Bevan Brittan

Claims Online

March 2020

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Welcome to Bevan Brittan's Clinical Risk's Spring 2020 edition of Claims Online. In this edition we take a look at a case where a medical expert was ordered to pay legal costs, the recent NHS Staff Survey, some common themes of bowel cancer claims, as well as a round-up of case law and news.

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Cost consequences for a negligent expert:

Thimmaya v Lancashire NHS Foundation Trust (1) and Mr Firas Jamil (2)

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Introduction

This case is a sobering reminder of the consequences for an expert failing to comply with his or her duties under Part 35 of the Civil Procedure Rules (CPR). Mr Firas Jamil, expert spinal consultant, was ordered to pay a wasted costs order in the sum of £88,801 after the court concluded that he had failed in his duties as an expert.

The case

The claimant brought a clinical negligence claim against Lancashire NHS Foundation Trust, relying upon an expert opinion from Mr Jamil. During the trial, Mr Jamil admitted that he did not know what the breach of duty test was for clinical negligence. The claimant discontinued her claim during the trial, but the defendant, having incurred significant costs defending this claim, sought a third party costs order against Mr Jamil. At the third party costs hearing, according to the judgement, Mr Jamil accepted, with hindsight, that he was not fit to give expert evidence at the time due to mental health problems. He gave evidence that whilst he was aware of the correct legal tests (Bolam/Bolitho) he had not been able to recall them because he was suffering an adverse psychiatric reaction to being cross–examined. From November 2017 Mr Jamil had been on sick leave and then retired in 2018 from clinical practice. He had however continued with his medico-legal work and had not told his instructing solicitors that he was ill.

The judge accepted that Mr Jamil did not know the correct legal tests (she rejected his explanation that he had forgotten the test). She criticised Mr Jamil for not taking sick leave from his medico-legal work in November 2017 (as he did with his clinical work) when he knew he was ill, or at least informing the claimant's solicitors that he was ill.

The judge said that in order to make the third party costs order that the defendant sought, she had to be satisfied that Mr Jamil's conduct was "improper, unreasonable or negligent". Whilst the judge accepted that the bar was set very high in terms of finding that an expert had acted negligently, and that the test would only be satisfied in exceptional circumstances, she was satisfied that Mr Jamil had failed "comprehensively" in his duty to the Court. The judge accepted that Mr Jamil's improper, unreasonable and negligent conduct had caused the defendant to incur significant, unnecessary costs. The court ordered Mr Jamil to pay part of (but not all of) the defendant's costs of £88,801 (which were the costs that the Defendant had incurred since November 2017 when Mr Jamil went on sick leave).

Conclusion

Mr Jamil's conduct went far beyond that of an expert misapplying the legal tests, straying beyond his area of expertise, or simply giving an opinion that was flawed, or even wrong. Mr Jamil had expressed a view without even knowing what the test was, and had concealed from his solicitors that he was not well enough to work clinically.

Whilst this is an exceptional case, it acts as a warning to experts that there can be consequences where their conduct falls so far short of what is expected that it amounts to negligence.

Before accepting instructions to act as a medico-legal expert in a civil claim, it is imperative that all experts understand their obligations and comply with the requirements of Part 35 and the current Practice Direction to Part 35. Experts who are too ill to work clinically must consider very carefully whether they are well enough to continue with their medico-legal work, and at the very least should notify the solicitor of ill-health that is likely to affect their work.

NHS Staff Survey

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The NHS Staff Survey 2019 was completed by 569,440 members of NHS staff, which is a response rate of 48%. The results indicate that morale has improved, although many staff have concerns about issues including health and wellbeing, discrimination and abuse.

Summary

Overall almost two thirds of staff (63.3%) would recommend the NHS as a place to work. Despite this, only half (48%) were satisfied with the extent to which their work is valued, although this figure increased to 73.3% when staff responded to the more specific question of how their manager values their work, rather than the overall organisation. Fewer than 4 in 10 (38%) were satisfied with their level of pay and over half (55.9%) work extra unpaid hours on a weekly basis. Only 59.5% of staff said they always or often looked forward to going to work. All of these figures have improved since 2018.

In relation to the care provided, 81.1% were satisfied with the quality of care they provide, although this drops to 68.5% when staff were asked whether they are able to deliver the care they aspire to. 71.4% said they would be happy with the standard of care provided for a friend or relative needing treatment. Again, all these figures are increased when compared with responses to the 2018 survey.

Health and wellbeing

Almost a third of staff (28%) experienced musculoskeletal problems as a result of work activities in the past year and over 40% reported feeling unwell as a result of work related stress. This latter figure has been steadily increasing over the past few years. Less than a third of staff (29.3%) said that their Trust definitely takes positive action on health and wellbeing, although rather worryingly, 56.6% said that they had gone to work in the last three months despite not feeling well enough to perform their duties.

