

REDUCING LEGAL COSTS IN CLINICAL NEGLIGENCE CLAIMS

A pre-consultation by the Department of Health



A response by the Association of Personal Injury Lawyers
21 August 2015

The Association of Personal Injury Lawyers (APIL) is a not-for-profit organisation with a 25-year history of working to help injured people gain access to justice they need and deserve. We have around 3,700 members, committed to supporting the association's aims and all of whom sign up to APIL's code of conduct and consumer charter. Membership comprises mostly solicitors, along with barristers, legal executives and academics.

APIL has a long history of liaison with other stakeholders, consumer representatives, Governments and devolved assemblies across the UK with a view to achieving the association's aims, which are:

- To promote full and just compensation for all types of personal injury;
- To promote and develop expertise in the practice of personal injury law;
- To promote wider redress for personal injury in the legal system;
- To campaign for improvements in personal injury law;
- To promote safety and alert the public to hazards wherever they arise;
- To provide a communication network for members.

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Preliminary points raised in the letter to stakeholders accompanying the pre-consultation document (the covering letter).

1. This pre-consultation is promoted as part of the Government's aim to address the issue of 'better litigation.' In our view, the proposals will have the opposite effect: preventing patients with avoidable injuries from being compensated for the NHS's negligence.
- 1.1 The NHS only pays costs to claimants when it has negligently injured a patient and either loses or believes it will lose the ensuing claim for compensation. These costs are incurred investigating the merits of the claim and (in many cases) proving that the medic is liable in face of a denial of liability.
- 1.2 Rather than addressing 'better litigation', the proposals all relate to the fact that the NHS does not want to pay for its avoidable mistakes. Stephen Walker, who retired in 2012 after 16 years as chief executive of the NHSLA said, "*if you stopped getting things wrong so consistently then you wouldn't have to pay in the first place...compensation ... is paid after all only to a minority of patients who are being harmed because at the end of the day their man [the defendants' 'man'] did it... I can guarantee you that I never paid a penny to a victim who wasn't desperately in need of the funds.*"¹
- 1.3 A relatively low percentage of those who are injured as a result of hospital mistakes instruct a lawyer to pursue a claim.² The number of claims is a reflection of the increasing number of incidents which these proposals do nothing to address. The focus should be on the injured and finding a way to avoid the injuries at all and to resolve claims with less stress for those who have them, rather than setting arbitrary limits on the legal costs they can recover. We recommend that the DoH examines the 'Michigan Model' of early disclosure and offer of compensation³, along with a commitment to learning from mistakes as soon as possible. See paragraphs 7.8 – 7.10 below.

¹ Dyer, C, BMJ 2013;346:f978doi: 10.1136/bmj.f978 (published 19 February 2013).

² In the six months from October 2013 to March 2014, 778,460 incidents in England were reported (<https://www.england.nhs.uk/2014/09/24/psa-improving/>) whereas the total number of clinical negligence claims for the 12 month period 2013-14 reported to the Compensation Recovery Unit was 14,249. (CRU Freedom of Information data supplied to APIL 27 July 2015). Just less than nine per cent of patient safety incidents can be said to lead to compensation claims.

³ *The University of Michigan's Early Disclosure and Offer Program* by Richard Boothman, JD and Margo M. Hoyler. <http://bulletin.facs.org/2013/03/michigans-early-disclosure/#> Bulletin of the American College of Surgeons. 2 March 2013.

