



**Clinical
Negligence
Annual Report
2012**

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Foreword

As 2011 drew to a close, the potential implications of two Government bills - the Legal Aid, Sentencing and Punishment of Offenders (LASPO) Bill and the Health and Social Care Bill - filled us with considerable disquiet on behalf of the victims of clinical negligence.

In this year's annual report, we set out our concerns about the potential impact of these bills on access to justice and quality of patient care; review the latest NHSLA statistics; comment on hot legal and medical issues; and relate some of the difficult and tragic cases that the Penningtons clinical negligence team has worked on during the year.

The mantra of our team is that the best way to reduce the high costs of clinical negligence to the NHS and, ultimately, to the tax payer is to reduce the incidence of clinical negligence. However, the two Government bills appear to be more focused on slashing the legal aid budget and increasing the burden of responsibility for primary health care on GPs – both of which are likely to have the effect of reducing the quality of patient care and restricting access to justice for the more vulnerable members of society.

Some of the provisions of the LASPO Bill are aimed at shaving £350 million off the legal aid budget by removing clinical negligence from the scope of legal aid. The Ministry of Justice (MoJ) specifically estimates that it will save £10 million a year by taking clinical negligence out of scope – just 1.3% of the NHSLA's total expenditure on clinical negligence in 2010/11. With such meagre savings to be made, the question could be asked whether the Government's real aim is to reduce the cost of clinical negligence claims overall – by making them more difficult to bring – rather than reducing the cost of legal aid.

The impact of removing clinical negligence from scope will simply be to transfer the costs from the MoJ (which will take over the administration of legal aid from the LSC) to the Department of Health (NHS). The NHSLA realises this and considers that the proposals will result in increased public expenditure. As a result, the NHSLA is firmly in favour of retaining legal aid for clinical negligence.

The publication of the Government's Health and Social Care Bill, which represents probably the biggest shake-up of the NHS since its inception, has also been widely criticised claiming that the proposed shift in power from hospital trusts, regional strategic health authorities and primary care trusts to newly-formed primary care commissioning groups made up of GPs will divide the NHS and result in a wide variation in the standard of care received across the country.

As solicitors who act primarily for victims of clinical negligence, this focus on cost-savings and reorganisation appears to be wrongly targeted. As the public enquiry into Stafford Hospital continues to reveal further horrors and the Care Quality Commission reports on 'serious failings' at Barking, Havering and Redbridge University Hospitals NHS Trust, we remain concerned that reducing legal costs appears to be a greater priority than improving patient care and reducing waste within the NHS.

Consider these statistics. The NHS budget for 2010/11 was around £104 billion. The NHSLA paid out £729.1 million in damages and £235 million in legal costs. The cost of damages therefore represents 0.7% of the NHS budget and legal costs 0.2%. Compare this with the £6.4 billion spent on the National Programme for IT in the NHS which, according to a May 2011 report by the National Audit Office "does not represent value for money" and which has now been put on hold.

We hope that our third clinical negligence annual report helps to improve your understanding of the challenging environment facing both claimants and the specialist solicitors who seek to achieve appropriate redress and justice for them.

If you would like to find out more about how we could help you or your clients, please do contact us.

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Key facts and figures

- Over the last five years the annual number of clinical negligence claims notified to the NHSLA has risen by 52 % from 5,697 in 2005/6 to 8,655 in 2010/2011. Claims rose by 30.1% from 6,652 claims in 2009/10 to 8,655 in 2010/11.
- Payments made by the NHSLA in 2010/11 for damages rose to £729.1 million, a 12% increase on £650.9 million in 2009/2010.
- Legal costs incurred settling CNST claims during 2010/11 totalled £235.3 million, up 44% on £163.7 million in 2009/10. Claimant costs were £181.3 million and defendant costs were £54 million.
- Legal costs (claimant and defence) represented 29% of the total costs paid out by the NHSLA to settle claims for clinical negligence in 2010/11, up from 20% in 2009/10.
- The three clinical specialties attracting the highest numbers of reported CNST claims in 2010/11 were surgery (25,867 claims representing 39% of all specialty claims), obstetrics & gynaecology (13,095 and 20%) and medicine (12,045 and 18%).
- Obstetrics & gynaecology specialty claims continue to generate the highest value claims with a total value of £5.2 billion in 2010/11, 15.4% higher than £4.4 billion in 2009/10. Surgery claims value £2.2 billion and medicine claims value £1.6 billion.
- At 31 March 2011, the NHSLA estimated that it had potential liabilities of £16.6 billion relating to clinical negligence claims. This is a 10 % increase on the 2009/2010 total of £15.07 billion.
- Contributions from the 238 NHS trusts towards damages and costs payments in 2010/11 were £781 million (up from £756 in 2009/10), an average of £3.2 million per trust. Five NHS trusts contributed more than £12 million each with the highest contribution from any individual trust being £14.9 million.
- Payments to settle obstetric claims in 2010/11 totaled £234.8 million, 30% of total NHS trusts' contributions.

Methodology

The Penningtons Clinical Negligence Annual Report 2012 is based on the findings of research undertaken by Penningtons Solicitors LLP together with the expert views of the partners and the collective experiences of actual cases handled by the clinical negligence team.

The National Health Service Litigation Authority Report and Accounts 2011 was a major source of information and statistics. All information provided by the NHSLA is credited in this Report.

Abbreviations:

APIL	Association of Personal Injury Lawyers
ASHE	Annual Survey of Hours and Earnings
ATE	After the event
AvMA	Action against Medical Accidents
BTE	Before the event
CFA	Conditional Fee Agreement
CMC	Claims Management Company
CNPP	Clinical Negligence Pre-action Protocol
CNST	Clinical Negligence Scheme for Trusts
CPR	Civil Procedure Rules
HAI	Hospital acquired infection
LSC	Legal Services Commission
MDU	Medical Defence Union
MoJ	Ministry of Justice
NHSLA	National Health Service Litigation Authority
NPSA	National Patient Safety Agency
PCT	Primary Care Trust
RPI	Retail Price Index

1 Clinical negligence claims – volume, payment value and time to settle

1.1 Volume of clinical negligence claims made against the NHS between 2006 and 2011

	2006/07 £'000	2007/08 £'000	2008/09 £'000	2009/10 £'000	2010/11 £'000
CNST	5,426	5,470	6,088	6,652	8,655
YOY increase		0.8%	11.2%	9.2%	30.1%

Source: NHSLA

The number of formal clinical claims recorded under the CNST scheme rose by more than 30% between 2009/10 and 2010/11. This significant increase may be explained in part by requirements for claimants to send the NHSLA a copy of the Letter of Claim at the same time as it is sent to the defendant NHS body.

Other reasons may include increasing awareness of clinical negligence claims as a result of the publicity surrounding the proposed funding changes, and claims being expedited ahead of the potential withdrawal of legal aid, along with other changes in funding.

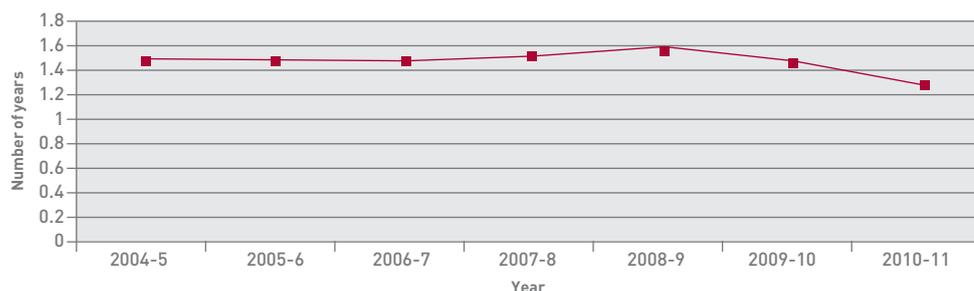
1.2 Value of clinical negligence damages payments made by NHSLA in respect of claims against the NHS between 2006 and 2011

	2006/07 £'000	2007/08 £'000	2008/09 £'000	2009/10 £'000	2010/11 £'000
CNST	424,351	456,301	614,342	650,973	729,072
YOY increase		7.5%	34.6%	5.9%	11.9%

Source: NHSLA

Since 2006/07 the value of clinical negligence payments made by the NHSLA to settle clinical negligence claims has risen by almost 72%.

