer acceptance is associated with a lack of the same problems. Important to note is that these mental health related difficulties are more comparable to the hearing population when the deaf child comes from a familial environment containing deaf parents. This supports the view that the difficulties are not inherent to deafness, but rather the barriers that arise out of being deaf.

The prevalence of mental health difficulties in large populations of deaf adults is a relatively understudied area; however, epidemiological research has consistently found deaf people to be at a higher risk of mental health difficulties than the general population. It is estimated that 50% of individuals in the UK who have prelingual deafness will develop a mental illness at some stage in their lifetime, ranging from mild depression to psychosis. It is therefore essential to consider what support and interventions are

available for those individuals who do experience mental health difficulties.

For individuals with severe to profound hearing loss, cochlear implants have been found to ameliorate the negative effects of communication barriers, particularly when implanted before the age of three years. Evidence shows positive changes in quality of life for individuals with a cochlear implant, with improvements being made in areas such as communication, self-esteem, self-care, psychological wellbeing and cognition. However, a proportion of the deaf population do not consider implants or hearing aids necessary for communication, rather they are considered an aid for the benefit of the hearing population, to communicate with those who are hard of hearing. It needs to be considered how the hearing population can break down barriers to communication and begin to understand the deaf population, rather than focusing on the contrary.

Ensuring equal access to psychological therapies to those who are deaf or hard of hearing must be a fundamental aim of psychology professionals. Working effectively with interpreters should be a skill which every psychological service provider possesses, to ensure that the deaf community are not denied access to any psychological services which they may require. The effects of deafness upon mental health does not only extend to the deaf individuals themselves. The experience of parenting a child with hearing loss may be a stressful and unexpected experience for parents, and discovering a child's hearing loss can produce stress, anxiety, and social exclusion in hearing parents. Stigmatisation of hearing parents of deaf children leaves this group of people more vulnerable to developing psychological health issues than hearing parents of hearing children, or deaf parents of deaf children. Research consistently shows that families of children with hearing loss with strong social support systems are able to cope more effectively, and have better wellbeing, than families with lesser social support.

When it comes to best practice for working with deaf people, more than just an interpreter is required. Communication is one area for consideration; albeit a large factor. There are additional difficulties to consider, with an overview being outlined above.

A number of guidelines have been created, and there are various organisations that are best placed to offer advice. For example, the National Deaf Children's Society (NDCS) have produced a guide for Social Care professionals during child protection cases involving a deaf child. The British Deaf Association (BDA) have produced a range of guidelines on various topics, including helpful tips for people working with interpreters, and health advice. A study was conducted by BDA in Northern Ireland, and a report subsequently produced which advised on access to justice for deaf people. In the UK, the development of 'toolkits' has been undertaken to protect vulnerable people in court, including a toolkit on questioning someone with deafness. The toolkit draws on a range of

professionals and represents best practice guidelines when communicating with a deaf person in court. It is recommended that the deaf client is asked as to the most appropriate resources they require so as to assist their involvement in proceedings, or specialist advice is sought. This may include hearing loops, assistive devices, or a communication service.

When looking for an expert opinion within any proceedings involving a deaf client, it is important to select the right expert with specialist experience and awareness of deafness. Ideally, these experts should be proficient in the use of sign language, and/or have experience of working with SLIs, and have specialist knowledge as to the developmental and educational experiences of deaf individuals and thus their potential additional needs (e.g. mental health, physical health or communication needs).

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# Looking Back Over the High Court and Appellate Clinical Judgments From 2019

by Nigel Poole QC - Head of Chambers, Kings Chambers

Looking back over the High Court and appellate clinical judgments from 2019 - collected together on my 2019 Judgments page - it strikes me as having been a relatively quiet year. No Darnley or Montgomery (in fact no Supreme Court judgments at all). No dramatic new developments. The issue of the year seems to have been causation: see Diamond, Marshall, Younas and Pomphrey. On consent, the ramifications of Montgomery are still being worked through in Olsson, Diamond, and Mills for example. Expert witnesses took their fair share of criticism - Arksey, PZW and ZZZ - and contributory negligence was considered in Dalton and PPX.

Defendants succeeded on disputed issues of liability in about two-thirds of the cases reviewed.

2020 promises to bring a greater number of high profile decisions. We can look forward to the return of the wrongful birth claim of MNX v Khan following the substantive hearing in the High Court, and no fewer than three Supreme Court decisions: in XXX v Whittington (heard in December 2019) - the commercial costs of surrogacy case - Barclays Bank v Cariious Claimants) heard in November 2019) - vicarious liability for a doctor's indecent assaults - and Henderson v Dorset Healthcare (yet to be heard, permission to appeal given in March 2019) - illegality as a defence.

My five cases of they year include one that is unfortunately not reported on Bailii, but is on Lawtel and in the Medical Law Reports. In choosing these cases I have in mind their usefulness in future litigation, In no particular order, my top five cases for 2019 are:

## **Pomphrey v Sec of State for Health and another [2019] Med LR 424 (not on Bailii)**

*My post on this case can be found here.*  
<https://nigelpooleqc.blogspot.com/2019/05/scope-of-duty-and-causation.html>

This was a judgment by HHJ Cotter QC sitting in the High Court. It brought together considerations of scope of duty and causation and the issues raised in Chester v Afshar, Crossman v St George's, Duce, and MNX v Khan. It is a very long judgment and earlier paragraphs deal with some interesting points such as the use by expert witnesses of proxies to help prepare their reports. However, the reader looking to examine the points of principle should start at paragraph 280. There had been a negligent delay of

10 days in operating on the claimant to decompress his spine after development of cauda equina compression. No material injury was caused by the delay itself but during the operation the claimant sustained a non-negligent dural tear. The judge found that the risk of such a complication occurring was about 7%. Arguably therefore, had the operation occurred on any other day (specifically 10 days earlier) there would have been a 93% probability that the tear would not have occurred. Hence, the claimant argued, but for the negligent delay the tear would have been avoided. The Court rejected the claimant's case. It found that on balance of probabilities the same complication would have occurred even had the surgery been performed 10 days earlier. The same surgeon would have performed the same operation, using the same equipment and technique on the same patient. In any event, the scope of duty did not encompass avoidance of non-negligent risks such as a dural tear. The duty was to act expeditiously in order to avoid deterioration in the claimant's condition. Unavoidable complications were coincidental and not harm against which the defendant had a duty to protect the patient.

## **Marshall v Marshall v Schembri [2019] EWHC 283 (QB)**

*The judgment of Stewart J can be found here.*  
<https://www.bailii.org/ew/cases/EWHC/QB/2019/283.html>

I have chosen this judgment because it contains a useful warning to litigants about over-reliance on statistics. This was a claim arising out of the death of a patient following Deep Vein Thrombosis, pulmonary embolism, in which negligence was admitted. The Court had to decide whether, had the defendant referred the deceased to hospital earlier, he would have undergone thrombolysis or any other treatment to have avoided death. The claimant had to prove on the balance of probabilities that the deceased would have survived, not by what precise route or mechanism treatment would have led to survival [para. 128]. On the evidence the court found that to a high degree of probability the deceased would have survived. However, the Court warned about use of statistics alone and noted that had the statistical evidence (and the expert evidence about it) pointed to a probability of survival of only slightly more than 50% it would have found for the defendant.

*"The court, in looking at the evidence as a whole, must take a common sense and pragmatic approach to that evidence,*

in circumstances where it is equivocal. The court must also be wary of relying on the statistical evidence in the literature which has a number of variables. Had the statistical evidence, in conjunction with the expert evidence, have led to the conclusion that Mrs Marshall's chances of dying would have been assessed on presentation as only slightly better than 50-50, I would have found for the Defendant." [146].

This does not change the civil standard of proof. Rather it is a recognition of the need for sufficiently cogent evidence to establish proof on the balance of probabilities and that statistics are but one strand of the evidence needed to prove causation. Patients are individuals. The balance of probabilities test for the court to apply cannot be reduced solely to a statistical measure revealed by studying a sample of patients.

I have been informed by the solicitor for the Claimant that the Court of Appeal is due to hear the Defendant's appeal in this case on 6 February 2020.

### **Younas v Okeahialam [2019] EWHC 2502**

*A link to the judgement of Ms Rowena Collins Rice, Deputy High Court Judge, can be found here.*

<https://www.bailii.org/ew/cases/EWHC/QB/2019/2502.html>

I have included this judgment because it includes a very interesting, and I dare say potentially controversial, approach to addressing the issue of causation following negligent omission. The defendant GP negligently failed to refer the claimant following an abnormal ECG. The Judge found in the claimant's favour on a series of issues necessary to establish causation. The Judge applied the principle of judicial benevolence to support certain findings in favour of the claimant. There were important questions about the timing of investigations that would have been carried out but for the defendant's negligence:

"[33] .... The question of timetable falls to be considered in full, on the basis of the evidence and submissions I received.

"[34] Mr Bradley raised another legal issue. This goes to the correct approach I should take to the necessary reconstruction of the diagnostic process in this case, particularly as to timescales. He drew my attention to the decision of the Court of Appeal in *Keefe v Isle of Man Steam Packet Co* [2010] EWCA Civ 683, and the principle that "a defendant who

has, in breach of duty, made it difficult or impossible for a claimant to adduce relevant evidence must run the risk of adverse factual findings." (paragraph 19). In these circumstances, "the court should judge a claimant's evidence benevolently and the defendant's evidence critically." (ibid).

"[35] It is clear, and Mr Bradley very fairly accepted, that this does not amount to a reversal of the burden of proof. It is also clear that *Keefe* was a case in which the breach of duty specifically related to a failure to make measurements (of noise levels). The claimant was directly, and wrongly, deprived of the very records which would have been the best, or only, evidence of the precise levels to which he had been exposed. The Court of Appeal in these circumstances took a 'benevolent' approach to such positive, if second-best, evidence as there was that it had been excessive, and found the claimant's burden of proof discharged on that evidence."

Adopting that approach to the question of the likely timetable of decision-making and investigation in the absence of the negligence, the judge held at [47]:

"Where I am satisfied that the evidence points to a decision within a range, but cannot otherwise discriminate within that range, then I should incline to the point in the range favouring the claimant. But it is the claimant's obligation to satisfy me as to that range. I must give him the benefit of the doubt, but he must persuade me to doubt in the first place."

Thus, if an investigation would have taken place within 1 to 2 months, the judge's approach was to find that it would have taken place within 1 month.

An alternative might have been to take the mid-point of the range. Claimants will seize upon this judge's approach and I expect that it will be challenged either on appeal or in subsequent cases.

### **Diamond v Royal Devon and Exeter NHS Foundation Trust [2019] EWCA Civ 585**

*This Court of Appeal judgment can be found here.*

<https://www.bailii.org/ew/cases/EWCA/Civ/2019/585.html>

It is not a novel point that in cases founded on a failure to obtain informed consent, the claimant has to prove that had they been warned of the relevant risk, or had they been properly advised more generally,



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they would not have consented to the treatment that subsequently caused them (or their then unborn child) injury.

However, the Court of Appeal addressed a specific point raised by the appellant about the trial judge's approach to that question of causation. The claimant alleged that the defendant's surgeon had failed to obtain her informed consent to a mesh repair of a post-surgical abdominal hernia. The trial judge found breach of duty in failing to advise of the risks to the claimant of mesh repair should she become pregnant, and failing to advise of an alternative suture repair even though that would have been likely to fail. However the claimant lost at trial on the issue of causation. Her evidence that she would not have elected to have mesh repair was not accepted. Amongst the findings of the trial judge was the following:

*"Overall, in the face of this information, looking at the matter both objectively and subjectively in the face of the advice which would have been given to her, it would have been irrational for her to opt for a suture repair; and I find that she is not a person who would act irrationally."*

On appeal the claimant complained that the judge had applied a rationality test and that in any event her psychiatric injury was intimately connected with the breach and should sound in damages. The Court of Appeal held that the trial judge had legitimately found as fact that the claimant would have gone ahead with the operation in any event, and it was reasonable to consider the rationality of doing otherwise when assessing her credibility.

Even though the court accepted that the claimant genuinely believed now that she would not have consented, it had held that in fact she would have done so.

At [22] the Court of Appeal robustly upheld the trial judge's findings and approach.

*"[His] assessment of the appellant and her evidence, was detailed, nuanced and insightful. It was an assessment that was properly open to him to make on the evidence before the court. The judge met the requirement set out in Montgomery in that he took account of the reasonable person in the patient's position but also gave weight to the characteristics of the appellant herself. He did not apply a single test of "rationality" without more to the issue of causation. No valid criticism of the judge's approach, still less his assessment of the factual evidence can be made. There is no basis for this court to find that there was a material error of law or that a critical finding of fact was made for which there is no evidential basis."*

Moreover cases such as *Duce* confirmed that there is no room for interpreting *Chester v Afshar* as supporting a claim for damages where the finding is that the claimant would have gone ahead with the same operation at the same time even if properly advised as to risks. There is no free-standing entitlement to damages for a negligent failure to obtain informed consent: causation of injury has to be established.

**Mills v Oxford University Hospitals NHS Trust [2019] EWHC 936 (QB)**

*The judgment of Karen Steyn QC (A Deputy High Court*

*Judge as she then was) is here.*

<https://www.bailii.org/ew/cases/EWHC/QB/2019/936.html>

Longstanding readers of this blog will know my involvement in stopping the Medical Innovation Bill becoming law so as to protect medical professionals from being sued for negligence when adopting innovative treatment. The judgment in *Mills* was of particular interest in that context. The claimant suffered permanent and severe neurological injury as a result of haemorrhage and stroke during the course of brain surgery to resect a glioma. The surgeon used a new technique not used by many neurosurgeons other than him, involving endoscopic assisted resection. The Court held that the surgery was performed non-negligently but that the defendant had failed to obtain informed consent to the operation. The surgeon failed to advise that the claimant's glioma had been an incidental finding (unrelated to headaches he had been suffering) and was asymptomatic. However, the Court found that that failure was not causative.

The surgeon also failed to advise that the proposed surgical technique was new, and that an alternative, traditional technique, using a larger craniotomy and a microscope, was available. That was found to be causative - had appropriate information been given, the claimant would have elected to undergo surgery using the standard technique. The technique in fact used made it harder to control the bleeding and the stroke would probably have been avoided with the standard technique.

The *Montgomery* test requires a patient to be informed of reasonable alternative or variant treatments to the one being recommended or proposed. This had not been done, and on the facts of this case, the failure to do so made a difference both to the nature of the operation subsequently performed and the occurrence of the complication. A patient is entitled to decide whether or not to undergo novel or innovative forms of treatment - it is not for the surgeon to decide.

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# Mustard v Flower; Are Recordings of Medical Examinations Now Going to be the Norm?

*In the recent High Court case of Mustard v Flower & Others, Master Davison was tasked with deciding whether the Claimant's recordings of her medical appointments with the Defendant's medical experts – some of which were undertaken covertly – were admissible in evidence. In deciding that the evidence was admissible he outlined that he considered that guidance was required but that it was outside of the realm of the court to provide it. However, in the absence of this guidance, the decision appears to pave the way for Claimants to record their examinations and those recordings be considered to be admissible evidence*

The claim arose out of a road traffic accident in which the Claimant's vehicle was struck from behind. Liability for the incident had been admitted by the Defendant but causation remained in issue between the parties. The Claimant alleged that she had suffered a brain injury as a result of a medium velocity collision. The Defendant alleged that it was a low velocity impact which was not severe enough to have caused the injuries alleged. The parties were granted permission to obtain expert evidence in various different disciplines.

The Claimant was advised by her solicitor to record the appointments with the Defendant's six medical experts. In two of the appointments the Claimant covertly recorded the examination; in one she sought permission to record and was allowed to do so but was asked to stop recording when it came to actual tests. In the remaining three appointments the Claimant sought and was granted permission by the experts to record (these experts undertaking their own recordings). The Claimant did not record appointments with her own experts despite the Defendant suggesting to the Claimant that this would have created a 'level playing field'.

Following disclosure of the Defendant's expert reports, the Claimant's solicitor provided these reports and the transcripts of the Claimant's recordings to their own relevant experts. The Claimant's experts were able to comment on the reports that were produced and what was said within the examinations, including consideration of the types of tests that the Defendant experts performed on the Claimant. Of particular focus was the evidence of the neuropsychologists. Following a copy of the Defendant's neuropsychological report and the transcript of the recording from the appointment being supplied to the Claimant's Neuropsychologist, he filed a supplementary statement indicating that the Defendant's neuropsychologist had made serious errors in the use of certain tests and, as such, her evidence was flawed.

The Defendant objected to the use of the recordings to assist in the preparation of the Claimant's expert evidence and asked the court to exclude the evidence under CPR r32.1.

In addition, six of the Defendant's experts wrote to the court seeking directions in respect of Part 35 questions which had been sent to them. The ques-

tions were exceptionally lengthy and included appendices which filled two ring binders. The experts also requested the court's input in respect of covert recordings which had formed part of the questions.

The Claimant submitted that, upon review of the Defendant's reports, it had become apparent that '...the reports had not in every case set out the history given by the Claimant and that there were other defects also'. For this reason the recordings were then transcribed and supplied to the Claimant's experts for comment. It also led to the lengthy Part 35 questions which were sent to the Defendant's experts.

The Defendant's experts complained to the court in strong terms; the orthopaedic surgeon stating that; '...the claimant's actions were wanting in honesty, transparency and common courtesy' and the neuropsychologist had been left feeling '...professionally violated, distressed, angry and disillusioned' by the issues. A couple of the experts had sought input from their professional bodies, such was their dismay at the use of the recordings and the excessive Part 35 questions.

It was argued on behalf of the Defendant that there had been a breach of the Data Protection Act or the General Data Protection Regulation (GDPR) and/or that the recordings should be excluded pursuant to CPR r32.1(2) (which allows a court to exclude evidence that would otherwise be admissible). The key aspect for the court to consider when assessing whether evidence should be excluded is with reference to the overriding objective that cases should be dealt with justly. To this end, one of the points made by the Defendant was that the recordings had created an 'uneven playing field or an inequality of arms' due to the fact that it was only the Defendant's experts who had been recorded.

In coming to the conclusion that the recordings should be allowed, the judge considered that the test to be applied was 'whether the public policy interest in excluding evidence improperly obtained was trumped by the important objective of achieving justice in a particular case'. Master Davison came to the decision that the object of achieving justice for the Claimant outweighed the argument for exclusion. He concluded that 'whilst her actions lacked courtesy and transparency, covert recording has become a fact of professional life' and '[i]t is in the interests of all sides that examinations are recorded because from

time to time significant disputes arise as to what has occurred’.

In addition, the judge referenced the use of covert video recordings and surveillance, which is a tactic often employed by Defendant insurers. He stated that, if he were to conclude that the covert recordings in this case were unlawful, it would also have the impact of raising questions about a Defendant’s use of surveillance evidence in a case. He considered this to be an undesirable consequence for a Defendant.

Whilst the Master considered that the recordings were admissible, he stated that it was not for the court to provide detailed guidance on the use of recordings generally. He considered that it was for the Association of Personal Injury Lawyers (APIL) and the Forum of Insurance Lawyers (FOIL) to put together a protocol to govern this. However, in the absence of this guidance, which is likely to take some time to put together and be brought into practice, this case opens the door for Claimants to record their medical examinations, even covertly and in a reprehensible manner, and still be entitled to rely upon them as admissible in evidence.

I suspect that a number of Claimant personal injury lawyers will now be advising their clients to undertake recordings of their examinations. Medical experts who are instructed by Claimant and Defendant lawyers alike will have to be conscious of the fact that the Claimant may be recording their examinations, including any testing undertaken. Should this recording occur, anything said between the expert and the Claimant, is to be subject to a higher level of scrutiny than could have been expected before. Whilst there are some positives to this, it does place a higher burden upon medical experts who will be under a more focussed microscope than before.

Master Davison did allow some respite to the Defendant’s experts in concluding that the Claimant’s Part 35 questions were; ‘...wholly disproportionate’, ‘...overwhelmingly not for the purposes of clarification and...amount[ed] to cross-examination’ which was entirely contrary to the purpose of any questions raised to an expert. The Master commented that he had ‘...never encountered a set of questions even

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remotely approaching the scale and complexity of these and I have never known questions to provoke letters to the court from an expert or group of experts phrased in such terms as the present’. Whilst the issues around the Part 35 questions were not the main focus, the comments are a reminder to parties to ensure that their questions to experts are proportionate and for the purposes of clarification.