The available data managed by the NHSLA

- 2.1 Claimant legal costs itemised on the first page of the covering letter are artificially inflated: they include ATE premia and success fees (both of which was recoverable from the paying party pre-LASPO) VAT, expert fees, and court fees. These figures have been taken from claims which settled prior to the commencement of the Legal Aid, Sentencing and Punishment of Offenders Act 2013 (LASPO) which will affect clinical negligence claims costs. It is inevitable that pre-LASPO costs will be higher than similar case costs being conducted where LASPO has begun to take effect.
- 2.2 The NHSLA Annual Report 2014/15 reveals that in fact, despite the claims to the contrary in this pre-consultation, reported claims volumes for clinical cases have *fallen* by 3.7 per cent between 2013/14 and 2014/15⁴. These figures, of course, relate to post-LASPO claims. Additionally, expenditure on clinical claims has *fallen* by 0.6 per cent between 2013/14 and 2014/15⁵.
- 2.3 A Ministry of Justice analysis of a sample of payouts in no-win-no-fee cases in 2010-11 suggests that around half the legal costs (the fee paid for the claimant's legal representation) paid in cases lost by the NHS were for success fees (non-recoverable since LASPO) and insurance premiums (non-recoverable in part since LASPO).⁶
- 2.4 Defendant legal costs are in reality much higher than the figures released by the NHSLA: the covering letter's statement that claimant costs are six times higher than defendant costs is grossly misleading. The figures recently released by the NHSLA relating to defendant costs failed to include the legal costs incurred within the NHSLA by its own lawyers and those of individual NHS Trusts' in-house legal teams. Only the costs of the law firms which the NHSLA instructs externally are compared with claimant costs.

Scope of the proposals

- 3.1 This pre-consultation is being run by the Department of Health and is stated to be about saving the NHS money, but the rules appear to relate to all clinical negligence claims and are not confined claims involving the NHS. This must be incorrect.

⁴ From 11,945 in 2013/14 to 11,497 in 2014/15 (see Figure 18, page 18).

⁵ From 1.0512billion in 2013/14 to 1.0444billion in 2014/15 - a fall of £6.8million (see Figure 10, page 14).

⁶ Dyer, C. "No win, no fee" system is proving costly to NHS, report says. *BMJ* 2012;344:e777

- 3.2 Why should private doctors have the benefit of a fixed costs scheme ostensibly designed to save the NHS money? We say this particularly in connection with the MDU whose behaviour is particularly problematic for claimants and their representatives. The MDU rarely admits to anything which prolongs the life of the claim, running up costs for all concerned, yet limiting the costs for which the MDU is liable will not save money for the NHS.
- 3.3 There are also clinical negligence claims against the MOD and against other non-NHS clinicians practising in England and Wales. From the draft rules issued by the CPRC so far and the pre-consultation document, it would seem that *all* clinical negligence claims are to be included, regardless of who has perpetrated the negligence.
- 3.4 On what basis can it be appropriate to legislate to protect private healthcare and its doctors? In our view, this is an illegitimate extension of government policy.

Conflict of interest

- 3.5 Given that the Department of Health is the negligent party when a claimant pursues a successful clinical negligence claim, then it should not seek to fix costs or to set the level of fixed fees. If they are introduced, an independent body should assess fee and expert fee levels, to be reviewed annually.

Basis of our response

- 3.6 The association opposes the implementation of fixed fees for clinical negligence claims, for the many reasons set out in our response below. However, we are responding to this pre-consultation and putting forward reasonable views and suggestions as we recognise that should fixed fees be imposed upon the profession, they should be as fair and equitable as possible and relate to all parties involved in these claims, not just claimants.

Q1

The Government proposes to introduce fixed recoverable costs for all cases where the letter of claim is sent on, or after, the proposed implementation date of 1st October 2016. Although this could affect cases where solicitors are already instructed but a letter of claim has not been sent, it leaves at least 12 months for such claimants to submit a letter of claim and so avoid the application of the proposed fixed recoverable costs regime.

*1. Do you agree with this proposed approach to the transitional provisions? Yes or No
If your answer is no, please explain how you consider the transitional provision should be set, having regard to the need for the effect of fixed recoverable costs to apply as soon as practicable.*