1.3 Time taken to settle claims



Source: NHSLA

Over the last two years the time taken to settle cases has fallen from 1.56 years in 2008/09 to 1.28 years in 2010/11. In our experience, there are still both significant delays on the part of the NHSLA in progressing matters and a tendency to dispute cases until late in the day before settling in full.

However, there have been some recent changes which we believe are expediting the resolution of claims. The first is the involvement of the NHSLA when the Letter of Claim is submitted. This avoids the scenario where the trust sits on the claim for several months and ensures that investigations start early. The second is the requirement for the defendant to obtain expert evidence under the Protocol if they intend to defend the claim. In our experience, this has resulted in earlier admissions. Thirdly, the NHSLA's current position that it will agree 'extensions' to the limitation period to allow investigation is enabling claims to be investigated and often settled without the need for proceedings to be issued.

Expert commentary:

There are likely to be a number of reasons for this continuing increase. The first is that NHS trusts are not learning from their mistakes. We see the same errors being repeated – often by the same hospital. Secondly, the increasing media focus on cases of unacceptable levels of care and the errors being made within the NHS may be encouraging more people with injuries from medical care to seek legal advice.

In terms of the damages being paid out, it is difficult to draw a year on year comparison because the claims settled in any one year will cover events that may have taken place several years ago.

However, damages in higher value claims in particular have increased in recent years due to decisions in the Courts on the obligation to rely on statutory services, rising care costs and, more recently, the likely increase in future earnings and pension claims with later retirement ages and the changes in pension rules. The recent Ogden 7 tables (see later) will also result in increased damages with increasing multipliers.



2 Legal costs for claimants and defendants

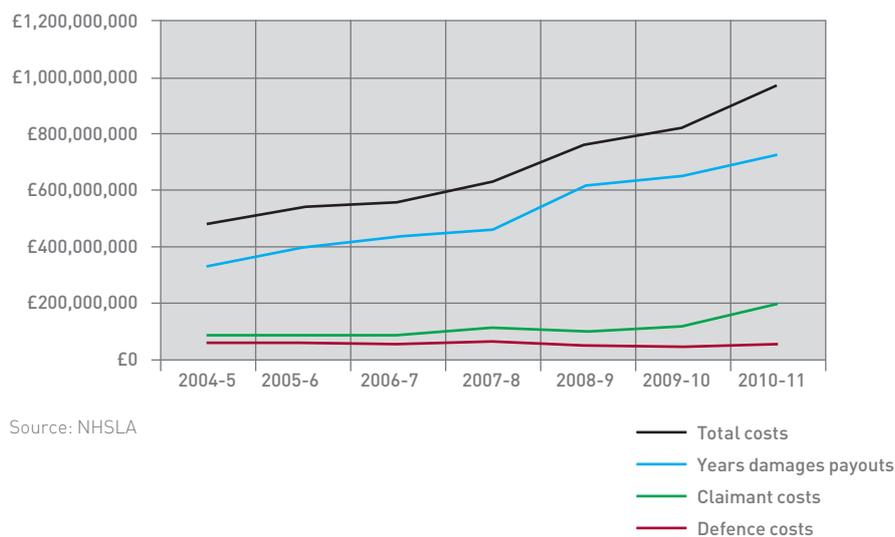
Legal costs incurred in connection with claims closed

CNST	Claimant costs £	Defence costs £	Total £
2007-2008	108,628,000	56,517,000	165,145,000
2008-2009	103,632,000	39,658,000	143,290,000
2009-2010	121,487,000	42,233,000	163,720,000
2010-2011	181,283,736	53,974,964	235,258,700*

Source: NHSLA

*These costs do not include £22,183,820 for ELS claims.

Costs as a proportion of damages



‘...the National Audit Office (NAO) has estimated that trusts could save around £500 million annually, 10% of their consumables expenditure, by amalgamating small orders into larger, less frequent ones, rationalising and standardising product choices and striking committed volume deals across multiple trusts.’

There was an increase in 2011 in both total damages paid out and in claimant costs. The most significant increase is in the total damages payable. This is followed by claimant costs, although there has also been a modest increase in NHSLA defence costs. This increase in legal costs is likely to be due to claimant solicitors issuing proceedings earlier where there is delay and the NHSLA involving solicitors earlier in cases. The increase in damages payable ties in with the ongoing increase in the number of claims being brought.

Expert commentary:

The NHSLA's Annual Report reveals that it paid out £729.1 million in 2010/11 in respect of CNST negligence claims. This excluded legal costs of £235 million (CNST), of which £181 million was claimant lawyers' costs (77% of the total CNST legal costs expenditure). These are large sums but need to be put in context.

The NHS budget for 2010/11 was around £104 billion, making the total cost of claims for the year approximately 0.7% of the budget and legal costs 0.2%. Given that the NHS self-insures against claims through the NHSLA, the 0.7% spent on claims could be regarded as the equivalent of its annual indemnity insurance premium – which compares favourably with the cost of obtaining professional indemnity insurance in the open market.

The cost of claims therefore appears to account for a very small proportion of the NHS budget but how does it compare with other items of NHS expenditure? Below are four 2011 examples of the NHS being accused of wasting sums that considerably exceed what it spends on legal costs.

1. In May the Daily Telegraph reported that almost £500m had been wasted on a scheme to use the private sector in the NHS. The Independent Sector Treatment Centre Initiative pays private providers on a "take or pay" basis to provide a set number of operations, many of which never take place. The cost of paying for operations not taken up is reported to be £217m. The scheme also includes payments to providers for their buildings when contracts come to an end and the provision of drop-in centres to allow people to visit

a doctor near their place of work. These are underused and most of them are to be closed down.

2. A report published by the House of Commons Public Accounts Committee (PAC) in May 2011 on the procurement of consumables in the NHS commented that: "The fragmented system of procurement has produced a great deal of waste, with trusts being charged different prices for the same goods, ordering in inefficient ways and failing to control the range of products which they purchase". It also noted that the National Audit Office (NAO) "has estimated that trusts could save around £500 million annually, 10% of their consumables expenditure, by amalgamating small orders into larger, less frequent ones, rationalising and standardising product choices and striking committed volume deals across multiple trusts".

3. Another report by the PAC in October 2011, *Managing High Value Capital Equipment in the NHS in England*, commented on the purchase and use of MRI and CT scanners, concluding that NHS trusts were not working together to combine their buying power when acquiring this expensive equipment and were failing to take advantage of bulk buying to achieve discounts: "At present the systems for buying and managing high value equipment are fragmented, with resources being wasted". It also noted that "Large variations persist in machine use, waiting times, opening hours and access to scans" and that there was no central repository of data which would help to drive improvements in efficiency.

4. Perhaps the most significant example of alleged waste of NHS money was, however, the National Programme for IT in the NHS. This project, aimed at using information to improve services and patient care, included the objective of ensuring every NHS patient had an individual electronic care record which would be accessible online throughout the NHS to NHS staff at all times. A NAO report of May 2011 concluded "that the £2.7 billion spent so far on care records systems does not represent value for money. And, based on performance so far, the NAO has no grounds for confidence that the remaining planned spending of £4.3 billion on care records systems will be any different".

The programme was also criticised by the PAC in a report in July 2011 and, following the conclusions of a review by the Cabinet Office's Major Projects Authority, the Government announced the acceleration of its dismantling. In December, The Times ran a series of articles commenting on the profits made by US software company Computer Sciences Corporation from the project. It was reported that CSC expected to receive a further £2bn from the Government.

While reducing the cost of clinical negligence claims would help the NHS – and as we have commented before, the best way to do that is to reduce clinical negligence – it seems clear that, at a time when the Government is asking the NHS to cut its costs by £20bn, reducing waste could also make a significant difference.



3 2011 hot legal topics

‘Currently, most children will be eligible for legal aid on the basis of their means and have the costs of investigation paid by the Legal Services Commission (LSC). If legal aid is taken away, it has been suggested that many potential claims on behalf of injured babies and children will not be investigated.’

3.1 The Legal Aid, Sentencing and Punishment of Offenders Bill - impact on legal aid

The Government's consultation on its proposals for litigation funding resulted in those proposals appearing unchanged in the Legal Aid, Sentencing and Punishment of Offenders (LASPO) Bill. The bill has been subject to much debate and some revision. It was criticised by 51 of the 54 peers who spoke when it was debated in the House of Lords but seems likely to come into force in the second half of 2012, although the legal aid changes have been deferred until April 2013.