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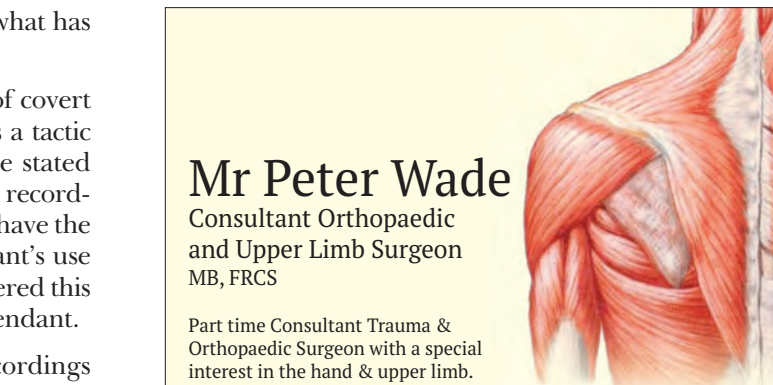
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# Pitfalls in Clinical Negligence Claims: A Case Study

On 18 December 2019, Her Honour Judge Melissa Clarke, the Designated Civil Judge sitting at Oxford Combined Court, handed down judgment in *Docherty v Oxford University Hospitals NHS Trust* (Unreported, 25, 26 & 27 November 2019). This was a clinical negligence claim in which the Claimant made various allegations in respect of her immediate post-natal care which led to her sustaining a serious ankle injury when she fainted due to anaemia caused by blood lost during an instrumental delivery the previous morning.

The judgment is worthy of consideration. Although this was a matter which eventually turned very much on its own facts, there are aspects of the way the Claimant's case was prosecuted and presented which was subject to comment from the judge, and ultimately led to the case being dismissed in respect of breach of duty and causation.

These are issues which litigators would do well to bear in mind when considering the strengths and weaknesses of a claimant's case.

## **Beware the overly long and over-lawyered witness statement**

The Claimant's witness statement was some 30 pages long. It pertained to events which occurred some five and a half years prior to trial when the Claimant had just been through a far-from-easy birth before sustaining a nasty and painful injury. This volume of material provided the Defendant with fruitful material for cross-examination as not only was some of it not consistent with other documents, but there were internal inconsistencies within the statement too. Whilst the judge found (as the Defendant submitted she should) that the Claimant was essentially a credible and honest witness in her oral testimony, the Court found that "*there were some parts of her witness statement which she did not understand and which were not in her own words*". Thus, the Court concluded that it did "*not find her a particularly reliable witness, for reasons which are no fault of her own*".

The obvious lesson for the litigator is the one which is currently subject to recommendations from a working group considering recommendations for reform of rules in relation to witness statements in the Business and Property Courts: beware of overly long and over-lawyered statements! In *Docherty*, the issue was it was clear that the Claimant's recall of the index events was extremely poor, thus her assertions in her statement that she specifically remembered not being told certain things caused more than a judicial eyebrow to be raised, leading to the conclusion that the Claimant's recollection, however honestly held, could not be relied upon. The inclusion of legal submission, some attempts at litigation 'point scoring', and purported justification

of certain quantification of special damage is also inappropriate and is rarely likely to do anything than do harm to the perceived value of a witness's testimony.

## **Beware the expert who assumes disputed facts**

In cross-examination the Claimant's midwife expert conceded that if the Trust's witnesses' evidence were to be preferred on certain points, she could not criticise the relevant care received by the Claimant. In her report and in the joint report, she failed to consider the Trust's version of events at all. The Court declined to criticise her for this and held that to some extent the Trust's midwife expert had done likewise, at least in the Joint Report.

It remains the case however, that had it been agreed that the question of breach of duty from the midwifery perspective had wholly depended on the factual outcome found, the course of the litigation may have been different. From a practical perspective, there may not have been any need to have called these experts to provide oral evidence; and from a litigation perspective, this may have allowed both Parties to better assess this case as one likely to turn on the facts and assess their risks accordingly. It may be speculated that this may have led to a reassessment of the quality of the Claimant's lay evidence.

Likewise, it was a feature of HHJ Clarke's judgment that she was not persuaded by the Claimant's obstetrician expert when he appeared to disregard nursing records which suggested the Claimant was outwardly well at all times post birth by saying that "*in my experience, not everything which is said is recorded in the notes*". The submission in closing from the Trust was that this was demonstrable partisanship, and although the judgment did not go as far as this, the expert was held to have shown a "*certain fixity in [his] position*".

The lesson must be that experts must consider competing versions of facts when producing their reports and rather than assume those of the party by whom they are instructed must be correct, should provide their opinion based on either potential eventuality being found to be correct. Of course, they are open to doubt the accuracy of a factual account and/or contemporaneous records, but this will be most persuasive when it is reasoned, not just because the same is inconvenient to a conclusion.

## **Beware the expert who may need to speculate in order to justify conclusions**

An issue in *Docherty* was whether the Claimant's blood loss during labour was reasonably estimated, in circumstances where it was accepted that it must have been underestimated during an instrumental delivery. The Claimant's obstetrician

expert maintained that the opening of a pack containing clamps suggested these were needed and used, suggesting a more significant episiotomy repair was required and speculated that the perineum was a likely source of significant bleeding. This caused him to criticise the note-taking in addition to the estimate of blood loss.

The learned Judge was robust in holding that *“The court does not readily indulge in speculation”*, particularly where, as in this case, there were other instruments unwrapped which were certainly not used. It was held that negligence is for a claimant to prove and there was nothing to suggest that further steps were required to arrest the Claimant’s bleeding in this case such as which would support the Claimant’s allegation in relation to the same or the estimate of blood loss.

**Beware the expert who is isolated in his or her opinion**

In Docherty, the Trust submitted that the Claimant’s obstetrician expert was isolated in his opinion that in every case where a woman suffers a postpartum haemorrhage, a full blood count was required six hours afterwards. This was disputed by the Trust’s obstetrician expert. Nor was this supported by the evidence of the Trust’s midwives nor the expert evidence of either midwife expert. The same was not mandated in the relevant NICE nor RCOG Guidelines. On the face of it, a contention premised upon such expert opinion is likely to prove to be difficult to prove, and this became harder still when, in cross-examination, the expert was far from forthright in answering the simple question as to whether such a

timescale was mandated: *“That is my interpretation of common practice”* was not held in Docherty to have been particularly persuasive.

Isolation in an expert’s opinion is all the more difficult for a party relying upon that opinion, should it have been given on a subject outside of that expert’s strict area of expertise. The Claimant’s obstetrician expert found the Court considering him isolated in his criticism of the index post-natal midwifery care, despite the views of the Claimant’s midwife expert. This was not a persuasive basis for the Court to consider allegations arising out of the same to stand proven.

**Conclusion**

Docherty is a case where a lot went wrong for the Claimant at trial. However, these difficulties may have been foreseen by demanding more from the Claimant’s medical experts, particularly in consideration of the alternative facts averred by the Trust and consideration that an expert’s confidence, adamance and forthrightness in his or her opinion will rarely eclipse that of the more considered, careful and dispassionate expert. Legal commentaries probably rarely quote modernist architects, but litigators assisting witnesses prepare their statements could learn something from the aphorisms of Ludwig Mies van der Rohe by remembering: *“Less is More”*, and perhaps also that *“God is in the details”*.

**Thomas Crockett of Hailsham Chambers** acted as counsel for the successful NHS Trust.

He was instructed by **Oliver Brady of DAC Beachcroft LLP, Winchester.**



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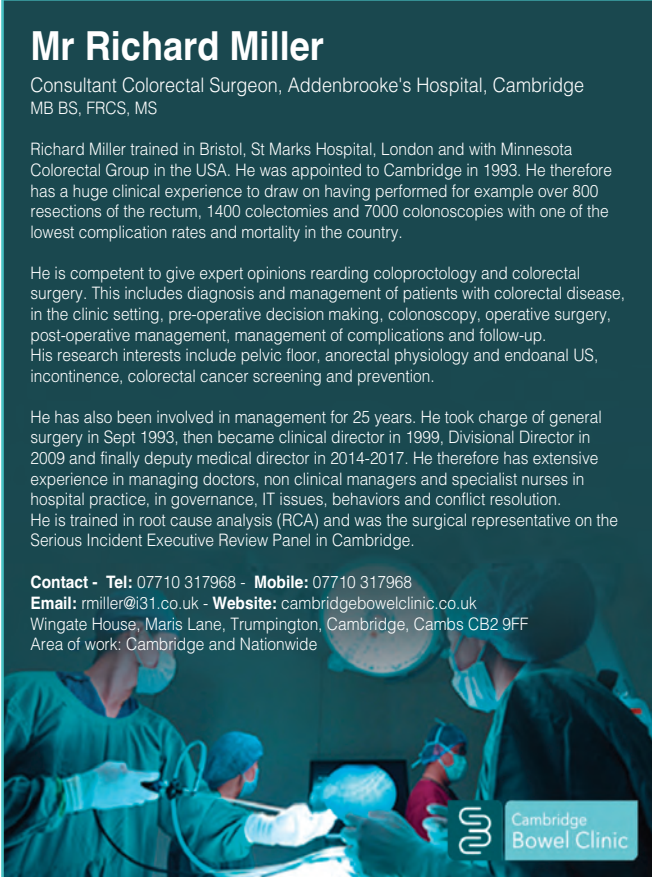
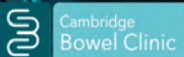
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# “Arising Out the Use of a Vehicle?” Common Sense Definition Prevails

by *Judy Dawson*

## The Facts

In *Neil Carroll v Michael Taylor, Michael Doyle, Emms Taxis Limited & QBE Insurance (Europe) Limited* [2020] EWHC 153 QB the facts were relatively straightforward; Mr Carroll hailed a black cab driven by the First Defendant and owned by the Second Defendant after a night out drinking. Rather than taking him home, the First Defendant firstly stole his debit card (in fact swapping it for the debit card he had stolen from a previous fare) and then secondly when the First Defendant asked him to stop so he could get cash out, watched as the First Defendant (presumably repeatedly) put in his pin number, not realising that his attempt to obtain cash was doomed to failure as he was using somebody else's card. Having thus obtained his pin number, the First Defendant then drove away leaving Mr Carroll stranded (and indeed within a short period of time removed £220 from Mr Carroll's account with the ill-gotten card and pin number).

Mr Carroll telephoned his partner who advised him to go to his Uncle's house nearby (which he rejected as he did not want to wake him up so late), get another taxi home (as she thought they would have enough money in the house to pay the fare) or to wait where he was and she would pick him up. She gained the impression that they had decided on the third course of action and departed to pick him up. He (perhaps confused through drink or perhaps in an attempt to meet her part of the way back) did not wait where he was but commenced walking home. After walking about 2km and it being at least 40 minutes after the taxi had left him, it was accepted for the purposes of the preliminary issue hearing that he had sat down on the barrier of the flyover on the M62, accidentally fell off and fell a considerable distance down onto the ground below, suffering catastrophic head injuries in the process. He was not found until 8am the following morning.

## The Law

Two questions were agreed to be dealt with by way of the preliminary issue.

**Question 1:** Did the Claimant's injuries arise out of the use of the taxi on a road or other public place within the meaning section 145(3)(a) of the RTA?

**Question 2:** Given the basis for the Court's finding on the first question and, in particular, the relevance or otherwise of the First Defendant's deliberate criminal acts, does the insurance policy issued by insurer to the Second Defendant respond to the Claimant's claims in tort against the First and Second Defendants if those claims in tort are proved?

The first question is the one upon which this article will concentrate given its wider importance. It gave rise to two issues, namely: (1) was there a use of the taxi on a road or public place; and (2) did the Claimant's injuries arise out of that use?

**Issue (1)** was not in dispute. The First Defendant's carriage of the Claimant in the taxi culminating in him driving away from the cash point on Prescott Road was a "use of the vehicle".

**Issue (2)** involved a study of the relevant statutory framework and law in relation to section 145(3)(a) of the RTA which states;

(3) Subject to subsection (4) below, the policy – (a) must insure such person, persons or classes of persons as may be specified in the policy in respect of any liability which may be incurred by him or them in respect of the death of or bodily injury to any person or damage to property caused by, or arising out of, the use of the vehicle on a road or other public place in Great Britain; ...

Section 151 of the RTA states that where a judgment is obtained against any person relating to a liability where liability with respect to that matter is required to be covered by a policy of insurance under section 145 of this Act, [the insurer must satisfy such judgment]

The RTA does not require all uses of the vehicle to be insured. Rather, there is an obligation on the user to have insurance for the particular use to which he puts the vehicle. If the use from which the injuries allegedly arose was outside the permitted use then section 151(2)(a) is not satisfied and the insurer is not required by section 151 to meet the judgment awarded against the wrongdoer.

Mrs Justice Tipples, in an admirably masterful judgment, reviewed all the relevant case law that had previously been before the Courts, including in particular the authorities of *Dunthorne v Bentley* [1996] RTR 428 (Court of Appeal) and *AXN v Worboys* [2012] EWHC 1730 (QB).

In *Dunthorne v Bentley* the insured, Mrs Bentley, was driving her car on the road when she ran out of petrol. She parked at the side of the road with the hazard lights flashing and stood at the rear of the car. After about 10 minutes she was seen by a colleague, who stopped her car on the opposite side of the road. Following some shouted conversation, Mrs Bentley ran across the road. She was struck by an oncoming vehicle and killed. The driver of that vehicle was Mr Dunthorne, who was seriously injured and claimed

damages against the administrators of Mrs Bentley's estate, who admitted negligence. The motor insurers were joined as defendants. There was a trial of a preliminary issue to determine whether the accident 'arose out of' Mrs Bentley's use of the car so that the insurers were liable for Mr Dunthorne's injuries under the terms of the motor insurance policy issued to Mrs Bentley pursuant to section 145(3)(a) of the 1988 Act. The trial judge inferred from the agreed facts that Mrs Bentley was running across the road to obtain assistance in restarting her car, and this was closely and causally connected with her use of the car and, as a result, the accident 'arose out of such use' and the insurers were liable. The trial judge's decision was upheld by the Court of Appeal.

AXN v Worboys [2012] EWHC 1730 (QB) arose out of in some ways similar facts to the incident claim in that Mr Worboys, like Mr Taylor, was using the perceived "safe" status of a black cab to in fact carry out criminal activities – in Mr Worboy's case drugging and then sexually assaulting single female passengers. Silber J summarised the principles that emerge from *Dunthorne v Bentley* as:

"first, that the concept of "arising out of" is a wider concept than "caused by"; secondly, that the focus of the inquiry has to be to consider whether the injuries of the claimant were matters "arising out of the use of the car"; and thirdly, that it is necessary to analyse the activities of the driver whose insurers are being sued to see what he was doing at the time when the injuries were suffered in order to ascertain if they were "arising out of the use of the car"."

The Claimant in the *Worboys* case was unsuccessful on the identical point as to whether the injuries suffered arose out of the use of the with the Judge in that case finding that;

"the relationship to which the words "arising out of" must be applied is between the injuries suffered (not the negligent and wrongful acts) and the use of the vehicle not at the start of the journey, but as at the time when the injuries were suffered;

the application of the words "bodily injury ... arising out of the use of a vehicle" entails considering all the material circumstances. What was crucially important in *Dunthorne* in reaching the decision that the injuries of the claimant arose out of B's [Mrs Bentley's/the insured's] use of the car is that she would not have crossed the road if she had not run out of petrol and sought help to continue her journey"

### **The Judgment**

Having considered that the injuries were not geographically, temporally or qualitatively closely linked to the use of the taxi, the journey having ended once the Claimant got out of the taxi, Mrs Justice Tipples found;

"There is no evidence whatsoever about what the taxi driver was doing, or where he was, at the time the Claimant sustained his injuries. Having stolen

money out of the Claimant's bank account, the taxi driver could have been anywhere in the Liverpool area. This fact alone makes it crystal clear that the accident to the Claimant did not arise out of the use of the taxi. In these circumstances it is impossible to see how there is a relevant causal link between the use of the taxi and the injuries suffered by the Claimant under section 145(3)(a) of the RTA.

In my view, the Claimant's injuries had nothing whatsoever to do with "the use of the vehicle on a road" in the context of section 145(3)(a) of the RTA. Rather, the injuries occurred where they did, and when they did, because the Claimant had decided to make his way home on foot and these injuries were not in any sense closely linked with the use of the taxi".

Given such decision, question two could be dealt with relatively briefly;

"The taxi driver had no intention of using the taxi to take the Claimant home to Huyton. Rather, he was using the taxi as an integral part of his "modus operandi" to steal from people, like the Claimant, who had been drinking and were seeking to make their way home in the early hours of the morning after a night out in the centre of Liverpool. On the facts of this case I have reached the clear view that, from the taxi driver's perspective, the essential character of the journey in which he took the Claimant in the taxi from Hardman Street to the Santander cash point was to steal from him and that he was using the taxi for a criminal purpose.

Section 145(3) of the RTA only requires insurance for the use to which the person, in this case, the taxi driver, is putting the vehicle. The policy in this case limits use to "social, domestic and pleasure purposes", "use for the Insured's business" or "use for the carriage of passengers for hire and reward under the terms of a Hackney Carriage Licence". The journey in this case did not therefore constitute a permitted user".

### **Comment**

One can understand the temptation for those advising a catastrophically injured Claimant to attempt to utilise the very extremes of definitions to try to persuade a Court to connect an accident to "arising out of the use of the vehicle" to enable such a victim to recover compensation against an insurance company. It is clear from a reading of the Court of Appeal decision in *Dunthorne v Bentley* that the appellate Court felt that the Judge's decision took the definition of "arising out of the use of the vehicle" to its limits and it only just (and not without hesitation) allowed that such facts could fall within the interpretation. The *Worboys* case sought (and failed) to extend the interpretation further and this claim attempted to do the same (indeed to do so, the Claimant's Counsel had to submit that at least one principle within the *Worboys* judgment was incorrect). It is to be hoped that this judgment will seek to

confirm what would appear to be the common sense approach and interpretation of the Road Traffic Act; I would suspect its draftsmen would have been flabbergasted were it to have been suggested that such an Act was intended to fix insurers with commercial liability for injuries from criminal enterprises far beyond the driving of such vehicles.

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Dr Baskerville has lectured and published extensively in the U.K. and internationally on the Care of the Surgical Patient and on vascular and venous disease. He is past President of the British Association of Day Surgery and an ex-council member of the International Association of Ambulatory Surgery. He was lately Senior Examiner in Surgery at the University of London and Examiner for Higher Medical Degrees at the same University. As a Council member and then President of the British Association of Day Surgery, he has also lectured widely on Day Surgery, including to a Select Committee of the French Assemblée Nationale. He is a fluent French speaker.

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He also has experience in the head and neck surgery with 8 years experience in maxillofacial surgery, including head and neck oncology.

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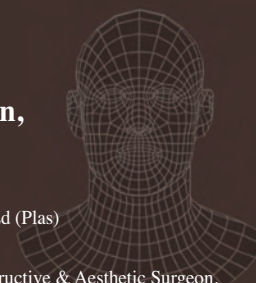
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## Seat Belt Injury to the Breast May be Under Reported Following Road Traffic Collisions - A Case Report

by Mr. George Ampat, Consultant Orthopaedic Surgeon, Mr. Jonathan Sims & Mr. Ben Hoyle, Research Assistants. [research@ampat.co.uk](mailto:research@ampat.co.uk)

*Consent was obtained from the patient for this publication. The patient also read through the manuscript and provided her own comments and reflection which are included.*

### Introduction

In road traffic accidents, seatbelt use saves lives [1]. However the use of seat belts has created some new injuries to the chest wall termed as “seat belt syndrome” [2]. Injury to the female breasts is one among those injuries [3]. The injury to the breast occurs as the soft tissues of the breast may get crushed between the bony chest cage and the tightening seat belt. Though the sash of the seat belt is soft and slack, as it tightens on impact, it stiffens and becomes firm and hard. The range of injuries to the female breast as a result of the seatbelt can range from bruising to complete avulsion [3].

The three year prospective study by Newman reported that the incidence of chest wall injuries were as high as 16% [2]. Though chest wall injuries can be as high as 16% of all road traffic accidents the number of reported breast injuries is not high [3].