- 4.1 We do not agree with the proposed approach, as it does not allow for the fact that a great deal of time is necessarily spent investigating clinical negligence claims before the letter of claim can be sent. The patient, who often knows nothing about what happened, bears the full burden of proving both breach of duty and causation. Unless liability is admitted at the outset, this is an onerous, time-consuming and necessarily expensive task.
- 4.2 The implementation date should instead be on or after the date on which the cause of action arises – i.e. date of injury on or after 1 October 2016. Any other date becomes unlawfully retrospective legislation in effect. The typical clinical negligence letter of claim is sent a long time after the client's initial instruction: there is a great deal of work which needs to be done between the date of first instruction and the letter of claim in order to properly investigate whether there is a valid claim. For this reason, the proposed implementation date would inevitably affect claims being taken on now under a completely different business model where clients have already been advised on their costs options.
- 4.3 For example: a client consults lawyers for the first time at Christmas 2015 for a potential claim. His clinical negligence lawyers are unlikely to have received all the medical notes from the various hospitals/GP and obtained the necessary expert evidence before the proposed implementation date (unless it is a very straightforward case). As a result they will not be ready to send a letter before claim by that date. The client will have already signed a conditional fee agreement which is contractually binding which will have to be honoured. The client will have thought he had agreed the extent of any sums which may be deducted from his damages, but those sums will prove to much more under the new proposed scheme. We don't know what the fixed costs are yet. Practitioners may not know until April 2016 and they simply will not be able to properly advise the client in those circumstances.

Q2

The Government considers that the Fixed Recoverable Costs (FRC) scheme could be applied in clinical negligence to cases up to a value of £250,000 in damages and will apply both to pre-issue costs and post-issue, pre-trial costs.

2. Up to what value of damages do you think should be applied to the FRC regime?

- a. Up to £25,000*
- b. £25,0001 - £50,000*
- c. £50,000 - £100,000*
- d. £100,000 to £250,000*

Why do you believe this to be the right threshold?

- 5.1 In our view, the fixed recoverable costs (FRC) scheme should only apply where the defendant admits liability in full in the letter of response.
- 5.2 The effect of earnings should not be forgotten when looking at the value of medical negligence claims. Fixed fees based on the value of the claim will disadvantage those who earn less. A claim for loss of earnings will have a noticeable effect on the final value of the claim. See **case study 1** in our appendix, page 15 onwards.
- 5.3 Additionally, for example, if the injured person can afford to pay for care at home after the incident, then this can be claimed back in the litigation. Claimants who cannot afford to pay for care before their claim is settled cannot make a claim for the cost of that care, which is then reflected in the final amount of the compensatory award.
- 5.4 Complexity in medical negligence claims does not necessarily reflect the value of that claim. In contrast to RTA and PL claims for example, even establishing liability will turn upon expert evidence in virtually all cases.
- 5.5 Furthermore, complexity is usually compounded by defendant behaviour, which is why we propose in paragraph 5.1 above that fixed costs should only apply where the defendant admits liability in full (both breach of duty and that this caused the injury). We do not see why a defendant who refuses to accept liability and who is either found liable by a court, or who admits liability late in the claim process (when attempts by the claimant to prove liability have run up substantial costs), should benefit from a fixed costs regime.

5.6 We are asked to comment on bands based on value of damages. We do so, despite our view being as set out in the preceding paragraphs.

Claims valued up to £25,000

5.7 We do not approve of the proposed value-related bands but we can see the rationale for a £25,000 limit, because there are other schemes already in existence which have the same limit: it is the fast track civil claims limit and it limits the effect of fixed costs to those injuries most likely to resolve within 12 months of the incident.

5.8 Even within the cohort of claims up to £25,000 in value certain cases should be exceptions to the FRC regime: fatal claims, still-births, claimants lacking mental or legal capacity, claims where the claimant has a very short life expectancy.

5.9 APIL has always been prepared to discuss fixed costs for minor claims. Indeed, we worked with the NHSLA in 2013 on a proposed low value clinical negligence claim scheme until the NHSLA refused to negotiate further.

5.10 Claims valued at more than £25,000 involve life changing injuries and putting fixed costs on those cases reduces the quality of the access to justice for those injured people, by limiting the amount of work the claimant representative can afford to do to prove liability and/or causation, for example. This can be avoided by ensuring the fixed costs regime applies only to cases where the defendant admits liability in accordance with the pre-action protocol.