The bill seeks to remove clinical negligence from the scope of legal aid and to change significantly the operation of Conditional Fee Agreements (CFAs) and the rules on civil costs.

There are concerns that the bill will deny access to justice to some of the most vulnerable individuals in society, including babies and children who have suffered severe brain injuries during their births.

Birth injury claims, for example, are complex and require careful investigation before the prospects of success can be estimated. This means commissioning expensive expert reports. Currently, most children will be eligible for legal aid on the basis of their means and have the costs of investigation paid by the Legal Services Commission (LSC). If legal aid is taken away, it has been suggested that many potential claims on behalf of injured babies and children will not be investigated. Even if solicitors and barristers were willing to accept such cases on CFAs, there may be difficulties in funding and/or insuring the large sums needed to pay the expert fees. That has implications not only for injured individuals but also for the medical profession and the NHS/private sector as opportunities to learn from mistakes may be lost.

Quality controls will disappear

The LSC operates a franchise system to ensure that only specialist clinical negligence solicitors handle publicly funded claims. Without those quality controls it has been suggested that non-specialists may take on these complex cases, with poor outcomes for claimants predicted. This concern could be dismissed as that of

a group trying to protect its own interests but it should be noted that it is not just clinical negligence lawyers complaining: two respected charities, the Spinal Injuries Association and AvMA, object so strongly to the withdrawal of legal aid that they have attempted Judicial Review proceedings.

The provisions of the LASPO Bill are aimed at shaving £350 million off the legal aid budget. The MoJ specifically estimates that it will save £10 million a year by taking clinical negligence out of scope. That is 1.3% of the NHSLA's total expenditure on clinical negligence in 2010/11. With such meagre savings to be made, the question could be asked whether the Government's real aim is to reduce the cost of clinical negligence claims overall – by making them more difficult to bring – rather than reducing the cost of legal aid.

NHSLA supports clinical negligence claims staying in scope

However, the impact of removing clinical negligence from scope will simply be to transfer the costs from the MoJ (which will take over the administration of legal aid from the LSC) to the Department of Health (NHS).

The NHSLA realises this and considers that the proposals will result in increased public expenditure. This is both because insurance premiums will potentially be payable in relation to disbursements and because spurious claims taken on by non-specialists or brought by litigants in person will have to be investigated and defended. As a result, the NHSLA is firmly in favour of retaining legal aid for clinical negligence.

Lord Justice Jackson, whose proposals on CFAs and civil costs led to the creation of the bill, also considers that legal aid should be retained for clinical negligence and has spoken out against this aspect of the reforms.



3.2 The Legal Aid, Sentencing and Punishment of Offenders Bill - the proposed changes to CFAs

The bill proposes the following main changes relevant to the funding of clinical negligence claims:

1. Abolition of the payment of success fees by the losing party. Claimants will pay success fees out of their damages (capped at 25% of damages). The intention is to give them a financial interest in controlling the costs being incurred on their behalf.
2. A 10% increase in claimant's general damages to offset some of their responsibility for costs (although this may be difficult to measure given the global nature of most negotiations).
3. Abolition of after-the-event (ATE) insurance premiums or at least the recoverability of such premiums from an unsuccessful defendant (but see below).
4. Qualified one-way costs shifting – losing claimants will not be liable for adverse costs in principle (thus obviating the need for ATE insurance cover) – but there are exceptions and when and how these exceptions will be applied is unclear.

Until the bill is in its final form, we cannot be sure how the proposals will operate but the Government's stated intention is to cut the costs of litigation and to ensure that claimants shoulder some of the risks and costs themselves.

It has been suggested that this will restrict access to justice, with claimants being unable to get funding to pursue more risky cases as solicitors will cherry-pick only the very strong cases where costs will be recovered. In turn, this could lead to a rise in the number of errors in medical care because a decrease in claims will reduce the amount of attention focused on errors.

It has also been argued that it is not right for claimants to use some of their compensation to pay legal costs. If the aim of compensation is to put the injured party in the same financial position as they would have been in but for the negligence, using some of it to pay legal costs would, by definition, leave them under-compensated. It remains to be seen whether solicitors will decide to take costs out of their clients' damages or whether they will only take on the strong cases and eschew the difficult ones.

One amendment to the bill will allow for recoverability of ATE insurance premiums for claimant's disbursements in clinical negligence claims. However, to what degree insurers will stay in such a limited market remains to be seen.

The bill is now being considered by the House of Lords. A number of amendments have been proposed and it is hoped that due note will be taken of the considerable concerns being raised in relation to the bill, particularly as far as it relates to clinical negligence claims.

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‘In her final report [into the case of Harold Shipman] Dame Janet Smith said that “the reality of the ‘remarkably low’ standard above which doctors will be revalidated does not square with the claim that revalidation gives an assurance that the doctor is ‘up to date and fit to practise’”. Now, nearly eight years on, nothing seems to have changed. This is why urgent action is required.’

3.3 Proposals to abolish referral fees in limbo

In September 2011 the Ministry of Justice announced that referral fees are to be banned in personal injury cases (expected to include clinical negligence cases) as part of the Government’s efforts to tackle the UK’s so-called ‘compensation culture’ and drive down civil litigation costs.

Referral fees are currently paid in a number of scenarios: to claims management companies who advertise for and find claimants and ‘sell’ them to solicitors; to repair garages who act similarly; and to insurance companies who also ‘sell’ claims to solicitors. The Government claims this encourages potential claimants to sue rather than considering other options. It is said that this, in turn, has led to higher prices and increased insurance premiums. However, this is felt to be far more relevant to the personal injury field than the clinical negligence field.

Justice Secretary Kenneth Clarke argues in favour of the ban claiming that “a ban on referral fees together with our changes to No Win, No Fee arrangements will reduce cost and speculative suing, so that businesses, schools and individuals can be less fearful of unnecessary claims encouraged by those looking to profit rather than justice.”

As yet we have no detail as to how the ban on such fees is going to work in practice. There are expectations that loopholes will prevent agreements from being properly monitored and that similar arrangements are still likely to occur but under a different description. For example, firms may pay for group marketing in return for receiving cases, rather than paying directly for cases. The introduction of alternative business structures where lawyers enter into partnership with non-lawyers may bring the whole process under one roof and mean that referral fees no longer have a place in personal injury litigation in any event. .

An attempt by Jack Straw, the former Justice Secretary, to make the payment of referral fees in personal injury cases a criminal offence was rejected by MPs. Justice Minister, Jonathan Djanogly, was quoted as saying: “Criminalisation would be too blunt an instrument...the circumstances

could be varied and complex and the straight criminal option would not be appropriate.”

How regulation will cover those varied and complex circumstances remains unclear and interested observers can only take a wait and see approach.

3.4 Discredited doctors carry on practising

There were several reports during 2011 of doctors who had been accused of poor practice continuing to be permitted to work. The Times reported that, of 102 doctors that the GMC wanted to remove from the register for malpractice, only 40 were finally struck off. This raises questions about the effectiveness of the General Medical Council’s (GMC) monitoring of doctors’ fitness to practise.

The House of Commons Health Select Committee reported on its annual accountability review with the GMC in July 2011. It commented “that the leadership function of the GMC within the medical profession, and within the wider health community, remains underdeveloped particularly in the areas of fitness to practise, revalidation, education and training and voluntary erasure”.

Bar set too low to protect patients

Sir Donald Irvine, former President of the GMC, had expressed the view to the Committee that the bar used by the GMC to establish good or problematic practice (in the GMC document Good Medical Practice) in the context of revalidation “is set too low to protect patients properly”. In his written evidence to the Committee he stated:

“In her final report [into the case of Harold Shipman] Dame Janet Smith said that “the reality of the ‘remarkably low’ standard above which doctors will be revalidated does not square with the claim that revalidation gives an assurance that the doctor is ‘up to date and fit to practise’”. Now, nearly eight years on, nothing seems to have changed. This is why urgent action is required.”



As regards fitness to practise, Sir Donald also stated that the baseline was too low. The Committee placed emphasis on his comment that “some doctors are allowed to continue to practise, possibly with conditions, at a level well below that required by the GMC, the universities, the medical royal colleges and specialist societies to get onto the medical register and qualify as a specialist or principal in general practice in the first place”.

The Committee went on to state: “Some of the decisions made by fitness to practise panels of the GMC defy logic and go against the core task of the GMC in maintaining the confidence of its stakeholders.