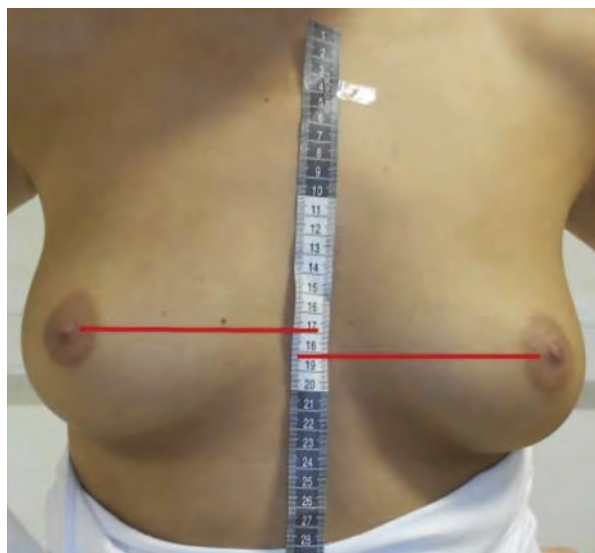
Majeski [3] was the first to propose a classification of the injuries sustained to the breast as a result of a three point lap-diagonal seat belt. There were 4 classes of injuries. Class I was a mild crush injury and Class 4 was subcutaneous avulsion of the breast from the chest wall. Most of the injuries in the series (14 out of 19) were mild Class 1 injuries. The suggested management proposed for a Class I injury is that it resolves with symptomatic care and analgesia. The index case had a Class 1 injury. The symptoms resolved within 6 to 12 months but she has been left with a mild asymmetry that developed following the road traffic accident.

### The index case

We present a case of a 21 one year old female who was involved in a road traffic accident. She was the seat belted, front seat passenger in a car. Another

vehicle coming in from the side road on the left came across their path. A collision ensued and the impact deflected their car which then crashed into a wall on the side. The violence involved was significant and airbags were deployed at impact. Following the accident the patient managed to get out of the car. She and the driver were then conveyed to hospital by ambulance on a spinal board. Following clinical assessment at the Hospital she was reassured and discharged. In summary she had sustained soft tissue injuries to her tongue, left little finger, cervical spine, chest wall, thoracic spine and lumbar spine. She had accidentally bitten her tongue which did not require any intervention, but the left little finger was buddy strapped. For the soft tissue injuries to the spine and chest wall, she was advised to take analgesics for pain relief and to consult her General Practitioner if the symptoms worsened. The left little finger and the tongue resolved within a month after the accident. With physiotherapy her musculoskeletal symptoms improved but did not completely resolve. A further assessment 17 months following the accident revealed ongoing pain and generalised soft tissue tenderness in the cervical, thoracic and lumbar spine. The claimant also complained of asymmetry in the breast that developed following the index accident. She had experienced pain and bruising in her breast and chest wall for 6 to 12 months. As the pain was resolving she started noticing an asymmetry with the right breast becoming slightly smaller following the index accident. She had initially noticed a slight enlargement immediately following the accident. Due to the presence of ongoing symptoms at the 17 month assessment, a whole spine and breast MRI scans were requested. The MRI scan of the cervical spine showed some early degeneration, with reversal of lordosis, The MRI scan of the thoracic spine was normal. The MRI scan of the lumbar spine showed some fat infiltration of the multifidus muscle. The MRI scan of the breasts was reported as follows;

*Age related prominent glandular elements of both breasts. The outline of the glandular elements of both breasts appear symmetrically intact and unremarkable. No cysts nor oil cysts seen in either breasts. Right Breast: The T2 fat saturated*



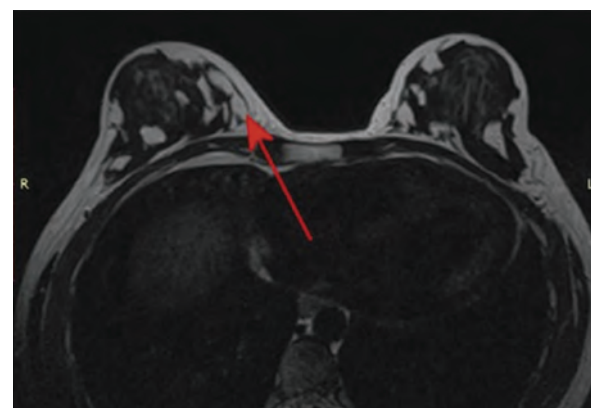
*weighted images shows homogeneous high Signal intensity of the subcutaneous fat along the inner, and the lower half of the right breast is more than in the UQ. There is also high signal of the fat intervening the glandular tissue of the lower half of the right breast as well. Those areas of altered fat signal shows normal signal pattern in both T1 and T2 FSE weighted images. Left Breast: The left breast shows intact fat signal in T1, T2 and FS weighted images in both the subcutaneous and the intervening fat within the glandular element. Conclusion: Above described right breast altered fat signal along the inner and lower aspect are suggestive of late fat necrosis. No gross evidence of post traumatic parenchymal distortion could be detected in such non enhancing study.*

With further dedicated physiotherapy and a regular self help exercise protocol the spinal symptoms resolved within 24 to 30 months. The asymmetry in the breast was static and had not changed. There was however no ongoing pain in the breast. The breast volume was measured by the Breast – V formula [4] and the left breast measured 260 mls and the right breast measured 223 mls showing a difference of 37 mls.

### Discussion

Seat belts prevent 6 of the 10 deaths that would normally have occurred in vehicular accidents if they were not being used [1]. The lap diagonal part of the seat belt cruises over the upper inner quadrant of the left breast and the lower inferior quadrant of the right breast in the occupant seated on the left side of the vehicle [5]. This is the passenger position in a right hand drive vehicle (UK vehicle). The reverse is true for the occupant on the other side. This obviously can vary according to the make and model of the vehicle and the height of the occupant. In the index case the patient was the passenger in a British vehicle (right hand drive) and the lower inferior quadrant of the right breast was affected.

Though 16% of vehicular accidents may result in chest injuries [2] there seems to be an under reporting of injuries to the female breast [6]. A recent review of these injuries in 2015 [7] only identified 26 articles reporting 42 patients. In addition majority of



*Above, MRI scan of breasts. Arrow points to homogenous high signal intensity in the lower inner quadrant of the right breast*

*Opposite, Photograph of patient showing injured right breast contracted and higher than the uninjured left breast.*

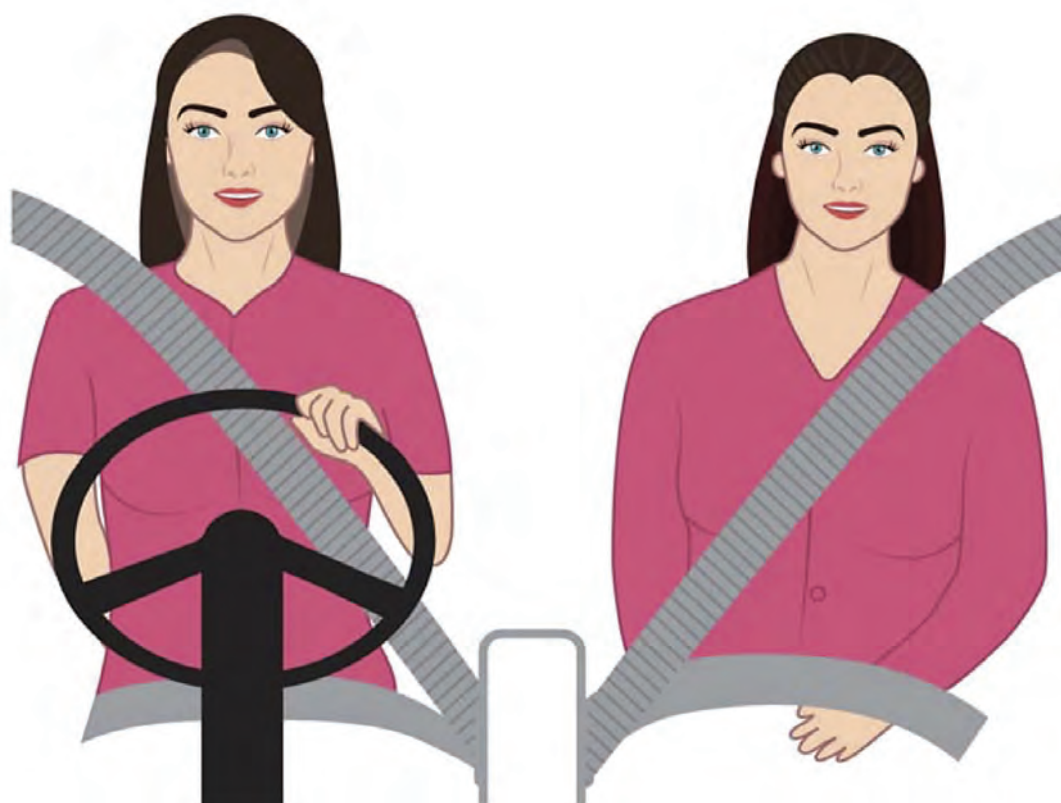
these patients presented late. In this series by Song et al [7], 69% of the patients presented late at a mean time of 6.8 months and presented between a range of 3 weeks and 5 years. The review by Song et al [7] also provides an alternate classification of the seat belt

injuries sustained to the breast. Though this classification includes injuries to breasts with implants we found the classification by Majeski simpler and easier to use.

**Table 1 Majeski’s classification of seat belt breast trauma and proposed management.**

Class	Severity of Injury	Management proposed
1	Mild crush injury consisting of bruising, ecchymosis, skin blistering, breast.	Resolves quickly with symptomatic care with analgesia.
2	Moderate crush injury consisting of intramammary haematoma, fat necrosis, skin avulsion or loss, skin laceration, skin ulcer.	Closure of skin lacerations, ultrasound-guided drainage of any expanding breast haematoma and analgesia.
3	Severe crush injury consisting of subcutaneous partial or complete transection of the breast resulting in a permanent diagonal furrow across the breast corresponding to the line of the seat belt that cleaved the breast tissue into two parts.	Most treated non-operatively.
4	Avulsion breast injury consisting of subcutaneous avulsion of the breast from the chest wall with rupture of perforating branches of intracostal vessels, active bleeding into the breast and the space between the breast and chest wall caused by the traumatic shearing force	Contrast-enhanced CT of the chest to show any active bleeding. Treat extravasation with endovascular or surgical intervention.

*Below, for an average car and a person of normal height, the seat belt goes over the left breast of the driver and the right breast of the passenger.*



The Majeski Class 1 injury is the most common (73.6%) of the injuries to the breast. In the index case the patient sustained a Majeski Class 1 injury. However though her pain and bruising had resolved within 6-12 months she developed an asymmetry without any palpable lumps.

Majeski Class 2 and 3 injuries can cause traumatic fat necrosis. Fat necrosis of the breast is an inflammatory reaction that occurs mainly following trauma [8]. The inflammatory response produces enzymes that liquefy the fat which combines with calcium and can form calcifications. Fat necrosis can cause tenderness and pain in the breast, a lump, discoloration of the skin surface and nipple retraction. Radiographically they may appear as lipid cysts with rim calcification. The changes in traumatic fat necrosis following seat belt injuries are in a band like fashion in line with the seat belt [9].

Majeski Class 4 injuries with significant soft tissue disruption require urgent treatment.

Though the published literature suggests that Majeski Class I injuries resolve with no sequelae the index case shows development of asymmetry most probably from generalised fibrosis as a result of the injury. Chest wall asymmetry is common, with about 88% [10] showing some asymmetry. However in the index case the patient clearly noticed symmetrical breasts prior to the accident with development of asymmetry and contraction of the right breast over a 6 – 12 month period following the road traffic accident. The MRI also confirmed the diagnosis of late fat necrosis.

The under reporting of these injuries may be due to the body part injured. A study among female athletes showed that only 10% of the players reported injuries to the breast to a medical professional or to their coach (11). Injuries to the breast are considered a taboo even among elite sports women [12].

A palpable lump or radiological abnormality requires a triple assessment (clinical examination, radiology and biopsy) even though there may be a clear history of trauma [13]. Though there is no association between trauma and cancer some of the features that follow trauma mimic cancer and hence the reason to rule out cancer if there is a palpable lump or radiological abnormality.

### Comments by the patient

It is a very uncomfortable and an awkward injury to report, as you wouldn't expect for such an injury to occur when involved in a Road Traffic accident. It made me question whether it was the result of the injury or whether it was just my breasts changing in shape naturally. This is because of the lack of information about this injury as compared to other injuries such as whiplash. Once knowing it was an injury, eased my mind. However the main issue for me now, as a 22 year old, who is very body conscious, is that, this has made me insecure.



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### Conclusion

Injury to the breast as a result of Road traffic accidents occurs as the breast tissue gets crushed between the bony chest wall and the tightened and firm seat belt. These injuries following road traffic accidents are under reported as similar injuries in sports. Embarrassment and lack of knowledge may be contributory factors to this underreporting. It is likely that this injury is also under reported in medico legal practice. However the most relevant learning point is that palpable or radiological abnormality even with a history of trauma requires specialist triple assessment to rule out cancer.

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# Finding a Physiotherapy Expert

by Mr Tim Edbrooke, Physiotherapist

Sometimes it can be difficult to locate the right expert physiotherapist, and whilst some will belong to various directories, the majority will belong to the Medico Legal Association of Chartered Physiotherapists, which has over 200 members undertaking a wide variety of medico-legal work. MLACP members can demonstrate that they are currently educated, trained and competent in medico-legal report writing to be eligible for inclusion in the Directory of Members. Those listed are not endorsed by the Association, but have agreed that solicitors may contact them directly to discuss their client's expert witness needs. <http://www.mlacp.org.uk/directory/>

Physiotherapy is a profession supplementary to medicine, and physiotherapists are independent practitioners bound by a code of professional conduct and standards in the same manner as other medical professionals. Physiotherapists use a range of physical, cognitive and other interventional approaches to restore, maintain, improve, or manage the planned decline of movement and activity in individuals caused by ageing, disease, injury and/or disability.

The statutory regulator for physiotherapists is The Health and Care Professions Council ([www.hcpc-uk.org](http://www.hcpc-uk.org)). Physiotherapy has been a fully autonomous diagnostic profession since 1977. The titles 'physiotherapist' and 'physical therapist' are protected by law and only those listed on the relevant register held by the Regulator may practise using a protected title. Some physiotherapists may also prescribe Prescription Only Medicines (POMs) for their patients, including some controlled drugs.

The degree to which an individual physiotherapist will undertake diagnosis of their patient's presenting

condition will depend on their experience and job role, and whether they are able to request and/or interpret diagnostic imaging investigations to assist with their clinical decision making. However, all physiotherapists are required to make a differential diagnosis and plan the management of their patient's condition independently of other medical professionals, and in accordance with regulatory requirements and good professional practice.

## Commissioning an Expert Report

There are many different types of report that solicitors might ask an expert physiotherapy witness to produce. Each will have their own particular requirements and the solicitor must be clear what type of report they require and are asking the expert to write to ensure that their report complies with the relevant rules and fulfils the client's needs.

Costs are often unnecessarily incurred through a failure to adequately sort and annotate the document bundle and to be sufficiently precise in the issues to be addressed by the report. In the initial stages it is often wise to seek advice prior to the commissioning of a full report:

## Advice Notes

Solicitors may ask for brief advice from an expert before deciding whether to accept a case. This may be a short letter or a desk-top report giving an opinion as to whether there is merit in pursuing a clinical negligence claim.

Solicitors may also ask for brief reports at a pre-litigation stage to enable them to write a Letter of Response to a claim. This can be common in NHS work which is managed through the NHS Litigation Authority. NHS Resolution specifies that reports should not contain a detailed outline of events, specifying

the basis for the claim and limiting the length of the report to 3 – 4 pages with a maximum cost set at the outset.

### **Clinical Negligence Reports**

These are independent reports which are used as evidence in cases of alleged clinical negligence. Such reports must meet the requirements of the current Civil Procedure Rules (Part 35). Physiotherapy expert evidence provided for the civil courts is tested to the civil standard of ‘on the balance of probabilities, more likely than not’. Experts can be instructed either by the claimant or the defendant (or their insurers) or in some cases a Single Joint Expert is appointed to act for both sides.

### **Liability reports:**

In order to establish clinical negligence both breach of duty and causation must be proved. Sometimes separate ‘Breach of Duty’ reports may be requested in order to limit unnecessary costs, because if breach of duty of not proven establishing causation is not necessary. A liability report will give an opinion on the standard of care provided and whether a failure to act as ‘a reasonably competent physiotherapist’ contributed to causing the alleged harm. This failure usually takes one of two forms:

**Action:** A rugby player attending a physiotherapist complaining of shoulder pain and muscle spasm was treated using a number of techniques including acupuncture. Shortly after treatment he experienced acute breathlessness and attended hospital where a pneumothorax (punctured lung) was diagnosed. This is a known risk associated with acupuncture of that area, and is a result of poor technique. In addition the patient had not been warned of the potential adverse outcomes of the treatment

**Inaction:** A 43-year-old plumber slipped and twisted his knee. He was seen by a physiotherapist following referral by A&E. Testing of the joint was suggestive of both cartilage and ligament injury. Exercises were given and the patient was reviewed after 2 weeks at which time there was slight improvement but the patient was still unable to work. Further exercises were given and another review arranged. This process continued for two months during which the patient was unable to work. He was eventually referred to the orthopaedic department, scans were organised, and he was listed for urgent repair of the anterior cruciate ligament and resection of the cartilage. The claim alleged correctly that referral should have been more timely resulting in loss of wages and a less favourable outcome of surgery.

**Failure to advise:** One of the most common claims results from a failure to advise patients with central low back pain of the risks and symptoms of spinal cord compression (cauda equina syndrome) which is a condition requiring immediate surgery. Symptoms include loss of bowel or bladder control and loss of sexual function, and these can become permanent if action is not taken within a reasonable timeframe.

### **Condition and Prognosis Reports (Quantum) and Physiotherapy Needs Reports**

To establish the amount of damages that might be awarded if a claim for clinical negligence is successful, accurate costings are a vital part of the report and may have a significant impact on the amount of any damages awarded to a successful claimant. Physiotherapy quantum reports typically involve a consideration of past, current and future physiotherapy costs, equipment costs, and other costs that may be associated with helping the claimant achieve a lifestyle as close to their pre-injury life as possible. Any report needs to consider all of these elements factored in for the normal expected life time of the patient.

Independent reports may be used for ensuring that the needs of vulnerable adults and children are met as part of health, social service or educational provision clearly stating current and future physiotherapy needs including equipment and including costs for the length of time required. The nature of the report may vary depending on what purpose it is to be used for. They may be requested by a solicitor, or can be commissioned by parents of children with special educational needs, or advocates for vulnerable adults.

All reports should include a clear physiotherapy assessment so that it can be clearly seen on what basis recommendations are made.

### **Whiplash Injuries**

All whiplash claims are now managed through a central portal run by the not-for-profit company MedCo ([www.medco.org.uk](http://www.medco.org.uk)). All physiotherapists who wish to write whiplash reports must be accredited with



### **Mr Tim Edbrooke Physiotherapist** - B.Ed(Hons); GradDipPhys

Tim Edbrooke qualified as a Chartered Physiotherapist in 1990 and has worked for the NHS; the Police Service in Occupational Health; as a Governing Body Physiotherapist for British Triathlon and UK Athletics, and as a private practitioner in Harley Street, London, specialising in spinal conditions, and in Exeter specialising in spinal conditions, sports injuries, and Occupational Health.

He prepares medico-legal reports in cases of personal injury and road traffic accidents, and in cases of Breach of Duty and/or professional standards involving the physical therapy professions (physiotherapy; osteopathy; chiropractic, and massage).

He has considerable experience of preparing reports for Health Care Professions Council tribunals, and of preparing reports for the Police in criminal cases of assault and sexual assault.

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MedCo either as an independent expert or as part of a larger medical reporting company. There are rules in place for the fees paid for this type of report and how claims are managed.

### **Tribunal Reports and Reports for Criminal investigations**

Physiotherapy reports can be used in Tribunal settings such as Employment Tribunals; in Regulatory Tribunals such as fitness to practice hearings held by The Health and Care Professions Council (HCPC), and as evidence in criminal cases. Physiotherapy expert evidence provided for the criminal courts is tested to the criminal standard of 'beyond all reasonable doubt.'

An expert physiotherapy report for criminal proceedings may be asked to give an opinion on a range of physiotherapy matters. For example, whether a defendant was capable of committing an alleged crime based on the existence of some physical injury or disability, or whether behaviour that a complaint believes is inappropriate amounting to some form of assault is acceptable professional behaviour.

Cases are thankfully infrequently brought against physiotherapists, and when they are the accusation is usually 'assault by touching'. It is frequent for these cases to fail in the Crown Court where no expert physiotherapy witness is called, but for the physiotherapist to be sanctioned by the HCPC at a Fitness to Practice tribunal where expert opinion is properly sought.

## **Mr Aniruddha Chakravarti**

Consultant Urological Surgeon

Honorary Senior Clinical Lecturer in Urology

MS, FRCS (Urology), MSc (Health Care Policy & Management)



I am a Consultant Urological Surgeon and Honorary Senior Clinical Lecturer in Urology, University of Birmingham, with special interest in Minimally Invasive Urological Surgery, including laparoscopy and robotics.

I qualified as a medical graduate in 1990 and attained post Graduate training in general surgery before training in Urology.