5.11 In the other existing low value fixed fee regimes (RTA, EL, PL) the 'low value' is set at £25,000 yet in this consultation, that figure is dwarfed by the sums on which we are being consulted: £250,000 is not a low value claim. For example, using JSB guidelines, a young male patient who suffers medical negligence which leaves him totally impotent and suffering a complete loss of sexual function and sterility will be entitled to damages in the region of £119,000. This is a life changing injury – it is not 'low value' within any interpretation of the meaning of those words.

5.12 Claims valued at between £25,000 and £50,000 do form a large cohort. There is a big jump in the number of claims within this band. However, these claims are often complex, requiring several experts. See for example our **case study 2** for a description of a failure to diagnose cancer claim. Even Lord Justice Jackson in his

proposals for reforming civil claims did not press for fixed costs in claims valued at more than £50,000. He felt it was inappropriate.⁷

Q3

The Government is also concerned with the number and cost of expert reports obtained in lower value cases, which can add to the disproportionate costs incurred. The Government is therefore considering a proposal to cap experts' fees at a maximum recoverable sum which fairly reflects the likely number and cost of experts' reports needed in such cases. Under this proposal, the cap would apply to all reports both on liability/causation and on quantum/diagnosis.

3. Do you agree that capping experts' fees in this way would be a useful way forward? Yes or No

If your answer is no, how would you propose that the use of experts and the cost of their reports might best be managed, particularly before the first case management conference?

- 6.1 If not doing so already, the Department of Health should consult with medical expert groups on this issue.
- 6.2 If there is to be capping of expert fees, then they should be capped for both claimant and defendant. There should be a level playing field with both sides of the litigation process equally restrained on the *number* and *cost* of their experts.
- 6.3 In addition, we believe that the experts should be prepared to accept the capped fees, to share the effect of the Government policy. This has not been the case in the past: medical experts continue to demand their full fee, even when it has been capped either by the legal aid rate or reduced by the court upon costs assessment at the end of the claim.

⁷ Extracts from Lord Justice Jackson's Final Report, *Review of Civil Litigation Costs*, December 2009:

- "4.1 I do not recommend that any general scheme of fixed costs be introduced into the multi-track at the present time. However, this question should be reconsidered after experience has accumulated of fixed costs in the fast track and capped scale costs in the PCC.
- "5.8 Decision in principle. I have carefully considered the competing arguments. My conclusion is that all costs for personal injuries litigation in the fast track should be fixed." (*Clinical negligence claims were excluded from this decision. They were the subject of a separate chapter in his report*).

- 6.4 Clinical negligence claims used to have the benefit of legal aid in certain cases, but expert fees were capped, so we already know from those claims that it proved very difficult, sometimes impossible, to find appropriate experts who were prepared to work for the legal aid capped expert fee. Junior medics had to be instructed instead, affecting the quality of the report received. Yet, at the same time the NHS defendant was not so constrained, did not change its behaviour and could outspend (and so 'out-gun') the claimant, using senior medics for their opposing reports.
- 6.5 The role of medical experts is different in medical negligence cases. They are being asked to comment upon whether or not professional colleagues have been negligent and so harmed their patients. Doctors cannot be compelled to provide medical reports on the standard of care provided by their colleagues. They do so as part of their private practices. Most good, independent, medical experts in medical negligence cases do not have any shortage of other private work. If they cannot charge their private rates for acting as experts in medical negligence cases, they will do other private work instead. The experts who will be prepared to cut rates will, by and large, be those who are not as eminent or as experienced. The quality of expert evidence will fall, thus affecting access to justice and also imposing an additional burden on judges.

Complexity vs. value

- 6.6 The assumption that the complexity of the claim (and therefore the number/nature of experts required to prove liability, causation, quantum) equates with the value of the claim is a common mis-understanding. We have also referred to this misapprehension in our answer to question 2 (page 7) above: in contrast with straightforward RTA claims for example, where liability is usually reasonably obvious, this is very rarely the case in clinical negligence claims, where the claimant must conduct liability investigations, usually requiring expert advice. See **case study 1** in our appendix. This is exacerbated when the defendant (such as the NHSLA) denies liability throughout the life of the claim. See **case study 3** in the appendix for an example.