Furthermore, they put the public at risk of poor medical practice”.

No power to appeal for GMC

As fitness to practise panels are independent of the GMC’s governance structure, the GMC has no power to appeal against their decisions, although another organisation, the Council for Healthcare Regulatory Excellence (CHRE), does. The CHRE opposed the concept of the GMC acquiring power to appeal but the Committee agreed with the GMC that it did need to have a right of appeal in cases where it thinks panelists have been too lenient.

This opinion was endorsed by Dame Janet Smith, who was quoted in *The Times* on 4 November 2011 as saying that it was vital that an appeals process be created to restore public confidence. She added: “... the truth is that the whole system isn’t good enough...there still seems to be a reluctance to be tough. We need a high-class system and we don’t have it now.”

The widely-reported case of Mr Gideon Lauffer, a surgeon about whom 20 complaints of “botched operations” had been made, including two instances where patients died, was one where the GMC was said to have been overruled by a fitness to practise panel. Mr Lauffer, who was suspended by a fitness to practise panel for six months in 2010, was permitted by a panel in January 2011 to return to work subject to conditions on his registration.

The BBC reported in August 2011 that five claims had been settled in relation to surgery performed by Mr Manjit Bhamra, a consultant orthopaedic surgeon at Rotherham General Hospital between 2005 and 2007. It was noted that the Rotherham NHS Foundation Trust had reported Mr Bhamra to the GMC. On 9 October 2011, the *Daily Telegraph* reported that Mr Bhamra continued to practise as a surgeon at Pinderfields Hospital in Wakefield and for the private Care UK group in Southampton and London. It was suggested that Mr Bhamra’s “botched surgery” had cost the NHS £1m and that he had been twice reported to the GMC.

When so much of our work concerns helping people who have suffered avoidable injury, we are concerned that the GMC’s recommendations can be overruled in this way and endorse the calls for reform of this procedure.

‘Some of the decisions made by fitness to practise panels of the GMC defy logic and go against the core task of the GMC in maintaining the confidence of its stakeholders. Furthermore, they put the public at risk of poor medical practice.’

*The House of Commons
Health Select Committee*

3.5 Mixed views on removal of immunity from suit for expert witnesses

In a landmark judgment in *Jones v Kaney* (2011), the Supreme Court stripped expert witnesses of the immunity from suit that they have long enjoyed.

The decision has received a mixed response. Some see it as the long overdue removal of an anomalous privilege that deprived clients of any remedy if their claim failed or suffered as a result of an expert not doing their job properly. Most clinical negligence lawyers have experienced this and, to date, there has been no remedy.

Others have concerns, particularly in cases of individual litigants, that this may result in a raft of claims and satellite litigation against experts and that this may stop some from providing expert opinion. In some areas of clinical negligence, the number of experts available is already very limited and there could be real difficulties if there were even fewer.

It is hoped, however, that this judgment will ensure that experts in all fields carefully consider their advice and prepare carefully for a case. It remains crucial in clinical negligence cases to choose experts who are well regarded as medical practitioners and medico-legal experts and who will provide clear, considered and robust advice.

3.6 Proposals for low value clinical negligence claims

AvMA and APIL, amongst other bodies, are in discussions with the NHSLA about the creation of a scheme to expedite the investigation and settlement of lower value clinical negligence claims.

The proposed scheme is still under discussion and there is currently no time frame but it is thought that the Government is keen for such a scheme – possibly in tandem with the changes proposed under the LASPO Bill. A scheme prepared with the input of those working in the field is likely to be a better model than simply extending fast track / fixed costs provisions to clinical negligence cases – which is something that has been mooted as part of the wide-ranging costs reforms.

At present, it is proposed that the scheme would initially apply to claims against NHS trusts with a value of up to £25,000 – although there may be pressure to increase this threshold at a later date. The scheme will cover all claims including those involving children, those lacking capacity and fatal claims.

One of the suggestions is that, once a case is in the scheme, there will be a limitation moratorium to enable conclusion of the matter without the costs of court proceedings. It is also currently proposed that claimants will not be at any risk of adverse costs while their case is within the scheme – along similar lines to the one way costs shifting proposals.

It is proposed that the scheme be voluntary, although it appears that claimants who do not use the scheme may be challenged on their costs. The scheme is currently proposed as a four stage process with the claimant having legal advice throughout but recovery of fixed costs.

The potential benefits of expediting claims and obtaining early admissions where appropriate are clear. However, there are concerns about ensuring that claims are properly investigated and assessed and also whether, given the recovery of fixed costs, there is a risk that claimants may end up paying some of their legal costs themselves if more work is required than is covered by the fixed costs provisions.

There is still further work to be done but it is anticipated that the scheme will come into effect in 2012 in some form.

3.7 Ogden 7 replaces Ogden 6

The new edition of the Ogden Tables (Ogden 7) was released in October 2011 by the Government Actuary's Department. These tables are used as the basis of calculations for future losses and replace the previous set, Ogden 6, which were published about four years ago.

The five key changes from Ogden 6 are as follows:

1. Updated mortality statistics have been used (from the 2008 ONS publications). These show quite a notable increase in life expectancies for both men and women.
2. Based upon the increased base life expectancy figures, the life multipliers for all ages have increased – more so for those who are older.
3. As a result of increased life expectancy, there are increases in pension multipliers – slightly more for men than women.
4. The multiplier for fatal accidents claims is now calculated at the date of trial not the date of death (as is currently practised based on case law) but this will remain an area of debate.
5. Given the Lord Chancellor's pending review of the discount rate (used for assessing the amount of damages for ongoing future losses allowing for investment returns), Ogden 7 now includes discount rates ranging from -2% to +3%.

As a result of these changes, multipliers will increase and so, in turn, will damages for future losses. If the discount rate is adjusted downwards, then this will have an even more significant effect on increasing multipliers and lump sum damages awarded for future losses.

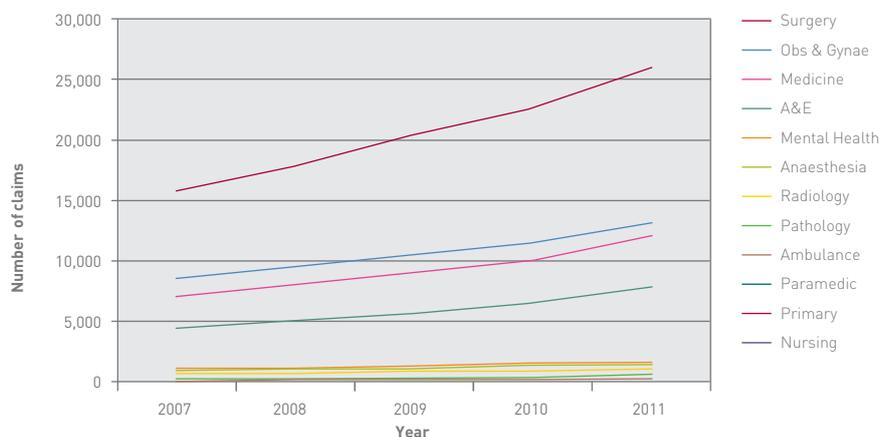


4 Claims' specialties league tables – volume, value and growth rates

4.1 Total number of reporting CNST claims by specialty as at 31/03/11

The total number of reported claims by specialty reached 66,056 in 2010/11, a 13% increase on the 2009/10 total. Claims for surgery (25,867), obstetrics & gynaecology (13,095), medicine (12,045) and A & E (7,800) continue to be the top four specialties attracting claims accounting for 89% of the total number.

Increases in number of reported specialty claims



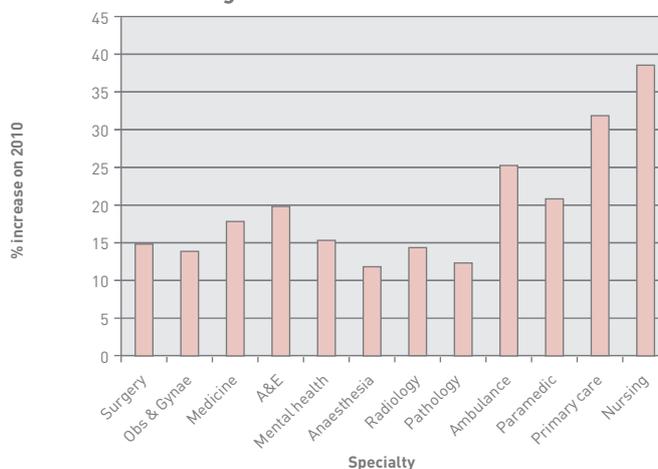
4.2 Percentage increase in number of specialties' claims

The three specialty areas where there has been the greatest percentage increases are Nursing, Primary Care (GPs) and Ambulance care: the percentage of Nursing claims has risen 39% from 176 claims in 2010 to 244 in 2011; Primary Care claims have risen 32% from 197 in 2010 to 261 in 2011; and Ambulance claims have risen 25% from 562 to 681.