With over fifteen years of Urological experience I have developed a Special interest in laparoscopic and robotic management of upper Urinary tract conditions. I had intensive laparoscopy training from the European Institute of Tele surgery in Strasbourg and obtained a Diploma in Laparoscopic Surgery from the Institute.

I also have experience of using all kinds of laser for prostatic surgery especially Holmium and Thulium laser.

I enjoy working as an expert witness in difficult clinical controversies to help the legal matters through an intuitive and experienced review of the case from an expert medical point of view. I have had the necessary training to become an expert witness and have done fifteen medico-legal reports on urological conditions arising from accidental injuries and clinical negligence claims in last two years. Most of my reports were on clinical negligence matters arising from Urological conditions and surgery for such conditions. I have undertaken Bond Solon Expert Witness Training through extensive courses in 'Excellence in report writing' and 'Courtroom skills'.

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# A New Rehabilitation Centre for the Survivors of Burns and Scars

*by Sarah Green, Chief Executive, The Katie Piper Foundation*

In 2019 The Katie Piper Foundation opened the UK's first residential Rehabilitation Centre for the survivors of severe burns and scars. The Centre, our overarching ambition since our launch 10 years ago, is inspired by the rehabilitation and care that Katie Piper received in France after sustaining severe burns from an acid attack as well as the feedback of thousands of burns survivors.

Based in Merseyside, the Centre offers an innovative approach to intensive scar rehabilitation, care and support outside of the acute hospital setting and helps survivors take vital steps forward in their recovery. Our multidisciplinary team of specialist scar physiotherapists, personal trainers & psychotherapists, overseen by Professor Kayvan Shokrollahi our consultant burns and plastic surgeon, make signifi-

cant, lasting improvements to the lives of those with severe scars. Running alongside existing NHS treatment, the Centre staff assess the needs of each burns survivor and design an individual programme of rehabilitation tailored to their specific needs.

Survivors of burns typically stay at the Centre for a month and with a busy timetable and 5 days a week dedicated care, survivors benefit from up to 100 hours of therapeutic support during their stay. The emphasis is on providing an immersive rehabilitation experience and ensuring that every person who comes to the Rehabilitation Centre receives the highest level of care, giving them the best opportunity to thrive. Survivors come to us with a variety of tangible goals, from wanting to improve their confidence and regain their independence to being able to walk

upstairs more easily or increase mobility in their arms. In one month, a survivor can expect to see improvements to their overall fitness and flexibility as well to the look and feel of their scars and will also feel more confident and independent in their lives. A primary aim is to ensure that they can continue with their rehabilitation progress after they have left us and therefore much of our work is focused not only on immediate improvements but on providing the tools needed to ensure sustainable progress post rehabilitation.

Overall physical fitness is key to recovery and is essential if survivors are to make headway with more specific goals such as improving mobility, balance and flexibility. The Katie Piper Foundation has invested in advanced technology to help ensure that an individual's fitness is constantly improving and that they are making sufficient and measurable progress during their rehabilitation stay. At the heart of our fitness training programme is progressive equipment that provides data on outcomes as well as delivering a range of therapies. This allows for objective baseline data and measurement of range of movement and fitness that is updated throughout the rehabilitation stay. By tracking an individual's progress from day one of their stay and every day until they leave, we know that they are on track to move on from us in improved physical health and that this will stand them in excellent stead for making ongoing improvements independently.

Scar management is at the heart of our programme and it's something that many of the survivors coming to us are most keen to experience. We are lucky to have a team of excellent clinicians with experience in specialist procedures including: focused massage, endermology, laser and minimally-invasive medical interventions. These can all help to improve scar manifestations such as contour, discoloration, pliability, and texture and help to reduce tightness and improve range of motion. Our ever popular LPG-Endermologie machine has a vacuum effect which massages scar tissue giving relief to tight, itchy scars, it also stimulates collagen which improves the health of skin and can contribute to an improvement in physical appearance. The combination of all of these techniques and scar interventions means that we can offer a comprehensive and advanced approach to scar management all housed under one roof.

A significant part of our timetable is focused on activities. These supervised activities work alongside our fitness and scar management programmes to improve core strength and mobility but also to widen experiences and increase confidence in a supported way. We have a full range of activities available to participate in, from boxing to real-snow skiing and climbing to swimming, rowing and horse riding to name but a few. The individual chooses activities based on supporting the goals they come to the Centre with and is also encouraged to think about what local community based activities they can incorporate into their daily life after their time at the Centre.

In this way they have a clear route to maintaining their psychological and physical wellbeing after their rehabilitation stay.

Underpinning all of this physical fitness activity is the work we do to ensure that all patients are supported in their psychological wellbeing. Our psychotherapist works with survivors from prior to their arrival to understand what they want to achieve in their rehabilitation stay and to talk to them about the impact this will have on their lives. During their stay they receive psychosocial support that helps them to overcome difficult experiences and to rebuild their social network, it helps them to access the things in everyday life that will help their lives to progress. Weekly sessions of 1-1 support help to evaluate psychological goals and expectations and to work on the self-care techniques that develop resilience and coping strategies. Survivors are encouraged and challenged to take on things that they have previously found impossible. This might involve something such as leaving the Centre on their own, getting a bus, doing some shopping independently, it all builds to a cumulative effect of regaining independence to a level that can be sustained at home on their own.

Often survivors feel incredibly isolated after their injuries, despite having strong support networks, over 40% of people with a visible difference say their family do not understand how they feel. This can be due to the trauma of what has caused the scars or the psychological impact of looking different, both to themselves and others. Through the peer-support element of the programme we bring survivors together with those who have already been through rehabilitation. This is often the first time they have met anyone else with severe scarring and it can be a life changing event, boosting both confidence and positivity for the future. It helps survivors to see someone who has been through what they have experienced and has moved on, it is demonstrable proof that they can get their confidence back and live the life they choose and this is proving to be a hugely successful element to the programme.

The ethos for everything we do at the Rehabilitation Centre is that a supportive and nurturing environment is vital if survivors are to achieve the progress we know is possible. We have worked to make every element of a stay at the Centre as comfortable as possible. To help foster a feeling of wellbeing, survivors don't stay in a hospital setting, rather in their own bungalow in the rural grounds of the hospital. Offering all the comforts of home, the bungalows provide a calm environment where survivors can fully relax in their own private space after a full day of activities. The bungalows can even accommodate visitors so family members can come and stay, providing even more support for the survivor through the rehabilitation process. We are also currently fundraising for a new facility based to expand the footprint of the Rehabilitation Centre, which will provide a more private space where survivors can improve their wellbeing independently.

Patient feedback tells us that The Katie Piper Rehabilitation Centre provides the highest quality, intensive rehabilitation support in the UK today. Andreas who stayed with us for a month, gave us his view - 'Your Rehabilitation Centre helped me in ways that I thought no one could, I feel like I've got my life back'. In our first year we helped twenty patients with severe scars to feel more themselves again, we want to help more. If you are representing someone who has severe scarring, The Katie Piper Foundation Rehabilitation Centre could be the answer.

To make a referral or find out more visit [www.katiepiperfoundation.org.uk](http://www.katiepiperfoundation.org.uk).

### Sal's burns story.

In December 2019 Sal came to stay for a month at The Katie Piper Foundation Rehabilitation Centre. Having been injured in Yemen and left with severe acid burns to his face and body he spent 9 weeks in intensive care having specialist burns treatment. Having had 10 operations in an attempt to reduce the damage done by the burns he began facing the realities of a life with severe burns. He learned to walk again, to feed himself and to begin to cope with the trauma of what he had experienced.

When he came to the Rehabilitation Centre his goal was to improve his fitness and regain his independence. His scars were tight from his skin grafts and he couldn't move one of his arms much, he was also struggling with his confidence and daunted by going out in public on his own. During his rehabilitation month, Sal had regular sessions of physiotherapy and specialist treatments to help ease his scars and improve their feel and texture. He worked with our personal trainers, trying boxing for the first time to improve his freedom of movement and his core strength. He was supported with his wellbeing through therapy and was encouraged and challenged to do things on his own, he began taking trips into the local town on the bus and talking to new people, all the time making small steps towards regaining his independence.

Sal gave his all to his rehabilitation and the staff were there to support him every step of the way, ensuring that his month was spent in the most beneficial way possible. The progress he made was transformational, the staff were amazed at his courage and sheer determination to reclaim his life and become independent again. By the end of his month Sal's confidence had rocketed and with a renewed optimism for the future he returned home, confident in his ability to start living his life again, ready for what the future could offer him.



*Above, Sal boxing*



## The Katie Piper Rehabilitation Centre

The UK's first intensive residential rehabilitation service for survivors of chemical, scald or flame burns.

If you are representing someone with severe scars, The Katie Piper Foundation's specialist team could help.

Find out more at [katiepiperfoundation.org.uk](http://katiepiperfoundation.org.uk)

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## Which Car Would You Pay More For? Car A or Car B?



# Diminution in Loss Claims

by *Tim Kelly - C.A.E. M.S.O.E. M.I.R.T.E Eng Tech Aff. I.M.I, (Appropriately Qualified Person) AQP. Managing Director and owner at MotorClaimGuru Ltd.*  
[www.motorclaimguru.co.uk](http://www.motorclaimguru.co.uk)

### **Diminution in Loss**

Diminution of Loss basically means that if you have been involved in an accident that was not your fault, then it could be argued your vehicle has been "reduced" in value due to being damaged and now repaired (even when repaired to a perfectly satisfactory standard)

The case law around it is based on a case called "Payton-v-Brooks" 1974 where it was argued that, "it is clear that the correct moral attitude towards a perfectly repaired car, especially if it has not sustained major structural damage, is that it should be worth the same as an undamaged similar car; but the obvious argument which is put forward is that if a potential buyer is presented with two identical cars, one of which is unblemished and the other with a history of accident damage repairs, for the same price, he is likely to choose the unblemished car, or expect a discount, that the one that had the connotation of being involved in an accident, would be worth less than one that had not.

This set legal precedent, meaning that it is a legal header of claim that you can claim for under common law.

In the research I have carried out I have uncovered one Court of Appeal authority from 1974, one Scottish appellate decision, one district judge-level judg-

ment on and a handful of brief reports on county court-level cases on current law. I will refer to as many case's as I can to assist in providing clarity on the relevant stances taken.

The starting point in considering a claim of this type has to be the Court of Appeal's decision in *Payton v Brooks* [1974] RTR 169 where it was held, albeit obiter on the facts of that case, that a claim can be brought for diminution caused by a vehicle having been repaired. This is not a controversial proposition given that, wherever there has been a loss, the principle of *restitutio in integrum* entitles the claimant to be placed in the position they would have been in had the tort not been committed. In the judgment of Lord Justice Ormrod, that if a reduced market value of a vehicle would be proved, irrespective of a good standard of accident repair work, that damages would be recoverable by which the value of the vehicle had diminished. However, in practice, controversy arises when attempts are made to establish whether or not there has been such a loss, and if so how much.

The court in *Payton* held that the claimant was not able to recover anything in respect of diminution because he had not proven a loss; the judgments make clear that diminution is not something that is self-evident.

As far as is known there has been no definitive high court ruling on this subject following the Payton case. In other areas of law, it can be argued that you cannot claim for a prospective loss, and that it could be theorized that unless the loss has been actualised (vehicle sold) no loss has occurred and the diminution claim is not valid.

This has now been disproven, on a number of cases,

### **Has the Loss Been Realised?**

It is often argued by defendants that diminution is not recoverable by a claimant until the vehicle has been sold, or at least put up for sale, as the loss has not been realised until this has occurred. This argument was rejected by the Inner House of the Court of Session in *Hunter v Thomson* and another (2004 Scot (D) 9/1) where the Sheriff Principal rejected the defendant's insurers' argument that the court could not be satisfied on the balance of probabilities that there was any diminution unless and until the car had been sold on at a loss.

If the vehicle has already been sold at a loss, or put up for sale at a lower value, this is a factor that should be brought to the court's attention as it conclusively shows the "after" value, meaning the claimant need only prove the "before" value. However, the lack of such evidence is unlikely to be fatal to the claimant's case. It is an issue that is ultimately likely to turn on the facts of a particular case.

If a claimant were to say in evidence that they had no plans to sell the vehicle for a long time there would be scope for the defendant to argue that there is no diminution as it is premised on a psychological reaction on the part of a prospective purchaser; if there is no purchaser then there is no loss of value. Claimants could counter that such an approach does not take into account the vicissitudes of life, i.e. the claimant may be forced to sell the vehicle sooner than they had otherwise planned. But now they do not need to due to *Hunter v Thomson* and also *Coles v Hetherington*.

Precedent was set on the basis outlining what the proper measure of loss is for the damage of a chattel.

This was stated in the case of *Coles v Hetherington* [2013] EWCA Civ 1704 at paragraph 33 per Aikens LJ ("Coles") at the court of appeal where the court found "found that the proper measure of loss was the diminution in the value of the damaged chattel. That loss occurred immediately at the time of the accident so could not be mitigated by having the chattel repaired at a lower cost".

"The "reasonable cost of repair" is, as a rule of thumb, taken as representing the diminution in value of the chattel that has been suffered as a result of the damage caused by the negligence of the defendant. However, it may not always represent the full amount of the diminution in value, as this court made clear in *Payton v Brooks*.

Though the court was referring to the repairs, it also follows that the diminution in loss in value also happened at that point, and as such does not need to be realised. (i.e. vehicle sold).

This has found to be true on a number of cases that have now gone through.

In diminution cases, the issues of whether or not there is a loss and the quantum of that loss are often intertwined; if a judge is not satisfied by the reliability of the evidence produced by the claimant then it is likely that they will simply reject the claim entirely as there will be no other evidence they could use to substitute an alternative value.

It must be remembered on the further cases that I will present, that *Coles v Hetherington* now takes precedent in that "the loss occurred at the time the chattel occurred".

### **Case law for claims that have been realised**

The case which was heard is entitled *A S Wood & Son Ltd v Parkinson*, heard in the Queen's Bench Division, Manchester District Registry, Plaintiff Number 1984W, Number 3290. The case was heard by Mr Justice Tudor Price. The plaintiff's counsel was Mr Rodney Scholes, instructed by Messrs Cohens of Hyde, and the defendants were represented by Mr David Stockdale, instructed by James Chapman & Company of Manchester. Two members of the Institute of Automotive Engineer Assessors gave evidence; Mr D. Griffiths, Cotton Griffiths & Company, for the plaintiff and Mr I. D. Lee, Martin-Lee & Partners, of the Manchester Region Committee for the defendants.

Liability for the accident was admitted and the only issue for the Court to decide was that of damages. The plaintiff had purchased the car new on 1 January 1984. It was a BMW 320i Automatic, bearing a cherished number, and the cost was £11,654.75. The car had covered 861 miles at the time of the accident and suffered extensive front-end damage in the impact. At first instance the Motor Insurers sought to deal with the matter on a constructive total loss basis but, insufficient offers having been obtained for the salvage, exercised their right under the terms of the Policy to repair the vehicle. This work was undertaken by main BMW dealers, Williams Motor Company (Manchester) Ltd, at a total cost of £3,777.87. The repair work was authorised by the plaintiff's Insurers on 9 April 1984 and was completed in early June 1984.

The plaintiff had obtained various offers for the sale of the vehicle in its damaged condition and had rejected offers of £7,000 to £8,000, formally accepting an offer, made by BMW dealers against a new car, of £8,250. The new car cost the plaintiff £12,281.75 it was an identical model and the difference in price was accounted for by an increase by the manufacturers early in 1984.

There was no criticism of the standard of repair work. The plaintiff claimed the difference between the amount he had paid for the car, £11,654.75, and the amount he actually obtained for the car, £8,250, a difference of £4,031.75. In their respective reports the plaintiff's expert assessed the pre-accident market value of the vehicle at £11,000 and the defendant's expert valued it at £10,500. Minor items of claim,

representing the insurance excess of £50 and a charge of £80 for the transfer of the cherished number, were agreed and the defendant contested hiring charges of £1,187.95 and also the claim for diminution in value.

The evidence given at the trial was relatively short. The plaintiff explained the circumstances surrounding the case and proved various documents. The plaintiff's expert maintained that the correct manner in which to assess the diminution in value was to deduct the price actually received of £8,250, from his assessed pre-accident market value of £11,000, giving a figure of £2,750.

The defendant's expert maintained that the correct measure of damages was to take his pre-accident market value of £10,500 and deduct what he considered to be the retail value available to the plaintiff of £9,500 and thus arrived at a figure of £1,000. In his judgment Mr Justice Tudor Price outlined the facts of the case and held that it was reasonable for the Insurers to investigate the situation regarding their manner of dealing with the claim, by obtaining offers for the salvage and that in these circumstances a hire charge of £1,187.95 reasonably flowed from the defendant's negligence. In addition, he awarded general damages for loss of use and inconvenience at £15 per week for 8 weeks. On the issue of diminution of value, he held that when a car was so badly damaged as to cost more than £3000 to repair, neither the approach of the Motor Insurers nor the plaintiff was unreasonable. He held that the plaintiff had a new car, which was damaged and he was entitled to be put back into his pre-accident position. He commented that the suspicion that a car may not have been properly repaired may be unfounded, but is real. He deducted the sum of £300, holding it to be due to the advantage of having a June registration, as opposed to a January registration, from the price of the new car £12,228, and took away the price actually obtained of £8,250. Judgment was, therefore, given for the plaintiff in the sum of £5,008, plus costs and interest. This case, it is submitted, must be treated as a one-off case, involving what amounted to a new car, but it gives some guidelines as to the approach of the Courts to the problem

of diminution of value following an accident, irrespective of a good standard of repair work.

#### *In short,*

If the loss has been realised, it can be claimed. What must be done is that the vehicle must have been inspected before the accident, and also after the repairs have been carried out to validate the loss was not as a result of breach of contract through faulty repairs.

Though I would advise on doing the above, if the vehicle has already been sold at a loss, or put up for sale at a lower value, this is a factor that should be brought to the court's attention as it conclusively shows the "after" value, meaning the claimant need only prove the "before" value. However, the lack of such evidence is unlikely to be fatal to the claimant's case. It is an issue that is ultimately likely to turn on the facts of a particular case.

#### **Has the Vehicle Been Examined?**

A claim for diminution is much more likely to succeed if the vehicle has actually been examined by an engineer after the completion of the repairs. This was considered the crucial factor in the claimant not being able to recover damages for diminution in *Schnitzer v Lyons* (2001, CL 01/1541) and *Good v De Klee* (Lawtel 30.08.07) and mentioned as an important factor in several other cases. In addition to confirming that the repairs were up to standard, an examination means that there is a justifiable basis for the figure that has been claimed.

In diminution cases, the issues of whether or not there is a loss and the quantum of that loss are often intertwined; if a judge is not satisfied by the reliability of the evidence produced by the claimant then it is likely that they will simply reject the claim entirely as there will be no other evidence they could use to substitute an alternative value.

If a vehicle has lots of pre-existing damage, it would be unlikely a claim would be successful.

There are many different factors that can impact upon the value of a vehicle. In addition to the more obvious ones such as model, specifications, condition, age, and mileage, a vehicle's service history is especially significant to those in the motor trade, and



## **MOTOR CLAIM GURU**

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even subtler still, is the issue of whether or not those services were carried out by a provider authorised by the manufacturer. In addition, some cars experience seasonal variations in value, eg convertibles will sell for more in the summer. It is very difficult to show that all of these variables have been factored into the equation if the valuer has not examined the vehicle in person.

A diminution report based solely on theory rather than an actual examination of the vehicle is likely to be discreditable by the defendant's insurers. This is because such reports are often based on assumptions that can be undermined on the facts of a particular case, especially when a proforma report is used. Judges appear to be more easily persuaded by a reasoned opinion of the vehicle's value before the accident and after the repairs, as opposed to a broad statement that it has lost a certain percentage of its value; this can sound like an arbitrary figure that has been plucked out of the air.

#### **What Type of Vehicle is it?**

It is clear that certain types of vehicles are more susceptible to losing their value purely by way of the fact that they have been repaired. In *Wadsworth v Surrey CC* (2005, CL 06/1030) the district judge accepted that a Ferrari F550 had sustained diminution, in contrast, in *Good v De Klee* the district judge was not persuaded that a Skoda Octavia had. The key factor in *Wadsworth* was that the judge believed that a Ferrari was an expensive prestige vehicle that would attract an entirely different type of customer than one would expect for an ordinary family car. It is more likely that a prospective Ferrari customer would prefer the car in its original condition, even if the circumstances of the accident were explained to them.

