



## CLINICAL LAW INSIGHT: January 2019

### Quantum

#### Discount rate latest: [Civil Liability Act 2018](#)

The Bill was given Royal Assent on 20 December 2018. Based on the Act's required timescales for setting a new discount rate, the first review will need to commence by 19 March and the new rate come into effect by 6 August 2019. The MoJ has already launched a [consultation](#) on a wide range of topics relevant to setting the new rate including particular investments available to claimants, investments made by them, investment advice available and model investment portfolios.

*Comment: a new discount rate (anticipated to be in the region of 0 to 1%) will have a significant impact on all lump sum awards for claims for future losses, but in particular on claims of maximum severity. For example, a lump sum award for care at £225,000 p.a. for a 10 year old with cerebral palsy and a life expectancy to age 65, reduces from £15,331,500 (based on the current rate of -0.75%) to £12,375,000 or £9,531,000 (based on rates of 0 and 1%, respectively).*

### Liability

#### Trusts should take reasonable care not to provide misleading information on waiting times in A&E

Overtaking the decisions of the High Court and Court of Appeal, the Supreme Court has determined in *Darnley v Croydon Health Services NHS Trust (2018)* that a hospital's duty of care includes taking reasonable care not to provide misleading information about waiting times for clinical review. Further, the duty is owed by both medical and non-medical staff. The Claimant left A&E after 19 minutes having been told that he would have to wait up to 4 to 5 hours to be seen. In fact, he would have been triaged in about 30 minutes. He had suffered a head injury and collapsed at home later that day, suffering brain damage. The High Court and the Court of Appeal found that there was no duty of care and in any event the Claimant should take responsibility for his injuries: they would have been avoided had he waited for treatment.

The Claimant's appeal was allowed as the High Court had determined that the misleading information provided by the A&E receptionist contributed to his decision to leave hospital without waiting. In the circumstances, he was not responsible for his injury. Read our in-depth [Insight](#) on the case and NHS Resolution's [case note](#)

#### Court of Appeal determines that adverse inference should not be drawn merely because witness not present

In *Manzi v Kings College Hospital NHS Foundation Trust (2018)*, the Claimant alleged that 8cm of placenta had been retained following her baby's delivery. If she was right the Defendant had been negligent; if not her discharge without removal was to an appropriate standard. Subsequently, the Claimant returned with an 8cm uterine mass and underwent surgery during which she suffered a haemorrhage leading to a psychiatric injury. She sought to rely on a contemporaneous note which suggested the mass might be placenta. The

Defendant had decided it was not proportional to call the doctor. Appeal dismissed. It was for the trial judge to determine the weight to be attached to evidence as part of a multi-factorial fact finding exercise

*Comment: this is a helpful case for Defendants. Provided there is a proper explanation for a witness' absence the court is less likely to draw an adverse inference, especially if as in this case, the Claimant has taken no steps to trace the witness. Nevertheless, an early decision needs to be made on whether oral evidence is vital for the success of the defence, so that the chances of tracing the witness are maximised.*

### **Employers can be legally responsible for malicious data breaches committed by employees**

The Court of Appeal has confirmed that Morrisons is liable for a rogue employee who leaked the payroll information of thousands of employees. In *WM Morrison Supermarkets PLC v Various Claimants (2018)* the supermarket chain was found vicariously liable despite the data breach being perpetrated from the former employee's home, as his actions formed a seamless sequence of planned events starting at work.

Morrisons have indicated that they intend to appeal to the Supreme Court.

*Comment: this case is the first application to data protection of principles derived from other Torts (e.g. sexual abuse or violence committed by staff). The problem for organisations is the potential for very high numbers of Claimants following a data breach and the increase in the level of damages being routinely claimed. Adding all this to the impact on reputational issues means that Trusts need to ensure that they have robust data protection policies in place to cover any type of breach. Read our in-depth [Insight](#) on the case*

### **Behavioural insights into patient motivation to make a claim for clinical negligence**

NHS Resolution has published [research](#) based on the factors which lead patients to consider a claim for compensation when something goes wrong in their healthcare. It was based on the experience of 728 patients and found that the response following an incident and the handling of any complaint made at the time, featured highly in decisions to make a claim for compensation.

*Comment: the research demonstrates that transparency, candour and saying sorry are critical not only to fulfill statutory and professional duties, but in determining whether a complaint becomes a claim. NHS Resolution has published [guidance](#) on saying sorry and the duty of candour.*

### **Learning from suicide related claims**

NHS Resolution has published a thematic [review](#) of 101 completed claims relating to suicide and attempted suicide, identifying common problems with care and making recommendations to improve service delivery. The review found some examples of good practice, but risk assessments were often inaccurate, poorly documented and not updated regularly enough. Observation processes were inconsistent and communication with families poor. There was evidence of poor quality SI investigations at a local level.