Possible reasons for the rising number of claims against GPs could be the increasing number of Primary Care treatment centres, Out of Hours centres and Walk In Centres. These services are commissioned by PCTs, which are covered by the NHSLA.

An additional factor is that PCTs are increasingly commissioning private companies to provide these services. If a claim is made against a private company commissioned by the PCT, the PCT will be covered by the NHSLA. It is interesting that this increase is occurring at the same time as the Government is pushing for more private sector involvement in community-based treatment and triage services.

Percentage increase YOY 2010-2011



There is also a significant increase in the number of Paramedic and Ambulance care claims. The level of pre-hospital triage provided by the Ambulance services (covered by the NHSLA-CNST) has increased over recent years in line with financial pressures to cut costs and more demanding targets to reduce hospital attendances and admissions.

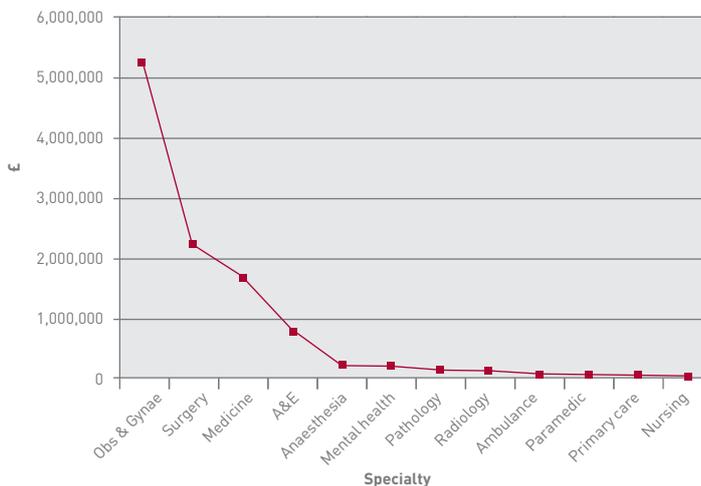
As a result, the Ambulance services increasingly try to manage patients in the community rather than transporting everybody to A&E. This can cause problems which may have been avoided by admitting the patient directly to hospital. An alternative explanation is that the new claims notification requirement is resulting in claimant solicitors simply contacting the trusts of the A&E departments and Ambulance services (thus creating an NHSLA notification).



4.3 Total value of CNST claims to 31/03/11

Of the total value of CNST claims of £10.68 billion, nearly 70% of this is accounted for by obstetrics and gynaecology (£5.21 billion) and surgery (£2.21 billion) claims. This percentage of the total value of claims has risen dramatically from just 49% in 2010. Medicine claims represent a further £1.67 billion (16% of the total value) while A & E claims account for £809 million (7.5% of the total value).

Value of CNST claims by specialty 2011



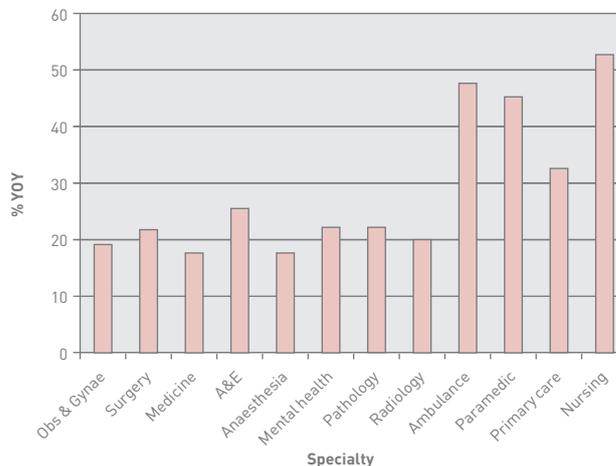
4.4 Increase in claims value by specialty

Not only has the number of nursing claims increased significantly but the value of the claims has increased by 53%. With the continuing adoption of the European Working Times Directives, many hospitals are switching to the "Hospital at Night" process where jobs are routed via a nurse practitioner. The increase could possibly be the result of poor nurse decision-making.

An alternative explanation for the increase in claims is that it results from increased levels of Nurse Practitioner clinic involvement and nurse prescribing. These are two key areas where the traditional nursing role has been expanded over previous years. The dramatic increase in the claims value – towards 'doctor' level claims values – could be due to the increased clinical responsibility and decision-making these roles now entail.

Ambulance claims have also increased by 48% in value while Paramedic claims have increased by 45%.

Percentage YOY increase in claims value





5 2011 major medical issues

5.1 Health and Social Care Bill – concerns about quality of care provided to patients

Critics have voiced their disappointment following the publication of the Government's *Health and Social Care Bill*, claiming the document will divide the NHS and result in a wide variation in the standard of care received across the country.

The bill (which contains surprisingly little detail about how the proposed system would work) represents probably the biggest shake-up of the NHS since its inception, bringing about a shift in power from hospital trusts, regional strategic health authorities and primary care trusts to newly-formed primary care commissioning groups made up of GPs.

These commissioning groups will be made up of GPs from a number of practices in a particular geographical area and will be responsible for procuring healthcare services from both existing NHS providers and private and third-sector organisations which will be able to compete under the proposed 'any willing provider' system.

The plans have led to widespread concern that patient care will suffer and there could be a potential variation in the quality of care between the different consortium areas. There is also concern that GPs will not have the time and experience to manage the level of responsibility and decision making that the bill proposes to put on their shoulders.

Reducing GPs' time to diagnose properly

We already deal with a number of claims against GPs who make diagnoses on the most obvious cause of symptoms and do not investigate other, potentially more serious, causes and where GPs do not take and/or document a full history – leading to errors or delays in diagnosis and treatment. We believe in many cases this is due to pressures on time and resources – will this increased burden on GPs and the need for them to be even more cost driven result in even more errors of this kind?

There is also concern about the fragmentation of care. Instead of an MDT team within a hospital or trust managing a patient's care and communicating with them, care could be split between a number of providers with consequent risks of poor communication adversely affecting patient care.

In recent years, the quality of NHS care and

availability of funding for certain drugs has varied widely across the UK to the point that its allocation is commonly referred to as 'postcode lotteries'. Will an even more cost-driven focus increase this effect?

Will niche areas of medical care become difficult to develop or maintain because they are expensive? Will the subsequent reduction in the breadth of doctors' training and experience in the NHS lead to wider skills gaps?

A massive gamble, says British Medical Association (BMA)

Many 'interested parties', including the BMA, have raised concerns, accusing ministers of 'gambling with the NHS'. While BMA members acknowledged the benefits of giving clinicians greater involvement in commissioning, they warned that these improvements would be threatened by other parts of the bill that enforce competition even when GPs believe the most appropriate services can be provided by existing NHS hospitals.

BMA council chairman, Hamish Meldrum, said: "Ploughing ahead with these changes as they stand, at a time of huge financial pressures, and when NHS staff and experts have so many concerns, is a massive gamble. Forcing commissioners of care to tender contracts to any willing provider ... could destabilise local health economies and fragment care for patients."

John Black, president of the Royal College of Surgeons (RCS), said its members were concerned that hospital clinicians would not be consulted in the future, adding: "The bill leaves the question of regional-level commissioning unanswered, with no intermediary structure put in place."

Royal College of Nursing chief executive and general secretary, Dr Peter Carter, said: "We are concerned that ... this reform programme could come off the rails as people concentrate on saving money rather than delivering quality care. We're already seeing this as trusts make short-sighted cuts to jobs with 27,000 posts already earmarked to go. ... financial savings can and should be made, but patients must always come first."

Radical reduction of healthcare bodies

The Government's plans will radically reduce the number of healthcare bodies and give

much more power to patients in terms of access to information and choice over their care.