This is not to say that the Skoda had not suffered diminution, only that the evidence provided did not persuade the judge! Ultimately, it is the opinion of myself that according to the case law "*Payton v Brooks*" that it is a legal header of claim to pursue, and that as a claimant you are entitled to claim it, but it is the quantification of that loss sustained that is needed to persuade the judge.

It should be borne in mind that a number of factors can affect the likelihood of a claim being successful, the value of the loss has a bearing on the claim, and that a claim for a few hundred pound may not be successful along with claims for older more common vehicles.

Rarer vehicles are more likely to suffer diminution following an accident. Vehicles that are out of the ordinary do not have the benefit of guide prices, eg through *Glass's Guide*, which means that prices are dependent on the idiosyncratic view of a specific purchaser or specialist who is more likely to take previous repairs into account.

The desirability and collectability of a certain model is a major factor in its value; specialist knowledge of a vehicle's market appeal may sometimes be necessary where this is not apparent, eg a Ford Escort

registered in 1970's will be highly sought after by some people.

The age of a vehicle is another important factor. An average vehicle loses approximately 50% to 60% of its value through depreciation in the first three years following manufacture. It is, therefore, more likely that the value of a nearly new vehicle will be affected by an accident. Age, however, can become an asset in the value of classic cars, usually thought of as cars at least 25 years old.

#### **Is there Evidence that the Vehicle was Repaired to a Satisfactory Standard?**

It is important that the claimant is able to establish that the repairs were completed satisfactorily; otherwise the defendant is likely to argue that any loss in value has been caused by the negligence of the repairer. This was a crucial factor in the case of *Smith v Loughlin* (2000, CL 00/1484) where the claim was dismissed on the basis that there was no evidence about the standard of the repairs that had been carried out.

In addition to the possibility of legal redress against the repairer if the repairs have not been carried out properly (the repairer could even be joined as a third party to the proceedings), in most cases the repairs would be covered by a warranty if they were not up to standard. Without evidence that the warranty could not be relied upon, a claimant would struggle to establish that the claim for the loss of value was correctly brought against the defendant tortfeasor. In most cases this factual argument can easily be dealt with by a competent engineer's report.

What can be said is that all vehicle's can suffer from Diminution in value, the damage to the vehicle need not be structural " *Wadsworth v Surrey CC* (2005, CL 06/1030) the district judge accepted that a Ferrari F550 had diminished in value as a result of having its engine replaced".

#### **How Severe was the Original Damage to the Vehicle?**

Common sense says that the greater the repairs that have been carried out on a vehicle, the more likely it is that these repairs cause the vehicle to lose value per se. Claimants often raise the argument that the reason for the loss of value is that the seller of a car is under an obligation to tell the prospective purchaser of any repairs that the vehicle has undertaken.

That argument is more forceful in respect of major repairs. A dealer will make a "hire purchase check" when acquiring a vehicle to confirm that the seller has title. At the point of sale the vehicle has to conform with sale of goods act, which is now the consumer act 2015, the dealer has a legal duty to disclose when asked if the vehicle has been involved in an accident and repaired.

It is more likely the vehicle will have a greater diminished value if it has had extensive repairs over one that has not, and some may try to argue that if a vehicle has only had minor panel damage it will not have suffered diminution.

This is not the case, especially on rarer vehicles where originality is key to the value.

#### **A case involving minor damage.**

This was found in Heath Engineering Products Ltd. United Co-Operative Dairies Ltd. Oldham County Court. Case No: 1988362.

The case was heard on the 10th February 1988, by Judge Hammond.

**Facts:** The Plaintiff's car, described below, was hit in the rear by the defendant's driver on the 21st December 1987. Liability was admitted; the trial was contested solely on the issue of diminution in value. The car had not been sold by the time of the trial and the Plaintiff's case was based on 10-15% of the pre-accident value, assessed at £16,500.

Vehicle Details Make and Model: Audi Quattro - 2144 cc. 2 Door F.H. Coupe. Registered Number: SCA 9. Colour: Red (Sun Roof) Speedo: 46,576 miles. Chassis Number: WAUZZZ85ZFA900195. Year of Manufacture: 1985.

**Damage:** This involved replacement of the boot lid, rear spoiler and decals. The rear panel and the near-side rear quarter panel were repaired and repainted.

**Judgement:** His Honour felt that this was an expensive car, which was not common on the roads. It had sustained minor panel damage, together with the replacement of "bolt on" parts. He considered both arguments and the evidence. The likely purchasers would be Smith Knight Fay. He accepted that in the case of a major repair involving rebuilding of a car that the diminution may be as much as 20%, but this was not serious damage. However, the trade purchasers would require written confirmation of the damage. He felt that, in this case, 7% to 8% would be appropriate and that an undamaged car in August 1989 would be worth £10,250. Applying the yardstick of a car salesman and allowing for accelerated payment and the possibility that in the intervening period the car may be involved in a further accident, the chances of which were not high, he awarded the Plaintiff £650 for the loss in value which would be suffered on sale. He did not, however, indicate how he had viewed the chances of a further accident, the amount deducted for accelerated payment, or the Plaintiff's bargaining power; nor did he calculate the matter precisely; this was a global award.

As I have mentioned above do not forget "coles v hetherton" takes precedent and the loss is from the time of the incident!!! The above piece of case law was handled incorrectly at the time, though it is a case of merit for minor damage and where the vehicle would be expected to be sold.

#### **How do you measure the loss?**

Judges appear to be more easily persuaded by a reasoned opinion of the vehicle's value before the accident and after the repairs, as opposed to a broad statement that it has lost a certain percentage of its value; this can sound like an arbitrary figure that has been plucked out of the air.

For years I have seen reports suggesting a certain percentage of value has been lost. Unfortunately this is like sticking your finger up in the air and wetting it... and create's the an opportunity for discussion as it is an arbitrary figure.

#### **So how do you measure loss?**

##### **First you need a starting point !**

What was the value of the vehicle at the time of the accident?

What reference you use to establish the value should be referred to in the report, if the vehicle is a vehicle that is in common use , I would suggest following the same approach as the ombudsman and refer to Glass, CAP, and a consumer guide like Parkers. I would then cross reference the market place to see whether the guides are accurate.

##### ***'It must be remembered that guides are just that.'***

I would then value the vehicle based on the make, model, year, reg, specification, mileage, options, service history, working from a **RETAIL FIGURE** and adjust for pre accident condition.

As most insurance companies and the FOS follow this approach to value vehicles the courts do view it as **ONE** of the ways of establishing a value.

It is NOT the only way though, and the principle when a "tort feisor" occurs is one of "restitutio in integrum" Restoration of an injured party to the situation which would have prevailed had no injury been sustained; restoration to the original or pre-contractual position.

This means that the court DOES view examples in the market place as indicative of the market value, along with specialist valuation reports that are backed up with "underwrites" and witness statements from experts in the industry who may sell the vehicle.

Again, if this is done, this should be referenced in the engineers report. The value should be where the owner can go out and replace the vehicle for one of the same.

##### **You now need a finishing point!**

Here is where the misunderstanding's arise, but what has to be remembered is that this IS the client's loss. We have established that had the vehicle been sold, the loss can be proven, as it is recognised that the loss has been "realised" so it would be "reasonable" to work on that basis even though the vehicle has not been sold.

I would suggest that should the vehicle be sold privately, or should a dealer offer to buy the vehicle at a trade figure, then the diminution in value is the difference between the retail adjusted figure that was set as the market value before the accident, and the reasonable expectation of what can be obtained. It might well be that the vehicle is a desirable vehicle, and even though sold privately obtains a figure higher than trade.

The argument of having two cars on a forecourt, and the one with accident history being worth less than

the one without, omits the fact that the owner is not a dealer, and would only have the option of selling the vehicle privately or to trade it in. The loss is the difference in what they could reasonably be expected to obtain.

It might well be that due to the extent of repairs carried out, that the vehicle obtains less than a trade figure as dealers often do not wish to retail a vehicle with that history and pass the vehicle through auction.

As a means of substantiating the loss, the engineers report would also stand more chance of success should it reference dealers 'offers' of what they would purchase the vehicle for.

If the vehicle was a specialist vehicle, I would advise on always doing this.

The basis of the report is to provide expert witness testimony to the courts, to do this the report MUST be CPR35 compliant.

### Court Compliance

When writing a report for court, the below is mandatory.

I understand that my overriding duty is to the court and I have complied with that duty. I am aware of the requirements of CPR Part 35, its practice direction and the CJC Guidance for the instruction of experts in civil claims.

I confirm that I have made clear which facts and matters referred to in this report are within my own knowledge and which are not. Those that are within my own knowledge I confirm to be true. The opinions I have expressed represent my true and complete professional opinions on the matters to which they refer.

When writing the report, it is also imperative to reference the case law that you are referring to that relates to the vehicle you are inspecting.

### What is the Entitlement to Interest?

Diminution, if proven, would be considered an item of special damages; the position is analogous to recovery of the pre-accident value in cases where the vehicle is an economic write-off. This means that interest can be recovered at the full rates awarded in the court's discretion pursuant to the County Courts Act 1984.

It was held in Warwick Motor Auctions v Bennett (1996, CL 97/1815) that interest should be awarded from the date of this accident because that was the date that the vehicle became an accident-damaged vehicle. Warwick Motor Auctions was followed on this point in Smith v Linser (2001, CL 01/1543). This approach seems correct if one makes an analogy with the position where a vehicle is an economic write-off, where interest is awarded from the date of the accident.

### Is the Cost of Producing the Diminution Report Recoverable in the Claim?

It is likely that, as long as the claim for diminution was reasonably arguable, the cost of a report proving that

diminution would be recoverable is a reasonable cost of the claim, even if nothing were recovered in respect of the diminution. This would, of course, be subject to the restrictions on expert evidence in small claims track cases. If the claim for diminution were unsuccessful then the defendant would be expected to argue that it should never have been claimed, and thus there was no need to incur the cost of the report.

### Case law referred too.

Payton v Brooks [1974] RTR 169

Hunter v Thomson and another(2004 Scot (D) 9/1)

Coles v Hetherington [2013] EWCA Civ 1704

A S Wood & Son Ltd v Parkinson, heard in the Queen's Bench Division, Manchester District Registry, Plaintiff Number 1984W, Number 3290.

Schnitzer v Lyons (2001, CL 01/1541) and Good v De Klee (Lawtel 30.08.07)

Wadsworth v Surrey CC (2005, CL 06/1030)

Smith v Loughlin (2000, CL 00/1484)

Heath Engineering Products Ltd. United Co-Operative Dairies Ltd. Oldham County Court. Case No: 1988362.

Warwick Motor Auctions v Bennett (1996, CL 97/1815)

Smith v Linser (2001, CL 01/1543)

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# In the Dock: Legal Training

At Disabled Living, we see the difference that life changing injuries can make to an individual's life. We also see the wider impact on those involved in working with, caring for and supporting those affected. Many of those who access our services are disabled from birth, others suffer injuries or illnesses which leave them disabled. These life changing events can happen at any time, but certain jobs carry a high risk of either hazards, or of our decisions and actions potentially injuring someone we work with.

This means that certain career paths and jobs have a risk of those employees ending up as part of a legal case. From healthcare workers to construction workers, you could be asked to give evidence in a civil investigation or at an inquest at any time throughout your working life.

We know that it is daunting for people outside of the legal profession to be involved in a real-life case. However, it is something that will happen to many of us during our careers. We want to improve the safety of workers, patients and service users, whilst also offering guidance to those who work with them on what it would be like to be involved in a real-life legal case.

This is why we created "In the Dock" legal training, in association with Clarke Willmott Solicitors. We have successfully trained people from all different backgrounds, by creating an interactive experience of working on real life cases.

We run our popular In the Dock training days for health and social care workers with expert witness, Elizabeth Hallows, and clinical negligence specialist solicitor, Sarah Jones, from Clarke Willmott. These training days often sell out. They are attended by a variety of delegates and the feedback has been incredible. Not only this, but we have all had a lot of fun doing it.

At Disabled Living, we often see and help people who have had accidents at work. Hence, we have courses that help not only healthcare professionals, but also people in other industries such as construction and road building who may be exposed to certain hazards. The aim of the course is to keep people safe and prevent people from having injuries at work.

## **What does In the Dock training involve?**

The day starts with a session from a solicitor who explains the legal framework in which a case could occur, who would be involved and how it is relevant to you. Then the process of making a claim outside of court and what would happen if the case ever got to court. Delegates will be asked to stand up in the dock and take part in a real-life case which has been anonymised. They are given a chance to work through the relevant documents and to prepare for court in teams. The case will take place with everyone involved. Afterwards, they will be asked to give their opinion on who won the claim and to see if their views fit with the judge's findings. There is then further opportunity to ask questions to the panel, which opens a lively discussion of shared experiences and goals to take away for improvement.

## **What will be covered on the day?**

The day will always use real life cases to give attendees the most relevant hands-on experience. Whatever the topic, it will include an overview on how the law works - whether it is focused on health and safety at work or negligence. We also offer training from an expert witness who will guide health and social care workers through record management and industry expectations - crucial evidence. This includes some interactive questioning. There is then an opportunity to work in groups to prepare for a real court case.



### **Who will benefit?**

The health and social care / negligence course has been enjoyed by everyone in Allied Health Professions (Occupational Therapists, Physiotherapists, Speech and Language Therapists etc.) care workers, social workers, NHS managers, charity workers and anyone considering a career as an expert witness. It will clearly help anyone who is responsible for patient record keeping, or anyone who could be called to give evidence in a court case.

The health and safety course will help workers stick to policies for their own safety and liability. Ultimately, this will help to increase safety in the workplace. The session will highlight real life cases to show what could happen if laws and policies are not adhered to.

Having spoken to the participants, one delegate gave us the following feedback “Excellent training, increased my knowledge greatly and I feel more confident about going to course next month.” – Suzanne, Adult Services Manager at Heathfields Resource Centre.

### **Why do Disabled Living deliver this training?**

We want to deliver training to a diverse range of people in order to help prevention of injuries and issues in which people are faced with problems surrounding their independence.

### **In the Dock training case study – Road surface workers**

In January 2020 we saw 60 men In the Dock facing a grilling by solicitor Phil Edwards, from Clarke Willmott, about their opinions on the legal cases presented before them. It became apparent that in defending their decisions, opinions are very diverse when it comes to apportioning blame in health and safety issues. Most were able to articulate and justify their decision on who should win the claim in court.

### **However, there were a few surprises...**

#### ***Why did the road surface workers end up In the Dock?***

We were contacted by Abi the SHEQ coordinator at Phoenix Surfacing who had heard about the established ‘In the Dock’ legal sessions delivered by Disabled Living.

After discussing some of the health and safety issues faced in the construction and road building industry, we decided that a bespoke and condensed version of the legal session would be a unique and innovative way to highlight the need for adhering to policies to the busy road workers who don’t want to sit in a conventional training session.

### **What happened on the day?**

After a great breakfast, the men from Phoenix were introduced to Disabled Living and to Phil Edwards, a highly regarded solicitor from Clarke Willmott who specialises in dealing with life changing and complex injury cases.

### **Topics of Discussion**

- Accidents at work: Why do they happen? Who is to blame? What does the civil law say? When can people make a claim?
- Why should we worry? What are the potential implications, financial and physical? The room was very quiet when the subject of serious injury and death were broached.
- Legal consequences: liability, negligence.

### **Then came the debates!**

#### ***This is when the room became a lot noisier.***

From fights at the works Christmas party, to high platform level electrocutions, every man in the room had their own opinion of who was to blame.

Are the companies to blame or the individual? Phil coaxed each man In the Dock to say why he had reached the decision he had about the incidents.

A few of the men managed to articulately defend their decision about the outcome of the case. They were able to state correctly who was to blame and whether a claim could be made.

Others managed to become undone by the questioning and ended up tripping themselves up.

There were a few surprises when Phil stated what the result of the case was in the end. Sometimes the liability lies in unexpected places!

### **What else could we teach these guys?**

Getting people to stand up and be interrogated In the Dock certainly was a great way to engage men who know all about health and safety. It was effective in highlighting what could happen to them and their co-workers if things go wrong, even when simple policies are ignored.

What surprised the organisers of the event was the enthusiastic engagement within the room. During coffee breaks, the conversation continued as to what should have happened and who had done what during the cases.

The workers at Phoenix Road Surfacing were asked if they had heard and taken on board anything that would affect the way they work and increase their safety.

The feedback was a resounding yes. Whether it was something significant or small that needed to change, the important thing was that by attending this interactive session, the changes will be made.

### **How will attending In the Dock make a difference?**

If only one small thing changes as a result of attending this session (e.g. through saving someone from a serious injury), we have made a difference.

Highlighting best practice and the consequences that could occur if health and safety procedures are not followed is an effective way of getting the message across. Our In the Dock training manages to do this in an interesting and interactive way.

The feedback from the training so far has been outstanding. It seems to be that having such an interactive way of training is the perfect way to get people thinking, help them build confidence and grow their understanding of the topics at hand. This is more likely to lead to them applying what they learnt in practice. One thing is for sure – there is no opportunity to sit back and switch off at our training days!

For more information and to sign up to one of our In the Dock training sessions, visit:  
[www.disabledliving.co.uk/training/our-workshops/in-the-dock-with-an-expert-witness/](http://www.disabledliving.co.uk/training/our-workshops/in-the-dock-with-an-expert-witness/)

Written by **Deborah Bell**, Enablement Manager at Disabled Living and Sarah Jones, Senior Associate at Clarke Willmott LLP and Trustee at Disabled Living



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# Has He Suffered Post Traumatic Stress Disorder? A Review of Medico-Legal Issues

*Hugh Koch, Clinical Psychologist and Visiting Professor in Law and Psychology to Birmingham City University (BCU)*

*Kirsten Nokling, Georgina Browne & Lisa Nolan, Clinical Psychologists with HK Associates*

*Michael Davies, Lecturer in Tort Law at Birmingham City University*

A recent publication (Koch 2019) in this journal summarises the several medico-legal evidential issues in a contemporary assessment of Post-Traumatic Stress Disorder (PTSD). This paper discusses several of the themes outlined in that paper in terms of diagnostic criteria, illustrative vignettes and key practical issues when assessing trauma and anxiety-related psychological injuries.

The unifying factor in many debates between experts, barristers and the judiciary about psychological diagnosis is that ‘something traumatic or stressful’ in the claimant’s history has been partly or wholly responsible for the cluster of psychological symptoms that have allegedly developed.

Whatever diagnosis is arrived at, the key questions for the Court are: -

1. Did the claimant at any time develop a recognised psychological disorder? That is, was there a cluster of valid and reliably presented psychological symptoms which were disruptive socially, psychologically and/or occupationally, and which met the criteria for one (or more) diagnoses in either of the two main

classification schemes, DSM-5 (APA (2013)) and ICD-10 WHO (1992)).

2. Can this disorder be attributed to a given index event, or did it pre-date or post-date the index event? For a practitioner this is the crucial issue. Given the “all of nothing” approach as to the proof of causation, the onus is to prove, on a balance of probabilities, that the index event caused the disorder if this cannot be established, then the case fails. Therefore, there is a requirement to demonstrate (or not) that the Claimant’s symptoms meet the relevant diagnostic criteria.

The group of diagnoses typically considered in civil cases where there has been a significant single event with or without physical injury include the following: -  
Post-Traumatic Stress Disorder (DSM-V 309.81)

Acute Stress Disorder (DSM-V 308.3)

Adjustment Disorder (DSM-V 309.28)

Other Specified Trauma or Stressors – related disorders (DSM-V 309.89)

Other diagnoses whose symptoms include but are not necessarily dominated by trauma-based symptoms frequently include:

Somatic Symptoms Disorders (DSM-V 300.82)

Specific Phobia Disorder (DSM-V 300.29)

Generalised Anxiety Disorder (DSM-V 300.02)

The reader is referred to either of the two classification schemes or to other relevant texts (Koch, 2016, Koch 2018) for in-depth discussions of these disorders. A summary of the main criteria for each of these six disorders given in a practical and differentiative manner is shown below alongside a stylised or anonymised case history for each disorder to aid clarity and understanding.

### **Post-Traumatic Stress Disorder (DSM-V 309.81)**

After a distressing event, the claimant experiences the following (Morrison 2014):

- Repeatedly relives the event, in nightmares (upsetting dreams), or in intrusive mental images or dissociative flashbacks. With reminders of the event evoking physical sensations (racing heart, shortness of breath) or distress.
- Takes steps to avoid the horror and fear: refusing to watch films or television or to read accounts of the event, or pushing thoughts or memories out of consciousness.
- Negative in their thinking: with persistently negative moods, gloomy thoughts (e.g. "I'm useless," "The world's a mess"). They may lose interest in important activities and feel detached from other people. Some experience amnesia for aspects of the trauma; others become numb, feeling unable to love or experience joy.
- Experiences symptoms of hyperarousal: irritability, excessive vigilance, difficulties concentrating, insomnia or a heightened startled response.