Bullying and harassment

Bullying and harassment remains a significant issue, with almost a third of staff having experienced at least one incident of bullying, harassment or abuse from patients, relatives or other members of the public in the past year. 14.9% have experienced physical violence, which equates to almost 85,000 staff. The figures are much higher for staff at Mental Health/ Learning Disability Trusts, at 20.2%, and Ambulance Trusts, where over a third of staff have experienced physical violence in the past year.

Discrimination

Discrimination appears to be an increasing issue, with 7.2% of staff having personally experienced discrimination from patients or other members of the public in the past year and 7.7% having experienced discrimination from managers or colleagues. Whilst the latter figure is an improvement on 2018, it remains higher than in 2015 and 2016. Discrimination from patients or other members of the public has continued to rise year on year.

Ethnic background is reported to be the most common reason for discrimination, although incidents have been reported relating to gender, age, disability, religion and sexual orientation.

Equal opportunities

The results are more positive in relation to equal opportunities, with 83.9% of staff feeling that the NHS acts fairly with regard to career progression, although this drops to 71.2% when only looking at responses from BME staff.

Conclusion

With staff recruitment and retention likely to be on the agenda for a while yet, the staff survey is likely to provide a useful insight in terms of what is important to frontline staff. It is perhaps unsurprising however that staff want to be valued and well-paid for the work that they do, and work in an environment where they feel safe and treated fairly.

Early diagnosis and colorectal claims

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Bowel cancer is the fourth most common cancer in the UK. Over 34,000 new cases of colorectal cancer are diagnosed in the UK each year. Although its prevalence has been linked to age (over 45), poor diet (high in fat, low in fibre), family history (of Familial Adenomatous Polyposis or Hereditary Non-Polyposis Colon Cancer) or a history of severe ulcerative colitis or Crohn's disease, very little is known about its causes.

A delay in referring a patient with suspected colorectal cancer could shorten that patient's life. Between January 2010 and March 2015, the MDU opened 453 files where a complaint or claim arose from an alleged delay or wrong diagnosis of colon/bowel cancer.

Colorectal cancer in primary care – when to refer?

The most common symptom of colorectal cancer is a change in bowel habits. These include:

- increasing constipation
- alternating bouts of constipation and diarrhoea
- blood or mucus in the stools
- a sensation of incomplete emptying of the bowels

NICE guidelines published in 2015 for Suspected cancer: recognition and referral, recommends referring adults for an appointment within 2 weeks, using the suspected cancer pathway referral, if:

- they are aged 40+ with unexplained weight loss and abdominal pain or
- they are aged 50+ with unexplained rectal bleeding or
- they are aged 60+ with:
    - iron-deficiency anaemia or
    - changes in their bowel habit, or
- tests show occult blood in their faeces.

A referral under the 2-week wait rule should also be considered:

- in adults with a rectal or abdominal mass; and
- in adults under 50 with rectal bleeding and any of the following unexplained symptoms or findings:
    - abdominal pain
    - change in bowel habit
    - weight loss
    - iron-deficiency anaemia.

Claims arising from delayed diagnosis

Where a claim for compensation is made following a delay in the diagnosis and treatment of cancer which resulted in the early death of a patient, there is usually a claim for the following types of damages:

- a statutory bereavement award;
- funeral expenses;
- pain and suffering that the deceased would have avoided with earlier treatment;
- any loss of earnings the deceased may have incurred as a result of the delay;
- loss of financial dependency that the family would have benefitted from if the deceased had lived longer and continued earning;
- loss of services dependency in respect of services that the deceased would have provided around the home had he /she lived longer.

For such a claim to succeed, the claimant must establish both of the following:

- Breach of duty – there was a delay which no responsible body of opinion would consider reasonable;
- Causation – on the balance of probabilities, the delay was causative of a quantifiable difference to the patient's life, e.g. death, a shortened life expectancy, and/or pain and suffering endured during the delay. Alternatively, where there were multiple indivisible causes (negligent and non-negligent), the delay materially contributed to a quantifiable difference to the patient.

Conclusion

Early diagnosis of bowel cancer increases a patient's chances of survival. If diagnosed late, it is harder to treat and places a higher financial burden on the NHS. Documenting a careful history (including duration of symptoms), any negative findings and confirmation that the patient has been advised to return if symptoms do not improve (safety netting advice) could prove invaluable in defending a claim for negligence.

Case Round-up / News

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Statements of Truth – important CPR changes on the way...