Among the organisations that will be legally disbanded under the bill are all strategic health authorities and PCTs, the Health Protection Agency, the National Information Governance Board for Health and Social Care, the National Patient Safety Agency and the NHS Institute for Innovation and Improvement. The bill proposes a new NHS Commissioning Board to replace these.

The Government is also mandating local authorities to set up Health and Wellbeing Boards to work closely with GP consortia on a wide range of public health issues.

A new advocacy organisation, known as HealthWatch is also being launched. A statutory department of the existing Care Quality Commission (CQC), its role will be to champion service users and carers across health and social care, including promoting choice and complaints advocacy.

The bill is still in process so there are ongoing amendments and discussions – it remains to be seen what the final outcome will be.

5.2 Care Quality Commission identifies failings at Barking, Havering and Redbridge University Hospitals NHS Trust

The CQC has published a report on 'serious failings' at Barking, Havering and Redbridge University Hospitals NHS Trust (BHRUHT), focusing mainly on the quality and safety of care provided at King George Hospital and Queen's Hospital. The trust is under fire over its maternity care after five women died in 18 months and complaints rose by a third from 2009 to 2010.

Of particular note is the report finding that: "Trust governance systems are reported as weak and corporate governance is underdeveloped. Governance systems have recently changed, but lines of communication in the new structure are unclear and there is a risk of duplication or issues being missed. The trust was reliant on external reviews to identify issues and, while it held extensive performance information, this was not used to drive change. There was a lack of learning from incidents, with investigations identifying recurring themes."

5.3 Caesarean section: the right to choose

Caesarean sections, involving the delivery of single or multiple babies via an incision in the mother's abdomen and uterus, have been performed since Roman times, although there are no documented instances of women surviving the procedure at that time.

The first caesarean section in modern times, using a transverse incision to minimise bleeding, is reported to have been carried out by Ferdinand Adolf Kehler in 1881.

As the safety of the procedure has improved, so the number of caesarean sections performed to deliver babies has increased significantly. One in four women in many European countries, including the UK, Asia and America are now delivered this way while caesarean sections account for more than 40% of deliveries in China.

Obstetric negligence accounts for largest proportion of NHSLA claims value

In the UK, a significant number of the claims handled by the NHSLA arise from alleged obstetric negligence. Very often it is averred that a baby has suffered harm, in the form of a significant brain injury, as a result of the delay in its delivery. It is often argued that the delivery should have been expedited by caesarean section and that injury would have been avoided.

Fear of litigation has often been cited as a reason why the number of caesarean sections has increased. However, we are continuing to see a significant number of cases where warning signs have been missed, deliveries have not been expedited by caesarean section and harm has been caused. On occasions, the mothers of injured children have berated themselves for not insisting on elective caesarean sections.

Clinicians have had right to decline request for caesareans

However, women have not historically been able to insist on caesarean sections being carried out on the NHS in the UK. The guidelines published by the National Institute for Health and Clinical Excellence (NICE) in April 2004 made it clear that maternal request was not, on its own, an indication for a caesarean section to be carried out and clinicians had the right to decline such requests if there were no reasons to advocate this mode of delivery.

However, the position changed in November 2011 with the publication of NICE's guidelines on caesarean sections which attracted much press coverage because of the purported new right for women to have caesarean sections on the NHS. In fact, the guidelines make it clear that, as before, clinicians should discuss the risks and benefits of caesarean section compared with vaginal delivery with each woman. Where a woman specifically requests a caesarean section, the reasons for this should be explored by the clinician.

A woman with a fear of childbirth should be referred to a healthcare professional with expertise in providing perinatal mental health support but, if a vaginal birth is still not an acceptable option, her request for a caesarean section should be supported within the health service. In practice, these circumstances may not apply to that many women.

Unclear if number of elective caesarean sections will increase

It is not clear if this new guidance will result in an increase in the number of elective caesarean sections and, clearly, there is a distinction between elective caesarean sections and those indicated in emergency situations where there is a risk to either the mother or the child. The question is whether a mother in labour who is fearful of continuing with a vaginal delivery because of perceived risks to herself or her child will now be able to insist on a caesarean section. If so, then this could conceivably lead to a reduction in the number of birth-related injuries.

That said, caesarean section is not without its own risks. It is invasive abdominal surgery with the associated risks to the mother of blood loss, infection and wound dehiscence. For the baby, the risk of respiratory problems in the neonatal period is increased by a caesarean section, particularly before 39 weeks' gestation.

We have been involved in a case where a caesarean section was performed on a premature baby without a proper indication to perform such surgery. The baby suffered respiratory problems associated with her prematurity.

In practice, while a woman will now be able to insist on a caesarean section, the vast majority will trust the advice of their treating clinicians and most deliveries will be vaginal ones. In the circumstances, it is vital that clinicians, faced with warning signs during planned vaginal deliveries, act on those promptly and treat their patients accordingly to avoid harm.

5.4 Never events' categories increased

The NHS classes certain untoward events deemed as serious but largely preventable as 'never events'. The policy relating to never events was introduced in April 2009 but the list of categories of never events was widely expanded in February 2011 from 8 to 25, as follows:

Never Events February 2011	
Surgical	Wrong site surgery
	Wrong implant/prosthesis
	Retained foreign object post operation
Medication	Wrongly prepared high-risk injectable medication
	Maladministration of potassium containing solutions
	Wrong route administration of chemotherapy
	Wrong route administration of oral/enteral treatment
	Intravenous administration of epidural medication
	Maladministration of Insulin
	Overdose of Midazolam during conscious sedation
	Opioid overdose of an opioid-naïve patient
	Inappropriate administration of daily oral Methotrexate
	Mental Health
Escape of a transferred prisoner	
General Healthcare	Falls from unrestricted windows
	Entrapment in bedrails
	Transfusion of ABO-incompatible blood components
	Transplantation of ABO or HLA-incompatible organs
	Misplaced naso- or oro-gastric tubes
	Wrong gas administered
	Failure to monitor and respond to oxygen saturation
	Air embolism
	Misidentification of patients
	Severe scalding of patients
Maternity	Maternal death due to post-partum haemorrhage after elective caesarean section



A welcome development

While some may adopt a cynical view about the decision to expand the list of never events and interpret this to be testimony to the prevalence of serious, avoidable incidents in UK hospitals, we welcome this extension. It shows a positive attitude towards the reporting of serious incidents and embraces the opportunity to conduct serious reviews into safety to learn lessons and ensure that the same mistakes are not made again.

We also welcome the extension from a practical perspective. Evidence is key in clinical negligence cases, particularly where the defendant disputes liability. We would hope that, where a claim is brought following a never event, an early admission of liability will be forthcoming together with an apology to the patient and their family.

Some commentators believe that the revised list is missing the issue of bedsores, which are, unfortunately, becoming an increasingly common occurrence in our hospitals. The effects can be extremely debilitating but they are easily preventable.

As with everything, there is a financial aspect to consider. Whenever a never event occurs, the culpable hospital is penalised financially as the commissioner may withhold funding from the hospital and recover the costs of remedial action and follow up care. They can, however, waive the principle of costs recovery where they believe that the provider is taking robust steps to learn from the incident or where the loss of income to the provider could have a detrimental effect on patient care.

Focus on safety not costs recovery

While the Department of Health stresses that this costs recovery policy is not intended to be punitive, we fear that it could potentially encourage inaccurate reporting or indeed discourage reporting altogether. We hope that the costs implications of never events do not overshadow what ought to be a focus on safety. We are, however, encouraged by the decision to extend the list of never events and the commitment to transparency at a time when the health service has to cut £20 billion from its budget over four years. This is a huge commitment to patient safety and we hope that the NHS can deliver.

5.5 Tamiflu vaccination: growing number of cases demonstrate adverse effects

There have been press reports of serious concerns over the side-effects of the drug Tamiflu, most recently used in the UK to treat the swine flu epidemic. A pattern appears to be evolving as people come forward claiming that Tamiflu has had a devastating effect on their lives.

Penningtons currently acts for SM, a 19 year old girl who started taking Tamiflu after being advised to do so by the National Pandemic Flu line in 2009, when she rang them suffering from earache. After taking just three tablets, SM developed Steven Johnson Syndrome, a potentially life-threatening skin condition which causes the skin to peel off. She later developed toxic epidermal necrolysis and has been left registered blind and disabled. Additionally, she did not have swine flu in the first place.