This cluster of experiences lasts larger than 1 month and disrupts their psychological, social or occupational life. Occasionally there can be delayed expressions of these symptoms until six months after the event. They can be accompanied by dissociative symptoms of depression or detachment and/or de-realisation in which the claimant seems distant and unreal. There is considerable controversy over the concept of "delayed expression."

#### **James A**

A motorcyclist riding along a motorway at 70mph was in collision with a lorry who had suddenly, without warning, changed lanes blocking his path. James had approximately three seconds to anticipate this high-speed collision without ability to avoid it. He remained conscious after the collision and was hospitalised for one week during which he was told he might lose his left leg. After discharge, he had 6 weeks' convalescence at home where his sleep was disturbed with accident-related nightmares (not just lorry and motorbike related), hyper-arousal to loud

noises (e.g. traffic outside his home). Despite a sympathetic family, he had great difficulty discussing the circumstances of the accident with them and preferred to keep his feelings hidden from them. Even when he had physically recovered, he avoided leaving the house, riding his second motorbike or driving his car. He found that his thoughts were negative, both about himself and his social situation. He became critical and distant, increased his alcohol intake and felt estranged from his wife.

### **Acute Stress Disorder (DSM-V 308.3)**

The criteria for ASD are similar to those required for PTSD (Morrison 2014) namely: -

- Exposure to an index event that threatens body integrity or death.
- Reexperiencing the index event.
- Avoidance of stimuli associated with the index event.
- Negative changes in mood and thought.
- Increased arousal and reactivity.
- Distress or impairment.

If symptoms last 4 weeks or longer, then the PTSD diagnosis is used.

#### **Rob M**

A car driver on a busy A road went around a right-hand bend at the 60mph limit and was faced by an oncoming van on his side of the road. Within one second, they had collided, and he was pushed back and off the road into a 3-foot ditch. He had significant chest injuries from the steering wheel and was hospitalised. During the hospital stay and when he returned home, he reportedly had nightmares where he relived the road traffic trauma. This also occurred when awake and daydreaming. He was unable to drive for 2 weeks but avoided driving for a further week. Apart from being driven to/from hospital, he could not tolerate being a passenger either. He felt useless and unable to do anything, and his mood was low with tearfulness. He was irritable with his family. He stayed off work for three weeks. After three weeks, many of these symptoms receded and he no longer met the criteria for ASD.

### **Adjustment Disorder (DSM-V 309.28)**

Whether the index event is, or is not, as life-threatening as it is in PTSD or ASD, a person who experiences a significant 'stressor' can develop symptoms of depression (mood and sleep disturbance, tearfulness, low self-esteem), anxiety (focused or generalised, physiological or emotional) and behavioural symptoms of avoidance and poor performance. This overall cluster exceeds what would be expected for most people in similar circumstances. It typically starts within 3 months of the index event, and stops within 6 months of the stressor's end. During this time, the person's psychological, social and/or occupational life is adversely affected.

The quality of this disorder is different than that of PTSD or ASD and is typically seen as less severe. This is reflected in the prognosis.

Persistent stressors may include ongoing travel, litigation and nightmares, and therefore in such circumstances symptoms may persist longer than 6 months.

#### **Gemma S**

Gemma had been working in the same job for ten years when it was suddenly announced that she was being made redundant. The unexpectedness of this information coupled with the realisation that her world had suddenly and irrevocably changed made her extremely distressed. She relied on her job income and managed her family, as a single mother with a handicapped child and could not, immediately, perceive how she would be able to cope. She developed sleeping problems often ruminating at night about how to cope, both financially and psychologically. She became depressed, sad and tearful. She felt useless and pessimistic about how she would get another job. She had been dating prior to this redundancy but felt lacking in confidence to continue. This exacerbated her loneliness and her self-esteem. She went to her GP who prescribed antidepressants and referred her for counselling.

#### **Other Specified Trauma- or Stressor Related- Disorder (DSM-V 309.89)**

This diagnosis is used when there is an evidential stressor or trauma which has caused significant distress or impairment in social, occupational or psychological areas, but the other criteria for an Adjustment Disorder, PTSD or ASD are not necessarily met.

Examples include delayed onset (although this concept is controversial); prolonged duration beyond 6 months and persistent complex behavioural disorder (with severe and persistent grief and mourning).

#### **Harry S**

Harry had been working in a factory operating a wood cutting machine when the cutting blades had malfunctioned and two fingers on his left hand had been severed. At the time there was significant loss of blood but, fortunately, his level of pain was manageable. He was hospitalised and had surgery on his hand. He returned home to convalescence for two months. During this time, he watched TV and walked both alone and with his partner. His sleep was relatively undisturbed after the first 3-4 days.

On his return to work two months later, he was put on light duties but the noise and smell of the wood cutting machine agitated him and he noticed that both back at work and when he returned home, he was upset, felt low and tearful and his sleep was immediately disturbed by nightmares and auditory flashbacks to the sound of the machinery. Although he was not pressured to return to operating the wood cutting machine, he found he could not tolerate being in a noisy factory environment and he resigned his job. His GP prescribed him beta-blockers for his anxiety.

#### **Somatic Symptoms Disorder (DSMV 300.82)**

Pain is a frequently presented symptom in personal injury claims. For many, pain is distressing but after the initial shock and treatment, people usually adjust to the experience of pain and cope well i.e., without undue anxiety or disturbance to activities of daily living.

However, with a proportion of clients a more problematic presentation is seen which consists of:

- Pain that seems excessive and chronic
- Complaining of isolated, non-specific symptoms that seem to have no medical cause
- Chronic, multiple symptoms in the absence of an adequate medical explanation
- Pain that doesn't improve despite treatment that helps most patients
- Excessive concern and pre-occupation with pain
- Magnified behavioural expression of pain

It is apparent in these presentations that there is a pronounced interaction between the physical and psychological aspects of pain, including self-perpetuating fearful beliefs about ongoing pain.

The main criteria for SSD is a single somatic symptom causing distress or markedly impairing the patient's functionality. The patient expresses a high level of health anxiety, investing excessive time in health care or being excessively worried about the seriousness of symptoms. Other descriptions include persistent chronicity of pain.

#### **Jenny F**

Jenny F has been involved in a significant multiple car pileup on the M4 but had fortunately emerged with left arm injuries only and no apparent psychological trauma apart from initial shock. Over the following months, she had many medical investigations of her ongoing pain which had now spread to her shoulder and neck. She became increasingly preoccupied by this pain and how it adversely affected her dexterity and agility. On meeting people, she would concentrate on telling others about the pain and also illustrate this by her facial expression and "holding" her arm to protect it. On one occasion, when being assessed by the orthopaedic surgeon, she was asked to draw on an outline person sketch exactly where her pain was – she drew this pain throughout the left arm and outside the arm – an anatomical impossibility.

#### **Specific Phobia (DSMV 300.29)**

Following a road traffic accident, some claimants develop a significant fear of aspects of road travel e.g. driving on motorways, driving at night, being a passenger or being a pedestrian. The anxiety produced by being in any of these situations can take the form of panic-based symptoms or as a generalised sensation of anxiety.

Once established, it is typically manifested and reinforced by avoiding the situation that makes the person afraid.

It is also maintained by irrational (albeit understandable) fear of increased likelihood of another similar accident. For example, a phobic driver may think the chance of another accident is 50/50 – such beliefs are highly likely to cause symptoms of anxiety when on the road again.

#### **Peter M**

Peter M had been cycling along the road in a designated lane when a car changed lanes suddenly and knocked him off his bike and threw him into a lamppost. He suffered significant leg injuries which took 3 months to heal. He had a second bike but couldn't face riding this. He used public transport instead which adversely affected his ability to get to/from work efficiently. He no longer cycled in his local cycling club, gained weight and generally felt at a low ebb emotionally.

#### **Generalised Anxiety Disorder (DSM-V 300.02)**

Some claimants develop excessive anxiety and worry which they find difficult to control and which cause significant distress and/or impairment in social or occupational areas. It is not typically focussed on any one specific area of concern.

#### **Mary P**

Following her accident in which she was knocked over at a pedestrian crossing, Mary developed restlessness, irritability, sleep disturbance and muscular tension in a number of different situations e.g., travelling in a car, crossing roads, leaving the house, being in meetings.

She needed CBT to help her control and manage this generalised anxiety.

#### **Medico-Legal Postulates**

The diagnosis of trauma-related psychological symptoms is multi-faceted; obtaining reliable and valid evidence to produce a robust clinical opinion, using various assessment methods including an analysis of self-report, contemporaneous independent information, medical records and behavioural indications of level of disruption, and includes the 'but for' test of causation. These are embodied in the medico-legal postulates (Koch, (1916, 1918) summarised below and amended for the context of trauma assessment.

#### **Koch's Medico-Legal Postulates**

I. A robust opinion about trauma should address diagnosis, causation and attribution, duration and prognosis.

II. A robust opinion about trauma will, whenever possible, include more than one type of evidence. An opinion based on claimant self-report only may still be valid but is not considered as robust as an opinion derived from several sources of data (e.g., self-report, medical records, impact upon activities of daily living) in medico legal terms.

III. Determining the appropriate diagnosis according to the DSM and ICD forms part of an expert's

opinion on trauma – this systematic check of relevant criteria should be balanced by wider clinical judgment and contemporaneous records, if available.

IV. The expert's Mental State Examination of the claimant, should be consistent with the claimant's description of currently active symptoms – a clear discrepancy reduces the robustness / strength of an opinion.

V. Wherever possible, GP computerized consultation records should be made available to the expert. The subsequent analysis (i.e., evidence of or lack of corroborative data) will increase the strength or reliability of the opinion given. Attendance where trauma has been discussed add considerable weight to the claimant's narrative.

#### **Other Relevant Postulates**

- A robust opinion should give particular emphasis to the 12-month period prior to and post the index event, but not to the exclusion of earlier or later history.

- An expert's opinion should be the 'best fit' professional view of all available data at that time, and should be modified, if appropriate, as and when new data becomes available.

- Irrespective of the prognosis for organically mediated pain, psychologically mediated 'overlay' can have a positive prognosis especially with pain-related CBT therapy resulting in increased pain coping and adjustment.

- Expert Witnesses should help the Court identify and understand inconsistency, leaving the Court to be the final arbiter of veracity.

- The claimant's self-report is essential but must always be balanced by contemporaneous medical or occupational records, when possible. Great care must be taken not to overemphasise the claimant's self-report.

Assessing trauma requires a logical and impartial approach to understanding what the claimant has experienced. It must also investigate whether the claimant was already suffering a pre-existing psychological disorder or had a vulnerability to developing a trauma-related disorder, which affected their reaction or recovery following a traumatic index accident.

Being involved in a non-fault significant traumatic event is very distressing and all parties involved in discussing the event and related litigation with the claimant, whether they be medico-legal experts, lawyers or barristers, have a duty to be empathetic to the claimant's experience as well as a duty to the Court to produce independent opinions that are robust, reliable and valid.

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# Exeter Psychologist receives Prestigious Award for Research in Traumatic Brain Injury

*A leading Clinical Neuropsychologist from the University of Exeter has received a prestigious award for his work.*

**Professor Huw Williams** won the British Psychological Society's (BPS) Barbara Wilson Award - the highest UK professional award for clinical neuropsychologists.

His recent work examined the links between traumatic brain injury (TBI) and crime, with the results influencing Parliamentary debates and government policy, in the UK and overseas. He had previously shown how survivors of TBI can often develop mood disorders - such as post-traumatic stress - and developed new approaches to treat survivors.

At an event in London, Professor Williams and Exeter colleague Dr Phil Yates were both awarded BPS Fellowships.

"It's wonderful to receive this lifetime achievement award from the BPS," said Professor Williams.

"It's especially nice to receive the Barbara Wilson Award because Barbara has been fundamental in changing services for people with brain injuries in the UK and internationally. To give them more hope to get back to work, and have a good family life. And our work, I hope, adds to her achievements."

Speaking about his work on TBI and crime, Professor Williams added: "The perpetrators of crime are often - at some early point of life - victims themselves.

"Our research has showed that TBI is linked to cognitive and emotional problems, violence and drug misuse and higher levels of incarceration.

"We also showed it was possible to intervene in prisons through brain injury screening and having brain injury "link workers". It's heartening that policy makers and the judiciary have been keen to implement our findings. Hopefully to help people can turn their lives around, and, maybe less crime".

Dr Phil Yates and Prof Williams, BPS Fellowship recipients, have, as Co-Directors of the Centre for Clinical Neuropsychology Research (CCNR), brought clinicians - from the RDE Hospital - and scientists and post-graduate students from the University - to work on developing a better understanding of the causes of TBI, especially in childhood, and its effects on schooling, and the need for services to be

developed. But also how staff, in the NHS, who manage trauma, need to be supported.

Dr Yates, who has also supported national initiatives in clinical neuropsychology training and continued professional development for the BPS Division of Neuropsychology said: "I am delighted to have received this award which is in part testimony to the collaborative approach to research we have undertaken in Exeter to better understand the longer term needs of young people who have sustained significant head injuries at an early age.

"We have been able to strengthen links for a range of research projects in a number of areas including mild traumatic brain injury and concussion disorders, brain injury rehabilitation, and the psychological well-being of emergency medicine staff."



## Dr Fraser Morrison

Consultant Clinical Psychologist/Neuropsychologist  
M.A. (Hons), D. Clin. Psych., P.g. Dip. Clin. Neuropsych

I am a Clinical Psychologist/Neuropsychologist working within the NHS and independent practice. My current practice includes two main clinical areas, brain injury and more general psychological symptoms (including anxiety and depressive disorders). I carry out neuropsychological and psychological assessments, and provide rehabilitation input and psychological treatment.

I have extensive medico-legal experience, within both English and Scottish courts. I complete around 50 medico-legal instructions per month.

Specialist area of expertise is acquired brain injury (e.g. TBI). I am a Chartered Psychologist with the British Psychological Society, of which I am an associate fellow, and am registered with the Health Professions Council.

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# Addiction Psychiatry could be Wiped out in a Decade Without Urgent Government Funding

Addiction psychiatry could be wiped out in the next 10 years unless urgent measures are taken to tackle the dwindling numbers of doctors training in addictions, according to a landmark report published by the Royal College of Psychiatrists.

It reveals the number of higher training posts across England have fallen by 58%, from 64 in 2011 to just 27 in 2019, leaving some regions without a single trainee.

The College is calling for urgent government funding to protect existing places and to create training posts especially in England, as the falling numbers cannot be solved by the current funding arrangements.

The findings come at a time when both drug-related deaths<sup>1</sup> and alcohol-related hospital admissions<sup>2</sup> in England have reached record levels.

Professor Julia Sinclair, chair of the addictions faculty at the Royal College of Psychiatrists and co-author of the report, said: "This report reveals the meltdown that has occurred within addiction psychiatry across the UK, but especially in England.

"Without urgent investment from government, training in the specialist skills that are an essential part of the treatment system could be wiped out in a decade, depriving thousands of people with this life-threatening condition access to the specialist help they need to recover and rebuild their lives.

"Assessment and treatment of people with complex medical and social needs arising out of addictions are the essential skills of the addiction psychiatrist. Helping bring people back from the brink of death and turn their lives around are just two of the many reasons why addictions psychiatry is such a vital career."

The report – Training in Addiction Psychiatry: Current Status and Future Prospects – found in 2019 there were just 16 people in higher training posts that would give them a qualification in Addiction Psychiatry in England, with five out of 12 English Regions - South West Peninsula, Severn, Wessex, Thames Valley and Kent Surrey and Sussex - having no such posts.

This means there are no opportunities to gain skills needed to equip psychiatrists to improve patient care, nor are there opportunities for a trainee to gain an endorsement in addiction psychiatry and work as a specialist addiction consultant.

Melissa Rice, who got the expert help she needed thanks to her local Alcohol Care Team and psychiatric care, said: "Alcohol was my friend, then my crutch and then my captor.

"It got so bad my family had to keep me locked in the house because I was so ill and they were afraid of what would happen to me.

"I wouldn't be here today if it wasn't for the Alcohol Care Team in my local A&E and the psychiatric

support I got in rehab. They helped me detox and made sure I got the right support for my mental health."

The report is based on interviews with key stakeholders, and draws on a raft of official documents from HM Government, NHS England, Public Health England, and the Advisory Council on the Misuse of Drugs (ACMD), that confirm the need for a trained workforce to meet the needs of people living with substance use disorders and mental health conditions, as well as the complex physical and mental health needs of older drug users.

Diane, whose life was saved because of the specialist addiction treatment she received, said: "I am in no doubt that my addiction psychiatrist saved my life. They brought me back from the brink and helped me to see that I had a future and my life was worth living.

"His unique expertise, knowledge and understanding ensured I detoxed properly and received the support and help I needed to treat my condition."

Responsibility for the delivery and funding of addiction services was taken out of the NHS and given to cash-strapped local authorities following legislative changes in 2012.

Funding for addiction services in England fell by £234 million (25%) in real terms from 2013/14 to 2018/19 following the move to local authorities, meaning providers must cut costs to secure contracts.

## Mr Jeffrey Hughes

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Mr Hughes has reported for Court and Tribunal on Criminal, Family, Education, Disability and Employment matters and has worked with children, young people, families and adults in many contexts looking at learning difficulties including dyslexia, dyspraxia, attention deficit, asperger syndrome and autism as well as understanding of arrest and interview, capacity to participate and fitness to plead.

Mr Hughes reports on how Assistive Technologies (ICT/ computers) give access and independence to disabled people facing barriers.

Mr Hughes works with a multidisciplinary team including psychology, psychiatry, SALT, OT, social work and education on integrated assessments providing cost effective and comprehensive joint reports.

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# Minorities' Higher Psychosis Risk Linked to Cultural Distance from Majority

*Social inequalities and language differences could be responsible for the higher psychosis risk in ethnic minority groups, finds a UCL-led study.*

The researchers say their findings, published today in *Psychological Medicine*, might reflect the impact of being more marginalised from mainstream society.

“We have known for decades that many migrant groups and ethnic minorities face higher rates of psychosis, without knowing the exact reasons behind the pattern. In this study we wanted to see if social and cultural distance from the majority group could be responsible,” said the study’s lead author, Dr Hannah Jongsma (UCL Psychiatry), who began the study at the University of Cambridge before completing it at UCL.

Rates of psychotic disorders, such as schizophrenia, can be as much as five times higher in some ethnic minority groups such as people of black Caribbean or African heritage in the UK. By contrast, there is no such pattern in Caribbean countries, suggesting the increased risk is context dependent. Rates of psychosis are more strongly influenced by ethnicity and socio-economic status than other mental health conditions.

## **People diagnosed with a psychotic disorder face a life expectancy 15 years lower than average.**

The researchers used data from the European Network of National Schizophrenia Networks Studying Gene-Environment Interactions (EU-GEI) study in the UK, Spain, France, Italy, the Netherlands and Brazil, involving 1,130 people with a psychotic disorder, as well as 1,497 people without a diagnosis who served as control subjects.

As a proxy measure of social and cultural distance from the majority population, the researchers considered whether or not each person spoke the majority language as their mother tongue (ie. English in the UK), or was not fully fluent in the majority language.

Ethnic minority status was associated with more than double the odds of psychotic disorders. Linguistic distance from the majority group, and social disadvantage, were both associated with nearly double the odds of psychosis, which appeared to mostly explain the increased risk faced by ethnic minority groups. The researchers say that both disadvantage and linguistic distance are potential markers of sociocultural exclusion.

The researchers also compared psychosis rates with self-reported data about direct experiences of discrimination. While they found these experiences were nominally associated with psychosis risk, the link didn’t prove to be significant after taking into account social inequalities and cultural distance. As the relationship between psychosis risk and sociocultural distance (disadvantage and linguistic distance) was more robust, the authors say this suggests that structural disadvantage and systematic barriers may be more pervasive risk factors for psychosis.

The researchers say social and cultural distance from mainstream society could contribute to an increased risk of psychosis due to feelings of disempowerment.

“Experiencing a lack of control over your own life may disrupt the dopamine system – a signalling system in the brain – which is known to be important in developing psychosis and is very sensitive to environmental factors,” explained Dr Jongsma.

Senior author Dr James Kirkbride (UCL Psychiatry) added: “There are substantial inequalities of psychosis rates in high-income countries, which can be exacerbated by the fact that ethnic minority groups often face worse mental health care and treatment. Addressing deep-rooted structural injustices which disproportionately affect disadvantaged and marginalised communities may help reduce such health inequalities.”