The Master of the Rolls has issued the 113th Update to the Civil Procedure Rules: https://www.justice.gov.uk/courts/procedure-rules/civil/pdf/update/cpr-113th-pd-update.pdf. This document makes a number of amendments to Practice Direction 22 (Statements of Truth) and Practice Direction 35 (Evidence) which will come into force on 6 April 2020.

With respect to Statements of Truth verifying Statements of Case and applications, Paragraph 2.1 of Practice Direction 22 will be amended to include a warning that contempt of court proceedings may be brought against anyone who makes a Statement of Truth without honest belief. The new wording is as follows:

'[I believe] [the (claimant or as may be) believes] that the facts stated in this [name document being verified] are true. I understand that proceedings for contempt of court may be brought against anyone who makes, or causes to be made, a false statement in a document verified by a statement of truth without an honest belief in its truth."

For Statements of Trust verifying witness statements, paragraph 2.2 of Practice Direction 22 will be amended as below:

'I believe that the facts stated in this witness statement are true I understand that proceedings for contempt of court may be brought against anyone who makes, or causes to be made, a false statement in a document verified by a statement of truth without an honest belief in its truth.".

In accordance with a new paragraph 2.5, Statements of Truth must be dated with the date on which they was signed.

Diagnostic tests and informed consent – Mordel v Royal Berkshire NHS Foundation Trust [2019] EWHC 2591

The claimant, a Polish native who spoke reasonably fluent English, became pregnant. She initially agreed to screening tests for Down's syndrome, but at a later sonography appointment, when asked whether she wanted the Down's syndrome screening, she answered 'no'. The contemporaneous records note that Down's syndrome screening was declined.

The claimant gave birth to a child with Down's syndrome. She sued the Trust, claiming that had she had not understood that screening had been offered and declined. She said that had she appropriately consented, she would have undergone the screening (which would have revealed Down's syndrome) and terminated her pregnancy.

Mr Justice Jay found that even though the midwife and sonographer had made informed offers of screening, informed consent had not been achieved. Jay J found that the sonographer was under a duty to take reasonable steps to ascertain whether the claimant's refusal was sufficiently informed. Jay J emphasised that the steps required to secure an informed decision were context-specific but the overall objective is to ensure that the patient understands the 'essential elements and purposes of' the procedure in question. Jay J concluded that the midwife and sonographer failed in their duty to achieve informed consent.

This judgment demonstrates that a simple record of the patient's decision, or a one or two word summary of the outcome (e.g. "declined" or "accepted") is unlikely to be sufficient evidence by itself of informed consent. The health practitioner responsible for the consenting process should ensure that not only has the relevant information been relayed to the patient, but that it has been understood. Expanding on the duty laid down in Montgomery, this case suggests that clinicians are also under a duty to facilitate patients' comprehension so they are empowered to make a truly informed choice. We suspect that it will be challenging for clinicians to evidence that not only has a patient received all the information they need to make an informed choice, but that they have properly understood and digested that information.

Clinical negligence costs: taking action safeguard NHS Sustainability – new analysis issued

Professor Tim Draycott, Vice President of the Royal College of Obstetricians and Gynaecologists, has published a paper in the BMJ, warning against the NHS's current litigation trajectory: https://www.bmj.com/content/368/bmj.m552. The NHS spent £2.4bn in clinical negligence claims in 2018-2019. Professor Draycott and his colleagues call on the government to shift the NHS's focus from litigation to prevention, citing a number of measures which they believe will better achieve long-term sustainability. The analysis explains that investing in staffing and infrastructure, enhancing the learning focus and improving processes are just some of the ways in which harm (and therefore litigation costs) can be avoided.

New legal duty of disclosure to non-patients – ABC v St George's NHS Trust &Ors [2020] EWHC 455 (QB)

The claimant's father had been diagnosed with Huntington's disease whilst detained under the Mental Health Act. The team of doctors treating the claimant's father were aware that the claimant was pregnant and they wanted to inform her of the disease but her father refused to consent to the disclosure. A number of years later, the claimant discovered that she too had the Huntington's gene.

She brought a claim against the Trust, arguing that the psychiatrists and other health care professionals (HCP) owed her a legal duty to disclose confidential information which placed her at risk of serious harm.

Mrs Justice Yip found that the HCPs did owe the claimant a legal duty to balance her interest in being informed of the genetic risk against her father's against the wider public's interest in maintaining confidentiality. Mrs Justice Yip held that such a duty only arises in circumstances where the disclosure would prevent serious harm and the HCPs have a close relationship with the person who is at risk. The claimant's case failed because Yip J found that the HCPs had in fact carried out such a balancing exercise. However, the judgment is significant because it codifies the duty of disclosure to non-patients. It is important to appreciate that whilst some specialist bodies already had published guidance advising on such disclosures, this guidance is now enshrined in law and applicable to all HCPs.

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