Q4

Our provisional thinking is that the fixed recoverable costs and ancillary rules would be sufficient to control behaviour on both sides and that no further sanctions would be required than currently appear in the rules for fixed recoverable costs generally. We consider that to this extent, the behaviour issues likely to be encountered in introducing fixed recoverable costs for clinical negligence will be no different from those encountered in other personal injury claims.

4. Do you agree that no special provisions will be required to control behaviour in clinical negligence claims? Yes or No

If no, what sort of Rules do you feel would assist in controlling behaviour alongside FRCs?

- 7.1 If defendants consistently acted sensibly and fairly, then there would be no need for rules, but in our view, there needs to be a complete culture change at the NHSLA and NHS. While claimant lawyers have evolved to deal with new claims regimes, the NHS and NHSLA have not evolved at all. Lord Justice Jackson identified various failings, such as the failure of NHS Trusts to notify the NHSLA when a letter of claim is received or the defence team fails to come to grips with the issues until too late, for example.⁸
- 7.2 Claimant's legal costs only arise in winning cases where there has been negligence by the NHS. From then on, the main drivers and control of how the claim progresses are in the hands of the NHSLA and the NHS Trusts. It is important that the NHS rigorously enforces the new duty of candour. We believe that by doing so, an increasing number of claims will be investigated with the benefit of clear admissions of breach of duty from the NHS Trust from the outset: this will reduce expert costs, allowing the claim to focus on causation only in many cases. The NHSLA should also ensure that that it abides by the new clinical negligence pre-action protocol. In the new protocol there is an innovation: the *letter of notification*, which is designed to speed up the investigations process and give defendants the opportunity to make earlier admissions, thereby saving costs. It has only just been introduced and the impact of it has yet to filter through into costs savings but there is potential for significant costs savings where defendants choose to investigate cases at an earlier stage and make earlier admissions.
- 7.3 The problem for claimant lawyers is that the medical defendants' representatives (NHSLA, MDU, MPS) quite often will not make early admissions and the claim drags

⁸ See Lord Justice Jackson's Final Report: *Review of Civil Litigation Costs*, December 2009. Part 4, paragraph 4.2
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on for years as the claimant runs up costs and instructs experts to prove that the medic was negligent. As the defendants (particularly the NHSLA) have access to experts who can provide an opinion in-house, it must know that it is liable much earlier than its later admissions would suggest. See **case study 3** in our appendix for an example of a seriously injured patient whose claim lasted five years until the NHSLA finally made a reasonable offer to settle.

- 7.4 We know from our Welsh practitioner members that the Welsh NHS Redress scheme operating in the Principality since 2011 has not evolved as anticipated by the Welsh assembly. That appears to be because the concerns teams within individual Health Boards have not received sufficient training and/or are under resourced. Welsh claimant practitioners report that many cases have to leave the scheme, usually due to severe delays in the NHS response and its gross undervaluation of claims. See **case studies 4 a & b** in our appendix.
- 7.5 As it is, the scheme proposed here by the DoH offers no incentive to settle early. Quite the opposite: without controls on behaviour the defendant will be allowed to stall and the claimant's advisors will be 'outspent'. There is no incentive for the defendant to make an early admission or to settle pre-proceedings.
- 7.6 The proposals fly in the face of everything all parties have been working towards for years: early notification of the claim to the NHSLA, the new clinical negligence pre-action protocol which promotes early engagement, the duty of candour to encourage openness within the NHS. Patients deserve to be told first of all what has gone wrong and they deserve for that wrong to be put right. Not only does the NHS need to act early and decisively to settle meritorious claims, it also needs to learn the lessons from what went wrong as soon as possible and not years down the line when the claim is finally paid out. These proposals offer no incentives for any of that.