Research has shown that there are also a number of concerns over the drug causing delirium, strange behaviour, fits and seizures. A recent case is that of LH, a middle-aged mother who used to suffer from infrequent, undiagnosed fits about five times a year. Shortly after taking Tamiflu, she began to have seizures up to 20 times a day and has been left disabled, can no longer work and requires constant supervision and care.

While Tamiflu was declared safe and the Government hailed the website and call centres set up to deal with the swine flu pandemic and prescription of the drug, more cases of adverse reactions are emerging. We are currently investigating the case of LH as well as further possible cases involving Tamiflu.

5.6 Product liability claims for hip implants

The past year has seen an increase in product liability claims following DePuy Orthopaedics' recall of two of its metal on metal ASR hip implants in August 2010 after evidence of higher-than-expected early failure rates.

Metal on metal implants were re-introduced in the 1990s. Made of cobalt chromium alloys, they are considered to be more durable and therefore suitable for the younger, active patient. A new hip prosthesis called the Birmingham Hip Resurfacing was introduced into the European Market in 1997.

This was acquired by Smith and Nephew and proved to be a popular option. DePuy, a division of Johnson & Johnson, set out to design a better product and two forms of the DePuy ASR came onto the European market in 2003.

By 2007 surgeons started to notice problems with the ASR as patients reported groin pain and difficulty walking. When the surgeons opened them up to explore the cause, they were shocked to find that the soft tissues and muscles around the hip had been destroyed. Other problems that arose included raised blood cobalt and chromium ions. Revision rates started to increase.

Despite the reported concerns, DePuy initially denied that the ASR implants had caused pain and disability in patients but eventually voluntarily recalled its ASR hip prosthesis from the market in August 2010. By this time, they were seeing a 15% revision rate at five years and almost all patients had tissue damage to some extent. The MHRA sent out a medical device alert warning about all metal on metal hip implants.

DePuy has now agreed to fund all investigations and revision surgery, providing that the cause can be linked back to device failure.

Safety concerns extend to other manufacturers

From a claimant's solicitor's perspective, there are now queries as to the safety of the other metal on metal implants produced by other manufacturers. The risk to patients of these implants is a progressive inflammatory response leading to tissue necrosis around the hip. If a painful metal on metal hip is revised before substantial soft tissue damage, then the outcome is likely to be excellent but, if substantial tissue damage has already occurred, revision surgery is associated with poorer function and higher rates of complication including limp and dislocation.

We are seeing an increasing number of potential claimants who are experiencing symptoms similar to patients who have had the DePuy hip. It remains to be seen whether the metal on metal hips can stand up to the test or whether we are likely to see a repeat of the DePuy recall with other manufacturers.

6 Penningtons' key trends and case notes 2011

The Penningtons clinical negligence team continued to go from strength to strength in 2011 with the recruitment of two new fee earners, Helen Hammond and Amy Milner. The team is one of the largest in the South East and London with 21 fee earners.

What this year's legal directories say about our team

Chambers UK 2012

THE FIRM, BAND 1 - The Penningtons team is formidable. It has real strength and is one of the best clinical negligence firms outside London. It is also continuing to grow and has made further appointments over the last year. The group has particular expertise in birth injury, neurosurgery and cosmetic surgery cases, and recently pursued successful claims for incorrect care following a hip operation and negligent surgery for a football player.

KEY INDIVIDUALS

The "superb" Alison Appelboom Meadows has impressed sources with her expert knowledge. She is based in Basingstoke, alongside the "absolutely brilliant" Tim Palmer, who heads the team in this office. Palmer focuses upon GP, A&E and child brain injury-related cases. Alison Johnson handles gynaecology, orthopaedics, oncology and GP negligence claims, while Justine Spencer specialises in cerebral palsy claims.

Philippa Luscombe leads the Godalming-based team. Her expertise lies in brain injury, orthopaedic and delayed diagnosis claims, and she splits her time equally between personal injury and clinical negligence cases. Also based in this office, leading practitioner Grainne Barton has a "great reputation" among peers and an interest in obstetrics.

The Legal 500 2011

TIER 1 - Jointly headed by Philippa Luscombe and Tim Palmer, the 'very experienced' team at Penningtons Solicitors LLP advises on cerebral palsy, caesarean and delayed diagnosis cases.

The team is continually involved with a wide range of cases involving claims for brain injury, birth injury and obstetrics, cerebral

palsy, surgical errors and delays and errors in diagnosis of many illnesses including breast cancer and meningitis.

The selection of short summaries of recent cases that we have won on behalf of our clients helps to illustrate the range and complexity of our team's skills and areas of expertise.

Birth injuries and obstetrics

Death of baby with congenital heart defect

Our client tragically lost her six-month old son, who had been born with a heart defect owing to failures on the part of both the health visitor who attended him at home and at the local A&E department. Our client's concerns about her baby's poor development and general health problems were ignored and her baby's heart block went undetected and untreated.

If he had been referred to the GP or a paediatrician and had surgery earlier, our client's son would probably have been saved. We successfully settled the case to achieve compensation for our client's bereavement and the psychiatric damage she suffered from witnessing her baby's appalling demise, as well as for her baby's avoidable pain and suffering.

Large baby dies from hypoxic brain damage following botched delivery

When our client, Mrs A, became pregnant with her son, it was clear from the scans that he was expected to be a large baby. She went into labour at term and had been pushing for an hour before the midwife asked the Registrar to review her. After several attempts at an instrumental delivery in theatre failed, he proceeded to a caesarean section but, in spite of encountering difficulty accessing the uterus to make the incision, did not call for the consultant.

Having identified that Mrs A had extensive adhesions, the Registrar should have been aware that inadequate abdominal access would cause difficulty with the delivery. However, he proceeded alone without calling for assistance although he was unable to deliver the baby as the head was impacted. The baby was eventually born in poor condition and died as a result of hypoxic brain damage.

'The Penningtons team is formidable. It has real strength and is one of the best clinical negligence firms outside London. It is also continuing to grow and has made further appointments over the last year.'

Chambers UK 2012



Baby dies in the womb from preventable anaemia

Our client Mrs B's baby died in the womb after the hospital failed to carry out a routine blood antibody screening at 28 weeks gestation. As a result, the baby suffered undetected haemolytic anaemia in utero and died. If the antibodies had been detected, the baby could have been monitored and, if necessary, given a blood transfusion which would have resulted in a live birth.

Large baby dies in the womb

Our client, Mrs C, suffered from gestational diabetes. A failure to refer to a Consultant and provide adequate obstetric care resulted in a failure to identify evidence of macrosomia (large baby) and to act upon this by earlier induction or delivery by caesarean section. Unfortunately Mrs C's baby died in utero at nearly 42 weeks gestation and at nearly 6kg. It is alleged that delivery at an earlier stage would have led to a live birth.

Baby delivered and dies in a hospital corridor

Our client arrived at the maternity ward with regular frequent contractions. Failure to examine her swiftly and act upon her presenting condition led to delivery with only junior staff in attendance. Although the baby was born alive, it died shortly afterwards. We are pursuing her claim that there was a failure to provide adequate midwifery/paediatric care to assist delivery and resuscitate her baby.

Cerebral palsy and meningitis

Failure to deliver twin quickly contributes to brain damage

We recently won a case against an NHS trust for baby JL, who has mixed dystonic spastic tetraplegic cerebral palsy. Following the safe vaginal delivery of his twin brother, JL was in a breech position presentation with a heart rate of 70-80 bpm. His mother was transferred to theatre for a caesarean section. JL was delivered in very poor condition 34 minutes after his twin and was immediately intubated and ventilated.

A cranial MRI scan showed abnormalities indicative of ischaemic brain damage in regions of high metabolism in the foetus approaching maturity. He is entirely dependent for all activities of daily living and his life expectancy is estimated to be to around 25 years.

The allegations of negligence were that the defendant failed to deliver JL expeditiously. As the timings in the claimant's case were very tight, there was substantial risk to the claim. We therefore accepted the NHA trust offer of £1.35million which represented around 45% of our estimate of capitalised full liability damages.

Inadequate treatment of E-coli led to meningitis

This claim concerned failure to adequately treat E-coli bacteraemia leading to meningitis and possible ventriculitis in a premature child of 32 weeks gestation. At five days old the claimant developed an infection. He was treated with conventional antibiotics for a short period and appeared to make a good recovery. Ten days later his condition deteriorated and the antibiotics were started again but two days later a much delayed lumbar puncture led to a diagnosis of meningitis. His antibiotics were changed to a more sophisticated drug which was also given for less than the recommended period after his condition improved.