The study was led by UCL researchers working with colleagues at the University of Cambridge and King’s College London, as well as scientists at the research centres in the other five countries of study. The EU-GEI study is funded by the European Commission’s 7th Framework programme, while the lead authors are funded by the Economic and Social Research Council, Wellcome, the Royal Society, and the National Institute of Health Research.

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# Pension Valuation and Divorce - Also Some Notes on Coronavirus Effects

by Peter Crowley

*This article follows on from my previous one in Expert Witness Journal– “Pension Offsetting – Some Further Thoughts” in Forensic Edition 30. As before, a review of the Guidance “A Guide to the Treatment of Pensions on Divorce”, published by the Pensions Advisory Group in July 2019 will be valuable.*

In summary, the Guidance says Pensions on Divorce Experts (“PODEs”) should follow these principles in valuing pensions for the purpose of offsetting against other marital assets:

- 1) Achieve a true/fair valuation
- 2) Use the actual pension benefits involved, not notional post pension share benefits.
- 3) Make an allowance for tax, but not for utility
- 4) Present more than one solution, (the Guidance lists five), and indicate one’s preferred solution, (without recommending an answer).

The key issues will initially rise when the PODE is being instructed. The question is then, how can the clients get the best value out of the PODE.

My view is that the more work that can be done and mutual decisions made before the PODE is instructed, the better. This allows more focus by all concerned. I have illustrated this via a series of questions, the answers (ideally) to be agreed by both parties.

## **Question 1 – Are any pension schemes Irregular, or Highly Irregular?**

By **Irregular**, I mean a pension scheme which is, by exception, allowed to disregard certain aspects of pension legislation – these, primarily, are unfunded public sector schemes. The main features are as follows:

Unfunded – therefore Cash Equivalents are based on hypothetical criteria.

Poor Cash Equivalent Transfer Values, or, in some circumstances, no Cash Equivalents allowed whatsoever.

Pension Sharing must be internal, providing a credit to the spouse

A “Club” system preserves value when transferring between such schemes.

A list of these is provided later.

By **Highly Irregular**, I mean those schemes which offer ‘precipice’ benefits - that is, benefits which effectively accrue over a short period, typically at the end of a specified period of service. These are rare, and I am only aware of closed sections of three/four schemes

(again, listed later) where this occurs. Again, these are listed later.

## **Question 2 – Is the case a “needs” case to the degree that pensions will be encashed where possible, (via “Pension Freedoms”), because providing immediate funds is a priority here?**

If this is the case, then the parties should think carefully whether a PODE needs to be involved at all. If needs are so compelling, the loss of a guaranteed pension or GAR become unimportant. However, if the funds after tax can be accurately calculated (perhaps in conjunction with “At a Glance” support), it is questionable whether a PODE needs to be instructed. Any IFA familiar in pensions could advise on the charges involved when moving from DB to Cash fund DC, or encashing a DC plan. The £30,000 CE limit above which advice must be obtained would be irrelevant if a Court Order was envisaged.

For Irregular schemes, Freedoms are not available.

## **Question 3 –In seeking a True or Fair value, what margins, if any, should be removed from our assessments?**

The Guidance discourages the use of Cash Equivalents for offsetting valuation, although it is unclear as to whether a method combining other factors as well as the Cash Equivalent may be acceptable.

The regulatory basis for calculating Cash Equivalents is laid down by the Pension Regulator, who is tasked with ensuring that these values are as fair as possible to recipients. I found the following note from them exceptionally clear:

[www.thepensionsregulator.gov.uk/en/document-library/regulatory-guidance/transfer-values](http://www.thepensionsregulator.gov.uk/en/document-library/regulatory-guidance/transfer-values)

In particular, the following extract should be noted:

“44. Reductions to ICEs are permitted with the aim of retaining parity in benefit security between those transferring and those remaining in the scheme.”

The “ICE” here is the Initial Cash Equivalent, equal to

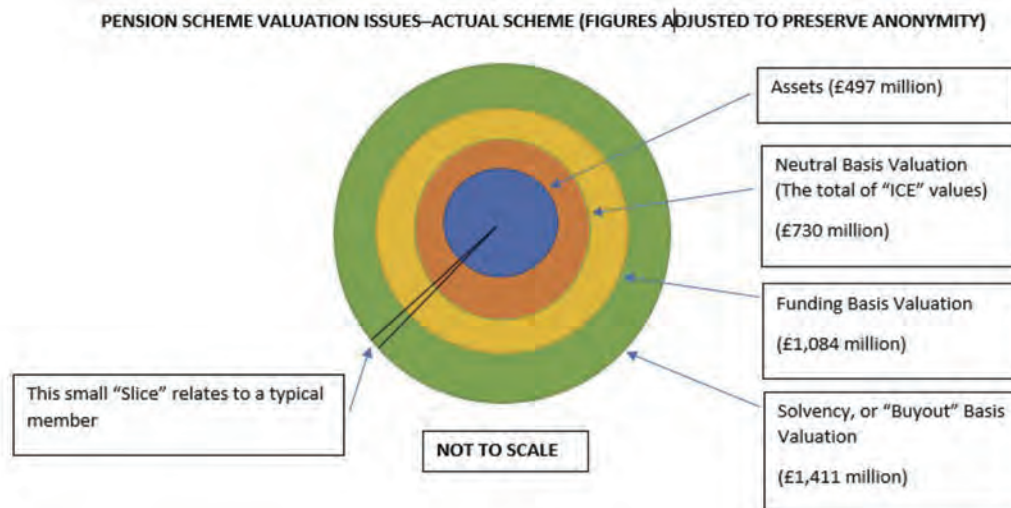
(8. A CETV represents)...the expected cost of providing the member’s benefits within the scheme.

The Scheme Actuary (a reserved role, requiring additional certification), who is responsible for advising the Scheme Trustees on scheme funding and cash equivalents, will calculate four values for liabilities for any pension scheme for which he or she bears formal responsibility:

- a) Neutral Value, which represents the best estimate of liabilities with any margins taken out. This seems an attractive assessment for true/fair.
- b) Funding basis (Technical Provisions), used for setting contributions. This contains funding margins to allow for adverse future experience.
- c) Cash Equivalent basis. This is the Neutral Basis adjusted for the current state of funding. This is likely to be at or below the Neutral Basis valuation, depending on the current level of the assets.
- d) Solvent (Buyout) basis – the cost of securing all accrued benefits with an insurer, and winding up the scheme. This is likely to be substantially greater than b).

This can be illustrated as follows:

Figure 1,



So c) should be equal to the Neutral Basis value, unless the Asset value is lower, as it is here.

If we describe the pension holder as P, and the spouse, who is to receive an offsetting credit as Q, my belief is that a) would appeal to both parties as the fairest. To use b) involves prudence margins which Q has no need of – he or she is now to have cash or equivalent, and will not incur those future risks that the margins are set to cover.

On the other hand, Q might well object if the CE is used unadjusted, as, in the vast majority of cases, the underfunding will be made good by the scheme – a degree of current underfunding is accepted by the Regulator. By the time P gets to pension age, his benefits can be regarded as practically guaranteed. Accordingly, penalising Q for the current state of funding also seems unfair.

(Against this is the "Market Value" theory – that the CE represents the amount the market will offer for someone to "take the benefit away" – even though this market is a monopoly!)

Obviously, using d) would then overcompensate Q even further.

The practical difficulty is that only the CE - c) - is available as a quoted amount for *individual members* by right from a pension scheme – the Trustees are under no obligation to provide any of the others ( a), b), or d) ).

Going through the other Guidance methods in turn, the DCFE\* method is based on the assumed future purchase of a pension annuity in the market in future, inevitably from a life assurance company. Such annuities involve substantial loadings, as the full solvency requirements for an assurance company are far more stringent than those for an occupational pension fund.

Under the Solvency II regime, life assurers must hold a "Best Estimate Liability", or "BEL", for each annuity on the books, which is calculated on the same philosophy as the Neutral Basis a) opposite. To this must be added not only an explicit Risk Margin, but also a Solvency Margin allowance ("Minimum Solvency Requirement").

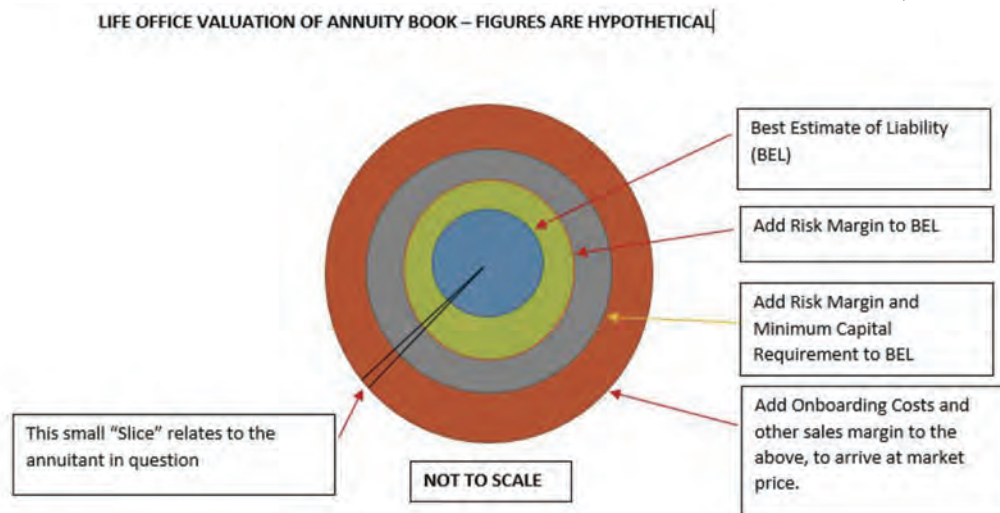
Although annuity providers operate in a competitive market, the Chief Actuary of the life assurance company (another reserved and certificated role) must regularly certify that the premium rates offered to the public are sustainable, and will not weaken the insurers' reserves. Maintaining competitive rates are secondary to this requirement.

On top of this, the mortality tables used to calculate the BEL are lighter than those used in pension schemes. This is due to selection - while poor health is not necessarily a barrier to entering or remaining in a pension scheme, the annuity market is acutely aware that individuals with poor mortality are very likely to opt for cash, rather than risk total loss by purchasing an annuity, if it is avoidable. Although the availability of medically enhanced rates has become more common, the decision in the "Test-Achats" case, and subsequent pension freedoms, have lightened market annuity mortality rates even further, and, accordingly, made most standard annuities even more expensive.

Our (Windsor's) method to date for valuing pensions for offsetting purposes has involved the averaging of

Cash Equivalent and DCFE values – the thinking being that should average out the margins in each method, and give a good approximation to the Neutral Value - a) opposite. However, the DCFE mortality means this method may be overstating the value. If this thinking is correct, it should be an improvement on using the DCFE method unadjusted. (\* Discounted Cash Flow Equivalent)

Figure 2



Valuation issues for a life assurer’s annuity book are shown in the following diagram. I intend to provide more detail in a further article.

(Figure 2 above)

The Financial Services Compensation Scheme also provides a backstop (similar to the way the Pension Protection Fund does for pension schemes)

Further information on life assurers’ margins is provided at the end of this article.

Another method is to use the Duxbury tables. These are published in A Glance to allow for the capitalisation of an income stream paid personally (say, again, from P to Q), and where replacing this stream with a lump sum allows a clean break. The methodology includes margins for “Payer Failure”, i.e., for P becoming unable to pay Q – which are not appropriate for pension assessment. These margins also appear very substantial – in some cases 50% of the total value – so any undervaluation is not trivial.

Another suggested method is to make allowance for one party appreciating cash more than the other. This seems to me to stray into the “Utility” adjustment, which is not considered appropriate for PODEs, unless provided as part of their instructions.

Finally, there is an “Actuarial Method”, which involves deriving a valuation from first principles. This can be more flexible with regards to avoiding unwanted margins, but it does suffer from the fact that two different experts may come up with different figures, and the reasons for the difference can be difficult for the non specialist to understand. It is, however, invaluable for schemes which provide a pension under retirement age 55 (these are our Highly Irregular Schemes), where external annuity quotations cannot be obtained.

#### Question 4 – Should a different approach be taken for Irregular, or Highly Irregular Schemes?

My investigations indicate that Cash Equivalents for Irregular Schemes are now significantly below those provided for regular (funded) pension schemes. The actuarial basis which the government uses takes an optimistic view of the future growth of the UK economy as a whole, rather than expected investment returns (as these schemes are “Pay As You Go”, there is

no fund, and accordingly, no investment return).

See [https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment\\_data/file/755674/basis\\_for\\_setting\\_the\\_discount\\_rate\\_for\\_cetv.pdf](https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/755674/basis_for_setting_the_discount_rate_for_cetv.pdf), for the theoretical basis approved by HM Treasury.

However, while the benefits under a funded scheme are highly secure, the security for Irregular Schemes is even higher. This is because in the event of a shortfall, any government can raise tax in order to cover it. The security of a government guarantee is greater than that of a private funded pension scheme, even if the greater part of the latter is underwritten by the independent Pension Protection Fund.

There is no easy solution to this problem, where we are seeking both a fair valuation, and compatibility with other pensions being valued. Our averaging method would need a perhaps arbitrary adjustment to make the CE up to a “Standard” CE level. If the CE is to be disregarded altogether, an acceptable solution might be to derive a “Neutral Value” directly, based on the benefits – this would be derived in the same way as the Actuarial Value described opposite.

The second obvious method is to opt for the DCFE method – simple to obtain - however, again, this suffers from both the margins above the BEL, and mortality being too light, pushing up the cost. It is important to emphasise that, while neither is the CE actually being taken, nor is the annuity being purchased, and the margins built into either are not actually being incurred – as opposed to the usual position with pension sharing. It does, however, prevent some unfairness when each party holds a different type of Scheme benefit. DCFE will almost always exceed a pension scheme’s buyout value.

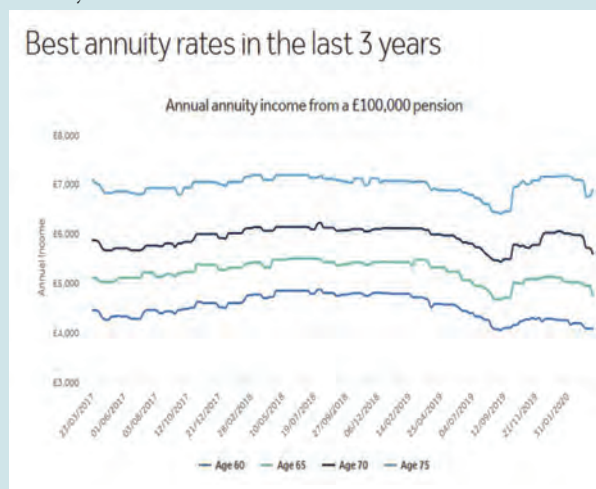
For the Highly Irregular schemes in question – Armed Forces, Police, Firefighters, and Prison Officers – bespoke adjustments – along the lines of the Actuarial Method – may be necessary, depending on the method used. For benefits not yet in payment, more than one option may need to be illustrated, in order to allow the Court to make a judgment on how the parties can be expected to take their post-divorce benefits, and how they can be expected to exercise any options.

Further articles will explore numerical examples, hopefully on all of these bases.

### Coronavirus Notes

The advent of the pandemic has reduced confidence in markets, and driven investment from more speculative markets into more secure assets. This has had the following effects:

Increased demand for fixed interest assets, including gilts, has pushed prices up, and, accordingly, yields down. The cost of annuities has accordingly been pushed upward. The following graph shows the last three years' levels of rates:



That period has shown unpredictable rates – the fear is that reports are prepared on current information,

and then the position changes prior to shares being implemented. A share based on April 2019 rates would be at risk if implemented in September 2019 – similarly, September to December of that year works the other way. The effect is most acute for pensions in payment – the greater the period of deferment, the more likely these acute effects are to be smoothed.

Cash Equivalents for Defined Benefit schemes will also experience upward pressure from this source – however, if assets are heavily invested in equity type investments, falls in these asset values will push downwards. To refer to the Scheme Actuary diagram above, if asset values fall below the Neutral Valuation basis (as shown in the diagram), there is justification for reducing them (if above that level, the Neutral Value should be paid, anyway, as a minimum). Cash Equivalents are not usually reviewed, or changed, as often as market annuity rates. For example, the Scheme Actuary may have a mandate to warn trustees if asset values fall for two quarters in a row.

For money purchase plans, the usual investment profile in equity type investments will mean falls in market value. For pension shares, a greater proportion of these funds may then be needed, and this may be exacerbated by higher annuity costs, to the degree that these are used to calculate shares or offsetting values.

The problem, as always, is the inability to foretell the future. In the early 1990s, money interest rates were around 10% - 11% per annum. Since then, they have fallen steadily, with some recoveries, but also with downward 'jerks'. The view that rates or fund values will revert to a previous 'normal' has been proven wrong time and time again. However, defined benefit promises have, with rare exceptions, been met. Until there is evidence to the contrary, my belief is that we should continue to rely on these in our calculations.

### Appendix 1 – Irregular and Highly Irregular Schemes

Irregular Scheme	Highly Irregular Sections
Armed Forces Pension Scheme	AFPS 1975 can allow retirement from around age 40 for "full service" members
Police Pension Scheme/ Firefighters Pension Scheme/ Prison Officers' Schemes	These Schemes can allow retirement from around age 50 for "full service" members
Civil Service Pension Schemes/ NHS Pension Schemes / Teachers Pension Schemes	Not Highly Irregular
NOTE The Local Government Pension Scheme is funded, and not Irregular, but has some similarities to the above schemes	

## Appendix 2–Information regarding Life Assurers and Solvency 2

- Professor John Hull - Highly respected and readable – “Risk Management and Financial Institutions”.

- Staple Inn Actuarial Society – 2012 paper – useful, but dated:

[www.sias.org.uk/media/1191/demystifying-the-risk-margin-theory-practice-and-regulation.pdf](http://www.sias.org.uk/media/1191/demystifying-the-risk-margin-theory-practice-and-regulation.pdf)

- Institute and Faculty of Actuaries – Useful Paper, including helpful diagrams:

[www.actuaries.org.uk/system/files/field/document/IandF\\_SA2\\_SolvencyII\\_2016.pdf](http://www.actuaries.org.uk/system/files/field/document/IandF_SA2_SolvencyII_2016.pdf)

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# The Accountant as Expert in the Family Court

*Tony Roe of Penningtons Manches Cooper and Robert Holland of James Cowper Kreston discuss the use of accountants in divorce proceedings, principally in valuing businesses.*

Divorce and family law matters are not entirely the preserve of lawyers. In matrimonial financial disputes there is often the need for expert evidence in which case accountants have a significant role to play.

In such a dispute before the court the first step is to ascertain what assets, less liabilities, there might be for division. The second step is to value this asset pot. The third step is distribution of the net assets in a settlement.

As part of this first step there is a duty to give full and frank financial disclosure. This duty is not just to the other party but also to the court. It has been likened to a 'cards on the table exercise' with those cards face up. This disclosure process is normally carried out by each party completing their own financial statement, called a Form E, which is a thirty or so page form supported by evidential documents. Forms E are employed whether a court application has been made or whether the disclosure is simply voluntary.

In more complex matters a party might ask their accountant to help marshal the documentation needed for the Form E or provide a capital gains tax calculation where the parties own more than one domestic property. Accountants should, however, avoid being fully responsible for completing the Form E without a very considerable input from the party as this might lead them to being held at fault where the Form E is shown subsequently to be incomplete or inaccurate.

## **Choosing an expert**

Experts are needed to value assets unless parties can agree their worth. Accountants' expertise is required when it comes to valuing a business interest. The court regulates what evidence is introduced hence where one wants such an individual an application must normally be made for the appointment of a single joint expert forensic accountant whose duty is to neither party but to the court. Part 25 of the Family Procedure Rules (FPR) 2010 governs the appointment of experts. Part 25.3 of the FPR states that it is the duty of experts to help the court on matters within their expertise and this duty overrides any obligation to the person from whom experts have received instructions or by whom they are paid.

Typically the solicitor who wants the expert appointed must prepare the application. This involves making enquiries of suitable experts as to their fee estimates, hourly rates, CVs and availability which

information accompanies the application. The court would normally consider the application to appoint an expert at the first directions appointment (FDA) and set a timetable with which the parties and expert must comply, and will not necessarily appoint the cheapest expert but cost will be a significant factor.

The court will order the parties to instruct the chosen expert to provide a report on, for example, the value of each party's shareholding in a company, its liquidity and maintainable earnings and the tax consequences upon a transfer or disposal of a party's shares in the business, and will direct one party, normally the applicant, to prepare the letter of instruction by a given date for the approval of the respondent and also timetable its dispatch. It would also direct by when the expert's report should be filed at court. The norm is that the court provides that the costs of the report are met by the parties equally.