The need for a culture change

- 7.7 For an example of the culture change required within the NHS, obstetrics claims (i.e. maternity cerebral palsy/ brain damage) provide an instructive case in point. Obstetric-related injuries represent 41 per cent of the value of clinical negligence claims received in 2014/15 by specialty⁹. As such, obstetrics represent an area where additional learning and safety would make a huge difference to the NHS

⁹ NHSLA Annual report 2014-15: Figure 22, page 20.

litigation bill. Yet the NHS still receives broadly around 200 maternity cerebral palsy/brain damage claims a year¹⁰ and this hasn't changed since 2006/07.

7.8 An example of a programme which has successfully improved patient safety and transformed the costs of avoidable medical mistakes, can be found in the 'Michigan Model': In late 2001 and early 2002, the University of Michigan Health System (UMHS) changed the way the health system responded to patient injuries, applying what has become known as the Michigan Model and has since been described as an early disclosure and offer (D&O) program.

7.9 The program demonstrated that the D&O approach has successfully cut the costs associated with liability claims by creating the safest possible environment for patients. Moving away from a 'circle the wagons' model where the traditional 'deny and defend' modus was in operation, the Model resulted in fewer claims, fewer lawsuits, and lower liability costs.

7.10 Researchers reviewing the programme found that the rate of new claims at UMHS decreased from approximately seven per 100,000 patients to fewer than five. The rate of lawsuits declined from 2.13 suits per 100,000 patients per month, to roughly 0.75. The median time from claim to resolution dropped from 1.36 to 0.95 years. Cost rates due to total liability, patient compensation and legal fees also decreased. Because UMHS generally refuses to settle what appear to be non-meritorious claims, patient compensation is now a direct indicator of substandard care in UMHS and a powerful motivator for increased safety and adherence to standards of care.¹¹

7.11 Important aspects which the rules should address:

- Reduce the number of patient incidents, through the implementation of additional learning and safety procedures.
- Early referral of claims by NHS Trusts to the NHSLA;
- Early admissions of liability: fixed recoverable costs to apply only where there has been an early admission of full liability;
- If expert fees are to be capped, then that should apply to both sides: claimant and defendant;
- Failure of defendant to keep to timescales within pre-action protocol to be penalised with loss of ability to rely on fixed recoverable costs.

¹⁰ NHSLA Annual report 2014-15: Table 9, page 12.

¹¹ *The University of Michigan's Early Disclosure and Offer Program* By Richard Boothman. JD and Margo M. Hoyler. Bulletin of the American College of Surgeons. 2 March 2013.

<http://bulletin.facs.org/2013/03/michigans-early-disclosure/#>

Q5

For pre-issue costs, the Government is proposing a sliding scale for the fixed recoverable costs, calculated by reference to the level of damages agreed. This type of approach has been used successfully with other fixed recoverable costs regimes; it has obvious benefits in terms of applying proportionality and it is also acknowledged that it should encourage the solicitor to ensure that damages are recovered at the appropriate level. (The proposal for post-issue, pre-trial costs is likely to be for fixed costs in various stages according to when the case is settled.)

5. Do you agree with a sliding scale pre-issue? Yes or No

- 8.1 If a claim is properly investigated by both sides in the pre-issue stage, more often than not it should be possible to avoid litigation and keep costs down.
- 8.2 As it is, the scheme proposed here by the DoH offers no incentive to the NHSLA to engage in constructive pre-issue negotiations and to settle early and instead creates an artificial incentive for the claimant to issue proceedings. Parties will become polarised and the benefits of the new clinical negligence pre-action protocol will be lost. We predict that there will be a substantial increase in the numbers of litigants in person, as firms turn away low value claims. It is doubtful that any money will be saved.
- 8.3 No time has been given to allow the effects of the following to begin to show in legal costs: the new clinical negligence pre-action protocol, the effects of LASPO (and the effects of non-recoverability), costs budgeting (which also controls costs once the claim is issued) and the duty of candour. Additionally, we do not yet know the result of the recently piloted NHSLA mediation scheme and whether consideration has been given to extending that pilot. We question why, in the light of those changes, these proposals are being brought forward now: an opportunity has been missed to wait for the effects of changes already implemented to bear fruit.