*Comment: the report makes recommendations around specialist referral, systems issues, risk assessments, staff training, safety and learning, SI investigations, involvement of families and carers and staff support around inquests. Some of these themes have featured in other reviews (e.g. NHS Resolution's [5 years of cerebral palsy claims](#) and NHSI's recent [consultation](#) on updating the SI Framework) and are fundamental to patient safety and learning to prevent future mistakes.*

## Inquests

### **Inquests do not have a role in the criminal process**

The families of those killed in the Birmingham pub bombings sought to challenge the Coroner's refusal to call evidence to identify those responsible. In *Coroner for the Birmingham Inquests (1974) v Julie Hambleton (2018)*, the Court of Appeal determined that despite art.2 ECHR being engaged, it was not the role of an inquest to supplement police investigations where there had been no conviction. The statutory questions of who the deceased was and how, when and where he met his death had been answered and the Coroner's conclusion could not be framed so as to appear to determine any question of criminal or civil liability.

*Comment: although this case involved a police investigation, the decision is equally applicable to a healthcare-related death where there has been an externally commissioned Level 3 SI investigation. Even if the investigation reveals failings in the care provided, the inquest cannot be used to supplement that investigation, given the extent of the statutory powers.*

## Advisory

### **Doctors' reflective journals and legal privilege**

Guidance has been issued by the GMC, AoMRC, CoPM&D and MSC in the wake of the case of Dr Bawa-Garba. ['The Reflective Practitioner'](#) confirms that a reflective journal is not privileged from disclosure in civil proceedings for damages. It includes guidance on writing reflections, including anonymisation, openness and honesty and the value of team reflection

*Comment: care needs to be taken when anonymising data. Removal of names and other personal details is not necessarily enough. The guidance refers to the Information Commissioner's guidance which states that not only should data not of itself identify any individual, but that 'it is unlikely to allow any individual to be identified through its combination with other data'*

### **Health Ombudsman seeks regulatory powers**

It has been revealed that the PHSO intends seeking powers to allow investigations to be launched without complaint and for the organisation to become a complaints standards authority with powers to regulate the NHS. An independent [review](#) has described outdated legislation as limiting the service's ability to do more in terms of improving public service. 'Own initiative' powers are the norm in Europe.

*Comment: a wider remit for the PHSO is likely to mean additional work for healthcare organisations. However, if more complaints can be resolved before a patient sees a solicitor both organisations and patients are likely to benefit. Power to initiate investigations could lead to a need for fewer public inquiries. The devil is likely to be in the detail and in a sector already heavy with regulation, it will be interesting to see how any increased powers fit with the current CQC/NHSI regimes.*

### **Learning from Gosport**

In its [response](#) to the Gosport Independent Panel, the government has declared its intention to legislate, requiring Trusts to submit an annual report of how they have dealt with staff patient safety concerns. Continuing the openness and transparency theme, the CQC will be asked to review how it regulates compliance with the duty of candour. Following the introduction of Medical Examiners in April 2019, every death will now be scrutinised.

*Comment: it looks as if the annual report requirement is the means by which the government will give teeth to 'freedom to speak up'. The report will create an additional administrative burden for Trusts, but should enhance patient safety and enable*

*shortcomings in care to be addressed early. At the moment the CQC requires healthcare organisations to ensure that good governance is in place to encourage and support staff to be open with patients when things go wrong. NHS Resolution has produced [guidance](#) on the duty of candour and how to say sorry.*

### **Investigating and learning lessons from stillbirth**

A progress [report](#) has been published as part of the RCOG's flagship safety and learning project 'Each Baby Counts'. It covers 1123 babies born in 2016 who were stillborn, died as neonates or suffered severe brain injury as a result of incidents during term labour. 124 babies were intrapartum still births, 145 early neo-natal deaths and 854 had sustained severe brain injuries. The stillbirth rate (11%) remained static from 2015. MBRRACE-UK's larger study of stillbirths in 2016 (not limited to the intrapartum period) drew a similar conclusion on the stillbirth rate, but revealed that fewer than 7% of stillbirths were discussed with a coroner /procurator fiscal and only 1.2% underwent a coroner's post mortem.

*Comment: in 2017 the government announced that it would look into enabling full term stillbirths to be covered by coronial law. If all term stillbirths are accepted for investigation, the workload for coroners and healthcare organisations will increase at a time when the system will be stretched by the likely increase in the number of deaths reported following the introduction of medical examiners in April 2019.*

### **New [guidance](#) to support doctors making decisions about Clinically Assisted Nutrition & Hydration for adults without capacity in England & Wales**

Joint guidance has been published by the BMA and RCP and endorsed by the GMC. It reflects the decision in *re Y [2018] UKSC 46* which established that there is no requirement to seek court approval to withdraw CANH in adult patients with a prolonged disorder of consciousness where the clinicians and the family are agreed it is in the patient's best interests, provided relevant processes have been followed. Guidance is provided on: legal context; decision-making and consultations; conscientious objections; clinical and best interests assessments and 2<sup>nd</sup> opinions; managing disagreement & uncertainty; record keeping; and governance & audit.

*Comment: re Y enables withdrawal of CANH in patients with a prolonged disorder of consciousness without court order where the family and clinicians are in agreement and the provisions of the Mental Capacity Act 2005 and relevant guidance have been followed and specialist medical opinion obtained, including senior. independent external opinion. However, an application to court should be made if the decision is finely balanced or there is a difference of medical opinion. In any case involving a child a court order must be obtained. Read our in-depth [Insight](#) on the re Y case*