It is incumbent on the parties to ensure that they cooperate with the appointed expert in relation to the provision of relevant information or documents so that the timetable is not put in jeopardy as the court will have listed a further hearing, the financial dispute resolution (FDR) appointment. Unfortunately in practice information or documents can often be delayed.

## **Expert's report**

When the expert's report is ready it may be that the parties have questions of its author. The court may provide that the costs incurred of replying to questions shall be met by the party raising such questions. Rule 25.10 provides that written questions must be proportionate and must be put within 10 days of the report being served and be only for the clarification of the report. The answers are treated as part of the expert's report.

As for the contents of the report, it must comply with Practice Direction (PD) 25B of the FPR. There is no substitute for the expert to read PD25B. Amongst other things, it deals with the content of the report in some detail and sets out that the report must conclude with a statement of truth. Other required reading is the Law Society's "Standard terms and conditions to accompany a letter of instruction to experts in family proceedings".

Often the expert's appointment is accepted by the parties in which case unless there are any questions

to deal with the role of the expert is over. However if the matter is fully contested and there is a challenge to the report, the expert must be prepared to attend court, give evidence and be cross-examined as to their findings.

### Questions

#### Can I speak to one party's solicitor?

You may wish to contact directly the other solicitors or any other professionals/experts in the proceedings in which you are instructed. Please feel free to do so. However, if in your contact with other professionals you discuss any matters of relevance, please inform your lead solicitor of that fact. Please keep a careful written note of all persons participating in the discussion and a summary of the discussion itself. If documents are exchanged with one party, please copy them to all the others.

#### Do I get to know the outcome of the final hearing?

Within 10 business days after the final hearing, the party who instructed the expert or, in the case of a single joint expert, the party who was responsible for instructing the expert, must inform the expert in writing about the court's determination and the use made by the court of the expert's evidence.

Unless the court directs otherwise, the party who instructed the expert or, in the case of the single joint expert, the party who was responsible for instructing the expert, must send to the expert a copy of the court's final order, any transcript or written record of the court's decision, and its reasons for reaching its decision, within 10 business days from the date when the party received the order and any such transcript or record.

This article has been co-authored by **Tony Roe** and **Robert Holland**.

**Tony Roe** is a consultant in the family law team at Penningtons Manches Cooper and a highly experienced solicitor. He regularly advises clients on complex financial and property matters arising from divorce and difficult disputes concerning arrangements for children. A collaborative lawyer and family arbitrator, Tony is widely acknowledged as a practitioner who works hard to find alternatives to the court process.

He was a member of the advisory group to the Law Commission on its work on matrimonial property, needs and agreements and the use of premarital contracts or "prenups". Shortlisted by LexisNexis Family Law in 2015, 2016 and 2018 as Family Law Commentator of the Year, Tony is asked by the press to provide a legal view on family law issues and has appeared as a family law expert on both television and radio.

With an established reputation built over almost thirty years of practicing family law, Tony has led a well-respected firm and been head of a busy family law department. A former national committee member of Resolution and chairman of its children com-

mittee, Tony remains a member of the organisation. He is a visiting fellow in family law at the University of Reading.

### Robert Holland

Robert is the Managing Partner of James Cowper Kreston and acts as an audit partner and specialist share valuer. Robert joined James Cowper Kreston as a partner in Newbury in 2000 and acts for a broad range of family and owner managed businesses.

A substantial part of his share valuation work comprises his acting as an expert witness in legal proceedings.

Robert is a Fellow of the Institute of Chartered Accountants in England and Wales. He is also a member of TPAC which is the technical committee for the audit faculty of the Institute of Chartered Accountants in England and Wales.

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# IR35 Branded to Peers as ‘The Sickly Child Who’s Never Got any Better’

by *Simon Moore*

The first expert-witness session at the Lords off-payroll inquiry has heard IR35 likened to a “sickly child ever since its conception 20 years ago who hasn’t got any better along the way.”

So reform of the law from April 6th 2020 should only be treated as a “temporary sticking plaster,” mindful that its design is imperfect, but that HMRC needs to plug a NICs gap.

Keenly nodding in agreement to this characterisation and recommendation, which was submitted to the peers by Justine Riccomini, head of tax at ICAS, were two other tax experts.

They were Colin Ben-Nathan of the CIOT, who sat behind Ms Riccomini ahead of his evidence, and Jason Piper, head of tax and business law at the ACCA, who flanked her.

## **'Tackle the status conundrum'**

She then submitted that a working group should be convened, made up of the Office of Tax Simplification among others, to “tackle the conundrum of employment status as a whole.”

Such a “remedy” (in the words of the Lords, who asked for solutions), is preferable because “we don’t have the necessary certainty at the moment,” tabled Anita Monteith of the ICAEW.

In fact, despite engagers banning and blanketing - a trend Ms Riccomini says won’t likely stop as individually assessing PSCs takes “until kingdom come,” nobody is totally prepared.

## **'Nobody's ready for reform because the rules aren't ready'**

“I wouldn’t say that anyone is completely ready, because the legislation is not ready,” the head of tax at the Institute of Chartered Accountants in Scotland (ICAS) added.

“And thus people have only been able to prepare as far as they can, given the information [from HMRC/HMT] that they currently have available to them.”

The ACCA’s Mr Piper, who today reflects on his experience giving evidence to the Lords in a piece exclusively for ContractorUK, agreed.

## **'HMRC is still finessing the rules'**

“As recently as Friday of last week, we were still having the actual implementation of these [April 6th] rules set out by HMRC,” he said, referring to the ‘services/payment’ update.

He added: “Until then, nobody even knew whether it [the new IR35] might potentially apply to any services which are paid for after 6th April, even if already performed now.

“[For HMRC] to still be finessing the rules and making those changes this close to implementation has to be a concern for business. The largest ones will often ask for 12 or even 24 months’ notice to change their systems or processes.”

## **'Our 100 questions on IR35 won't ever be answered'**

And it’s not as if advisers haven’t tried to extract details from the Revenue.

Ms Monteith, for example, spoke of 100 questions on private sector IR35 reform she has posed but which HMRC says it will not answer, as she was told the answers will “become apparent.”

The public sector experience of IR35 reform isn’t providing much help either, partly as any “read-across” implies its PSC usage is the same as the private sector’s, which it isn’t.

## **'Too early to have a proper grasp'**

Mr Piper also said that it was simply “too early to have a proper grasp” of the lessons that should be learned from the April 2017 off-payroll reforms. Both Ms Monteith and Ms Riccomini agreed.

There was further agreement from the experts on CEST, most vocally by Ms Monteith (“inadequate,” “not fit for purpose” “a blunt tool”), and Mr Piper, who estimated 40,000 contractors to have undeterminable IR35 status (based on HMRC estimate of 230,000 PSCs and CEST being conclusive in just 85% of cases).

But it was the tax technical lead at the Institute of Chartered Accountants in England & Wales (ICAEW) who also found fault with HMRC’s Status Disagreement Process, expected of engagers to install, run and administer.

“It’s inadequate. We need a much better system for doing this. We wanted an independent dispute resolution process,” Ms Monteith said.

“[Also], we need a better process for if the client says, ‘no I stand by my original determination.’ There needs to be a better way for the worker to actually challenge that again, properly and independently.”

## **'Call HMRC in Newcastle'**

The tax expert, who has been involved with IR35 since before its formal introduction, says the recommended process for workers to also disagree with CEST is, likewise, wanting.

“If you get to the end of the CEST tool and you get ‘undetermined,’ you are told to call HMRC in Newcastle. I’m not entirely sure how satisfactory that is.”

Following his testimony, Mr Piper told ContractorUK: “In practice, if these rules cannot be delayed or reformed then the softest of soft landings, allied to a properly resourced and supported education campaign from HMRC, would be most likely to mitigate the impacts on business.”

## **'We need real reassurance from the taxman'**

At the session, Ms Monteith said much the same: “Given that is unlikely that it will be put back again. I think we need real assurance from HMRC that the enforcement of this

when it comes in is going to be proportionate and we don't want to see any draconian measures being taken by individual officers."

Ms Riccomini, who told the peers there has been "significant delay" from HMRC in rolling out relevant communications to parties liable under the April rules, appeared to suggest that not even a soft landing, nor a light touch approach, could square the circle.

She said: "I don't think it's going to be possible for people [at end-user companies] to become employment status experts especially in such a short space of time. It's an extremely complicated issue. I don't think [a significant proportion of engagers will ever arrive at the level of proficiency required to implement this framework]."

*This article first appeared on ContractorUK.*  
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### Simon Moore

Simon is a freelance writer, reporter and editor who trained under NCTJ-approved journalism tutors.

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# Helping SMEs Through the COVID-19 Crisis by Making Adjudication Simple and Affordable

by *Martin Burns*

*RICS, Head of ADR Research and Development*

COVID-19 has changed everything. The world we were living in just a few weeks ago has melted away and, indeed, much of it may be gone forever.

The impact on our economy is immense and no more so that in the construction industry. Sites are shutting, employees are absent or being laid off. Cash flow, a perennial problem, is now a deepening crisis.

Most construction businesses, from the largest to the smallest, are experiencing considerable difficulties, the likes of which they have never experienced before. It is, however, the plight of the smaller businesses, that is at the forefront. Today, as I write this article, the BBC has reported that nearly 20% of SMEs in the UK need cash now if they are to secure their short-term future. In many cases they are measuring this in weeks, not months.

The measures the Government has put in place to keep money flowing to industry employers and workers have been bold and necessary. They are clearly working to ensure those who need help benefit from these measures as quickly as possible.

SMEs' high dependency on free cashflow is not helped when the amount of monies they claim they are owed by employers and clients are disputed. Getting disputes resolved quickly and cost-effectively is now an imperative. All construction contracts in the UK enable parties to resolve disputes about payment and other matters using a 28-day adjudication procedure. However, many SMEs currently feel they cannot afford to challenge disputed payments using adjudication. They are worried that the process has become too costly and complicated to the extent that they cannot afford to use it where the amount of money claimed is relatively small.

This view has recently been backed up by a government consultation on costs in adjudication. The government response to the consultation, which was published in February, suggests that rising costs and increasing complexity have made it difficult for businesses to understand and therefore use adjudication. Some respondents described the procedure as being onerous and time consuming. It was suggested that adjudication does not provide a cost-effective process, and simply cannot be used where the value of a claim is less than £30k. Even for slightly higher value claims, there is widespread acknowledgement that the costs of adjudication discourage many in the supply chain.

The government consultation revealed there is a genuine appetite in the industry for a low value disputes adjudication procedure that was simple, had fixed steps, involved limited documentation, capped fees of adjudicators and focussed on getting disputes decided within the 28-day period set out in the Construction Act.

Last year, the Construction Industry Council (CIC) decided that it should develop a simple and inexpensive procedure for adjudicating low value disputes, that was Construction Act compliant and would be supported by key organisations such as: RICS, ICE, RIBA and others.

The CIC set up a working party to scope what is now known as the CIC Low Value Disputes Model Adjudication Procedure (LVD MAP). CIC was scheduled to launch the LVD MAP at RICS in March, then along came COVID-19 and the planned launch, like hundreds of events across the globe, was postponed. In the past week or two, however, it has become very clear that many small businesses need the service now.

RICS, one of the main contributors to the development of low value disputes adjudication, has moved quickly to implement the service at a time when it is very much needed. We expect other contributors to quickly follow the RICS lead and ensure parties have access to adjudication by eminently qualified adjudicators who are willing and able to adjudicate under the low value procedure.

The service is aimed at disputes where the amounts claimed are for £50,000 or less, and the issues in dispute are relatively uncomplicated. It is anticipated that most adjudications will be conducted on a documents-only basis. The procedure complies with the Construction Act and includes an uncomplicated timetable and structure. It provides a flexible, yet simple to understand, approach to the key elements of the adjudication process and can reduce the amount of reliance parties may need to place on professional representation. Crucially, the procedure is relatively inexpensive, the adjudicator's fees are capped to a maximum of £6000. Both parties will know beforehand how much the adjudicator will charge and how much each of them will have to pay. The Government has welcomed the development of the low value disputes adjudication procedure. Industry Minister Nadhim Zahawi has said: "This new, more transparent process will offer access to justice

for small and medium sized companies in the construction industry - helping ensure small disputes are resolved quickly, cheaply and effectively. We welcome the work of RICS and the CIC in developing this initiative."

The Construction Leadership Council (CLC) has also welcomed the initiative. In a statement posted by CLC, its Co-chair, Andy Mitchell, is quoted as saying: "This new process for resolving low value disputes will reduce the costs and time involved in settling these, and help to create a better and fairer industry, particularly for the SMEs that make up the majority of the sector. We hope that it will be widely used and will work with the CIC and RICS to encourage its adoption by firms in the industry".

It is hoped that the quick and effective implementation of low value adjudication, which is easy to access and is supported by leading industry organisations, will provide immediate assistance to businesses through these immensely challenging times.

**Martin Burns**

RICS, Head of ADR Research and Development  
02 April 2020

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Robert also has media experience having appeared on national television for the BBC, giving advice and evidence for the consumer protection series of programs 'Don't get done get DOM' and XRay, BBC Wales version of 'the popular primetime BBC program 'Watchdog'

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# Four Common Building Defects to Look Out For

by Simon Levy Associates

Unfortunately, building defects can affect homes of any age; whether you live in a brand new build or a listed building that's been around for centuries. Building defects can cause a lot of damage if left undetected but luckily there are companies who have the skills, expertise and knowledge to identify and rectify these issues before they cause long-lasting problems. If you'd like to know more, see below for four of the most common building defects to be aware of and the warning signs that might be present.

## Damp penetration

Damp can enter your home for a number of reasons, including heavy rain, rising damp from a basement or leaking pipes. Damp can cause serious structural damage to your home, so if you notice any of the following signs it's time to call a professional damp specialist. A musty smell, discoloured walls or peeling wallpaper are all signs that damp is present.

## Mould

The presence of mould is often a side effect of damp issues, but if mould is left untreated it can cause serious health problems. Mould is able to thrive in warm, damp environments and can worsen health conditions such as asthma or chest infections, as well as cause damage to materials like leather, paper and cloth.

## Condensation

Condensation takes the form of those telltale water droplets on the inside of your windows and while it might seem minor, condensation can lead to more serious issues if left unchecked. Too much condensation can lead to severe damp and mould, so take steps to reduce it such as opening windows when showering or cooking, or buy a dehumidifier to reduce the amount of moisture in the air.

## Structural cracks

This defect can be caused by many things, including poor soil bearing, ground shifts or weak foundations. Not all cracks are indicative of structural damage, but if you notice vertical cracks that are wider at the top than the bottom, cracks in stair steps or cracks in beams or foundations, this is a sign that you should call a professional for a diagnosis.

If you're in need of a building defect diagnosis for your property, get in touch with the expert team at Simon Levy. We have plenty of expertise in this field and have all the skills and knowledge needed to identify a range of issues, including damp penetration, mould, distorted walls, condensation and more. To arrange an appointment or find out how we can help, give us a call today or visit our website.

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Tim Davies is a Chartered Building Surveyor, and the practice principle and founder of T R Davies Limited, (established in 1998). An established independent practice providing property related services throughout South Wales and Nationwide.

Tim has over 30 years experience. Tim is a fully qualified Chartered Building Surveyor, a RICS Accredited Valuer and Expert Witness. Tim has the Cardiff University Bond Solon Certificate in both Civil and Criminal Expert Witness Practice. Tim is a registered property expert with the National Crime Agency, working with police and trading standards, principally dealing with rogue traders.

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Although the consultancy was established in 2001, Carl has experience as an Expert Witness since 1991, covering both Copyright and aspects of land law dealing with Boundaries, Adverse Possession, and Rights of Way (both private and public) in both the High and County Courts and experience as a Surveyor for nearly 35 years with the Ordnance Survey.

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# Commercial Businesses Set to Benefit From Update on Lease Negotiations

The professional statement, Code For Leasing Business Premises, - which will be mandatory for RICS members in England and Wales to follow – aims to make the process of lease negotiations faster, more transparent and fairer.

With the support of leading organisations including Law Society, BPF (British Property Federation) and the BCO (British Council for Offices), the new requirements will encourage businesses to work with landlords to negotiate more flexible leases.

This initiative is of particular significance in the struggling retail sector, where it is hoped the new requirements will improve activity on the UK high streets.

The latest RICS Commercial Market Survey shows landlords are trying to entice businesses back to the high street, with the incentives on offer for prospective retailers returning the highest net balance since the financial crisis in 2009 and the incentives for office space growing since the EU referendum.

The new professional statement will aim to make lease negotiations faster and smoother, as landlords continue to try and entice businesses back to the high street

Geoff White, RICS Policy Manager commented: “Many high streets and town centres face a perfect storm from online competition, challenging changes in consumer behaviour, plus seemingly ever-increasing rents and rates.”

“The government has committed to tackling this on a number of fronts, including a fundamental business rates review – which RICS has demanded for a number of years – rates exemptions and reductions

for smaller businesses, as well as through its High Streets Task Force and Town Centres Fund.”

“One aim is to boost town centres by attracting more locally-based small businesses back to the high street and by introducing the new Code for Leasing, RICS is playing an important role by offering a route to reduce complexity, risk and cost faced by hard pressed business owners.”

Code For Leasing Business Premises promotes the value of and encourages businesses to seek the advice of property professionals, saving companies time and money. Lease negotiations can be complex and time consuming, and under the new requirements the process is set to improve the efficiency of lease negotiation.

“One aim is to boost town centres by attracting more locally-based small businesses back to the high street and by introducing the new Code for Leasing, RICS is playing an important role by offering a route to reduce complexity, risk and cost faced by hard pressed business owners.”

**Geoff White**  
Policy Manager, RICS

This professional statement follows the RICS Service charges in commercial property which aimed to outlaw ‘rogue’ landlords and managing agents whilst making service charges more transparent for the end user. These RICS statements set out to create a fairer and more professional approach to property management in the commercial sector.

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# A Review of Ethical Standards for RICS Chartered Surveyors: Avoiding Conflict When Carrying out Red Book Valuations

by Julie Norris, Partner and Charlie Roe trainee Solicitor at Kingsley Napley

*Across all industries there has been an increased focus on ethical behaviour of businesses in recent years. Adhering to a strict ethical code of conduct is seen as both a social and commercial imperative. In keeping with this trend, the Royal Institute of Chartered Surveyors (RICS) has recently announced that it will be reviewing its ethical and valuation standards throughout 2020, citing “changing public expectation over the independence of professionals.”*

This consultation appears responsive to concerns about possible conflicts of interests where regulated firms have been appointed to provide valuations of specific assets whilst also being engaged by the same client, and charging fees for the provision of other consultancy services such as property advice or management.

When such commercial interests are at stake, the integrity of the valuation may be called into question. This situation is specifically highlighted in the RICS Valuation Global Standards (the Red Book) at section PS 2, paragraph 3.9 as one which should be regarded as presenting a potential or actual threat to the independence and objectivity of the valuer.

## **The current RICS guidance on conflict of interests**

RICS currently has in place mandatory guidance concerning the avoidance and management of conflicts of interest. This guidance mandates the use of information barriers in order to effectively manage situations where a conflict of interest exists between departments within a multi-disciplinary firm. VSP 1, paragraph 3.1 of the guidance states:

RICS regulated firms must have in place effective systems and controls appropriate to the size and complexity of their business.

The Red Book also necessitates the inclusion in the terms of engagement of a statement disclosing any factors ‘that could limit the valuer’s ability to provide an impartial and independent valuation.’ These ‘factors’ would include the valuer-firm providing other consultancy services to a prospective client.

The Red Book further highlights the potential for problems arising when the same surveyor provides valuations for the same client for a number of consecutive years. PS 2 paragraph 5.4.2 states:

Where the member responsible for the valuation in accordance with this standard holds that responsibility for many years, familiarity with either the client

or the asset valued could lead to the perception that the member’s independence and objectivity has been compromised. In order to mitigate this risk, the Red Book goes on to state: RICS considers it good practice, albeit not mandatory, to rotate valuers at intervals not exceeding seven years. Having correctly identified the risks, this can hardly be said to be a stringent policy. It has been suggested that one of the proposals following the RICS consultation will be to ensure there is a more frequent rotation of valuers who deal with specific clients.

## **What the future may hold**

Despite being the largest investment asset class in Britain, the real estate sector has so far escaped the level of political scrutiny and regulation that has been directed at the financial markets. This scrutiny is exemplified by the recent ministerial calls for the separation of audit and consultancy functions in accountancy firms following a series of high profile scandals involving conflicts of interest. The RICS consultation and commitment to review its standards should be understood in this context and be seen as an important step in efforts to retain public trust and relevance, and to stave off potential governmental regulation.

## **About the authors**

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