- *Case studies: overleaf*

Case study 1

- **Effect of loss of earnings on value of claim**
- **Need for liability evidence.**

K v (1) Dr Chandok (2) Dr Inthira-Raj (3) Dr Singh (4) Dr Mohan

This study is taken from a case report first published on APIL's website and in PI Focus, APIL's membership publication.

Mr K, aged 50, had a history of hypertension for which he had been prescribed Olmesartan. Mr K had blood tests in January 2006 revealing normal renal function.

Routine blood tests in February 2007 showed a raised creatinine of 157 and a reduced eGFR of 43. No action was taken by the GP surgery. Following an attendance at hospital for pain in his leg in September 2007 the claimant was found to have a raised creatinine level of 179 and an eGFR of 37. A letter was sent by the hospital to the GP surgery advising of the claimant's renal problems and advising that investigations be carried out. A series of consultations and appointments both with his GP and at hospital for apparently unrelated reasons followed.

On 22 April 2009 the claimant registered at a new GP surgery as his symptoms were becoming worse. Blood tests were immediately carried out revealing creatinine levels of 353 and an eGFR of 16. On 05 May 2009 the new GP referred him as an emergency to a renal physician. Advanced renal disease and renal scarring was confirmed following a biopsy. The claimant went onto renal dialysis in May 2010 and underwent a transplant in May 2011.

The opinion of a GP expert was sought to comment on liability. Following this the opinion of a consultant nephrologist was sought and it was confirmed that there were several opportunities for renal referral.

As a result of the failure to refer Mr K, his symptoms were not appropriately managed. He had two years of unnecessary pain and suffering, water retention and general lethargy and malaise. He was also unable to work.

- The NHSLA made an offer to settle the claim for £10,000 for pain and suffering which was accepted by Mr K.
- Additional sums for two years' loss of earnings were also agreed in the sum of £20,000.
- **Total damages: £30,000**

An example of the need for liability experts can also be found in case study 2 of this response, for a higher value claim where liability was denied.

Case study 2

- **Number of experts**
- **Low value and complexity**
- **Defence of claim delaying settlement for four years.**

W v Shrewsbury & Telford Hospitals NHS Trust

This study is taken from a case report first published on APIL's website and in PI Focus, APIL's membership publication.

Mr W was 75 year old part-time baker, husband and grandfather with various co-morbidities including heart disease, hypertension, chronic obstructive pulmonary disease (COPD), prostate cancer and renal colic.

In 1997 Mr W had been diagnosed with an aortic abdominal aneurysm which was monitored by the defendant hospital Trust. At the same time the Trust was monitoring the deceased's PSA levels, as he had carcinoma of the prostate with bony secondaries.

Mr W was referred for open surgery to repair his aneurysm in May 2007 when it became 5.9 cm in diameter. On 25 June 2007, the deceased's PSA was measured at a level of 13.7, which was a substantial increase from earlier measurements taken in late 2006 suggesting that his prostate cancer was progressing. The plan was to review him following his surgery and consider whether he would benefit from chemotherapy.

He was assessed for the suitability of open surgery by a respiratory surgeon and by a cardiologist who noted "*overall Mr W will carry a higher risk for abdominal aortic aneurysm surgery than usual, but nevertheless his heart is stable and he would certainly require careful fluid balance, as he may not be able to tolerate significant volume overload*".

In early October 2007 Mr W signed a consent form which stated a mortality rate of five per cent. He was not advised of his suitability for endovascular repair of his aneurysm and its more favourable mortality rate particularly in the short term. He was also not advised that by the time of the surgery in December 2005, his PSA levels had risen to 56.9 and that his life expectancy was probably less than two years, due to the progression of his prostate cancer.

On 17 December 2007 he was admitted to the hospital for surgery. His pre-admission medications were recorded on the admission note, but the details were not written up on a drug chart.

On 18 December Mr W underwent the surgery, which lasted six hours, following which he was admitted to the high dependency unit. By 20 December he was becoming unwell, his legs were swelling and he was breathless. He told his family that he was concerned that some of his pre-admission drugs had been stopped. This was communicated to the nurses.