Two weeks later he deteriorated again and he was transferred to Great Ormond Street Hospital for more specialised care and the insertion of a cerebral drain. This process contributed to the damage to his brain but would not have been necessary if the earlier treatment had been correct. The client now suffers from a left sided weakness, learning disability, considerable memory loss and a profound obesity.

This claim was rejected by many other firms of solicitors before we were instructed. It was defended up to exchange of expert evidence but settled for a substantial sum including periodical payments, mainly as a result of the clarity of the evidence given by a combination of the neonatologist and microbiologist expert given on behalf of our client.

‘The group has particular expertise in birth injury, neurosurgery and cosmetic surgery cases, and recently pursued successful claims for incorrect care following a hip operation and negligent surgery for a football player.’

Chambers UK 2012



‘We are seeing an increase in the number of cases that involve either a GP’s failure to refer on, a dismissal of a patient’s concerns or misinterpretation of the results. Given the numerous campaigns for breast cancer awareness, these are very worrying.’

Late diagnosis and inadequate reporting

Breast cancer patient urges women to speak up after winning claim against GP for delayed diagnosis

We have recently settled a claim for Mrs W against her former GP, in relation to her delayed investigation of a breast lump which transpired to be breast cancer. The claim highlights the difficulties for women who seek help from their GPs to allay their fears of possible breast cancer only to find their concerns are dismissed.

Mrs W regularly carried out breast checks and, when she identified a small but firm lump in her left breast, she saw her GP who carried out only a cursory examination and did not advise any further investigation or to return for a further check.

Over the next few months, Mrs W continued to feel the lump and again saw her GP who made a full examination and a non-urgent referral for her to the local hospital. The letter referred to a ‘thickening’ rather than a lump, which had been present for ‘a few months’.

Fortunately, the reviewing consultant decided to expedite the appointment and Mrs W had a biopsy, mammogram and ultrasound resulting in a diagnosis of breast cancer that was subsequently found to be invasive ductal carcinoma for which she ultimately had a mastectomy and chemotherapy.

We obtained expert evidence from a GP expert and a breast surgeon, both of whom supported a claim against the GP that she had failed to carry out a proper examination of the left breast. It was Mrs W’s case that a proper examination would have resulted in the lump being identified and that she should then have been referred under the 2005 NICE guidelines’ two week rule.

We are seeing an increase in the number of cases that involve either a GP’s failure to refer on, a dismissal of a patient’s concerns or misinterpretation of the results. Given the numerous campaigns for breast cancer awareness, these are very worrying.

Delayed diagnosis of compartment syndrome

This claim arose out of orthopaedic treatment received by Mr R following a fall and surgery to repair a leg fracture at Salisbury District Hospital. Mr R developed compartment syndrome but the diagnosis was delayed resulting in a lower limb fasciotomy to save his leg and subsequent surgical procedures including a muscle transfer. The surgery left Mr R with a permanent foot drop and muscle and vascular damage.

Due to his injuries, Mr R could not return to his previous occupation as a highly paid IT security consultant. Not only has he lost past and future earnings but his injuries and inability to continue working at his previous level have also resulted in a psychiatric injury.

Evidence was obtained from orthopaedic, plastic surgery and psychiatry experts and quantum reports were obtained relating to employment and accountancy/pension loss issues. The claim was litigated through to exchange of reports but was settled for £400,000 plus costs following a Round Table Meeting and subsequent negotiations.

Ambulance trust settles claim for family of Surrey man who died after being dropped

We settled a claim for the family of Mr T who died after he was dropped and hit his head while being carried into an ambulance. The key issue in this claim was the failure of the ambulance crew to document and report the incident which meant that the hospital caring for Mr T did not investigate the possibility of a head injury until it was too late for him to receive treatment.

Following an inquest, a Letter of Claim was submitted to the Ambulance Service alleging that the fall that caused the injury to Mr T’s head was itself evidence of negligence and, when acting in the ordinary course of their duties, an ambulance crew should not drop a patient. The coroner had concluded that the crew had not passed on the history of the fall and head injury to the hospital and the trust indicated during the investigation that the fall should have been documented and reported to the hospital.



The claim was submitted on the basis that there was a failure to properly document and report the incident.

Following submission of the Letter of Claim, negotiations were entered into and a settlement agreed without the need for Court proceedings.

Surgical negligence

Settlement achieved for youngster injured during spinal surgery

We settled a claim for Miss M in relation to surgery for scoliosis that she underwent at the Royal National Orthopaedic Hospital in Stanmore under a surgeon who performed the same surgery on Princess Eugenie.

Miss M was diagnosed with spinal scoliosis when she was three and was eventually operated on to correct the deformity.

During the operation, a fragment of bone from the facet joint entered the spinal canal. The piece of bone was retrieved but its presence in the spinal canal caused contusion of the spinal cord and resulting neurological damage, leaving her with severely impaired urological (bladder) function which will be long term.

Our spinal surgeon expert was of the view that the occurrence of the intra operative accident of the fragment of bone entering the spinal canal is not consistent with the exercise of the care and skill reasonably to be expected of a consultant spinal surgeon. He could think of only two ways in which the event could have occurred, neither of which, in his opinion, were consistent with the exercise of reasonable care.

The defendant trust via the NHSLA robustly denied the allegations of negligence in the performance of the surgery but admitted the event and that the bony fragment had caused injury to the spinal cord – although no admissions were made as to the effect of this injury.

Negotiations were entered and a settlement agreed. Miss M had the benefit of public funding (Legal Aid) throughout. This is a good example of the sort of case where an individual has suffered a serious injury during complex surgery and therefore any claim is, by definition, difficult and likely to be contested.

Under the proposed reforms of civil costs with the withdrawal of Legal Aid and changes in the way that No Win, No Fee Agreements would work, Miss M may not be able to get funding or may have to pay some of the legal costs out of her damages

7 The Penningtons clinical negligence team



Tim Palmer, Partner
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Member of Law Society's Clinical Negligence Solicitors Panel and AvMA recommended solicitors panel and an APIL Senior Accredited Litigator. Specialist area - A&E, general practice and child brain injury cases.



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Member of AvMA recommended solicitors panel and Law Society's Clinical Negligence Panel and an APIL Senior Accredited Litigator. Specialist area – heads the team investigating cerebral palsy claims and also specialises in claims involving serious neurological injuries.



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Over 20 years' experience in the fields of clinical negligence litigation and defamation. Member of the AvMA referral panel and the Law Society's Clinical Negligence Panel and adjudicator for the Legal Services Commission.



Alison Johnson, Associate
Member of Law Society's Clinical Negligence Panel. Particular focus on gynaecology and cosmetic surgery claims. Volunteer on the AvMA Helpline.



Emma McCheyne, Associate
Particular focus on fatal claims and general surgery issues.



Justine Spencer, Associate
Special interest in obstetric and gynaecological claims as well as oncology, paediatric medicine and fatal actions. Member of APIL.



Kay Taylor, Associate
Special interest in obstetric and gynaecological claims as well as oncology, paediatric medicine and fatal actions. Member of APIL.



Tim Wright, Associate
Member of the Law Society's Clinical Negligence Panel. Particular interest in consent and ethical issues.



Grainne Barton, Associate
Particular interest in birth injuries, inquests and private hospital cases. Member of the Law Society's Clinical Negligence Panel and AvMA recommended solicitors panel.



Elise Bevan, Solicitor
Particular interest in spinal injury, oncology and cosmetic surgery cases.



Andrew Clayton, Solicitor
Particular focus on ophthalmology and dental claims.



Rebecca Hall, Solicitor
Has advised in relation to a wide range of cases.



Helen Hammond, Solicitor
Has advised in relation to a wide range of cases.



Steven John, Solicitor
Particular focus on orthopaedic and sports injury related claims.



Amy Milner, Solicitor
Has advised in relation to a wide range of cases.



Lucie Prothero, Solicitor
Particular focus on general surgical, orthopaedic and brain injury cases.



Camilla Wonnacott, Solicitor,
Case manager
Particular interest in catastrophic birth injury cases. Member of APIL.



Vicki Kingston, Case manager
Particular interest in head and spinal injury cases. Member of APIL.



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