On 21 December Mr W suffered a sudden onset of atrial fibrillation and pyrexia. A diagnosis of chest infection was made. On 23 December his catheter was taken out but he continued to experience swelling in his legs and scrotum. By 28 December Mr W was in renal failure, and on 29 December 2007 he died.

Negligence and causation

Allegations of negligence included failure to advise Mr W adequately on the risks, advantages and disadvantages of having elective open surgical repair of his AAA. In

particular he should have been informed that with his pre-existing co-morbidities his risk of mortality following surgery lay within the range of 12-15 per cent instead of the five per cent contained in the consent form.

Had Mr W had been provided with appropriate informed consent he would have either opted for endovascular aneurysm repair and its lower mortality rate or he would have chosen not to have surgery at all in view of his limited life expectancy.

In respect of causation (ie – the causal link between the negligence and his death) if Mr W had been administered his pre-admission medications and in particular his beta blockers, then it is likely he would not have experienced cardiovascular problems following surgery which inevitably contributed to his deterioration and death.

Experts

It was necessary for the claimant to rely upon the evidence of a

- consultant vascular surgeon;
- consultant radiologist experienced in the assessment of aortic abdominal aneurysms in relation to liability.
- consultant intensivist,
- cardiologist
- urological surgeon in relation to causation and life expectancy.

Defence

The case was robustly defended.

Settlement

A global sum was agreed in settlement just prior to the first court case management conference. The settlement reflected the claimant's own medical evidence on a short life expectancy.

Heads of loss included claims for his pain and suffering, bereavement damages and funeral expenses. His wife and family made a claim for financial dependency and loss of Mr W's services and attention.

The defendant hospital trust sent a formal letter of apology to the claimant. The settlement was formalised by a consent order on 4 April 2011.

Value of the damages awarded: £35,000.

Case study 3

This study is taken from a case report first published on APIL's website and in PI Focus, APIL's membership publication.

Mr H v Bradford Teaching Hospitals NHS Trust

- **Denial of liability delaying settlement for five years.**
- **Loss of earnings substantially affecting value of claim**

The 54 year old claimant, Mr H, had a history of intermittent attacks of gout which would leave him bedridden. He presented to the defendant NHS Trust on 1 September 2008 with a swollen, erythematous, hot left ankle. He had been vomiting and had diarrhoea. He was in septic shock, clammy and pale with hypotension and in renal failure with impaired liver function tests and very high C-Reactive Protein in the blood. The claimant was presumed to be suffering from cellulitis in the left ankle, and also an allergic reaction to his gout medication. The correct diagnosis of septic arthritis in the left ankle joint was negligently not considered, notwithstanding that it fitted with all the claimant's symptoms and despite blood culture results which were inconsistent with cellulitis, but entirely consistent with septic arthritis.

The appropriate diagnosis and correct treatment only commenced on 14 September and, coming so late, were ineffective and ultimately Mr H was advised that he would have to undergo a below the knee amputation of the left leg. But before the amputation could take place, Mr H was re-admitted, a chest x-ray showing pleural effusions: the ankle infection had colonised his spine and lungs.

Mr H's amputation took place, and as a result of the secondary infection, he developed severe kyphosis of the spine. He was not able to tolerate a standard spinal brace in order to prevent the kyphosis from becoming so pronounced, as he found that he could not breathe properly when wearing a standard brace. No bespoke alternative was ever offered to him.

Effects of the negligent treatment: Mr H was unable to become ambulatory with the use of a prosthesis due to the severe curvature of his spine, and became confined to a wheelchair. Due to the imbalance caused by the curvature of the spine, he cannot even walk short distances with crutches. He suffers from severe back pain and phantom pain in the missing limb. He suffers symptoms of fibromyalgia including fatigue and pain in various parts of his body. He takes extensive analgesia.

Previously independent (and with no dependants of his own) with his own business, he now requires assistance with all aspects of daily living. These care needs were not able to be satisfactorily met by Local Authority provision. He was unable to continue running his successful consultancy business.

While the NHSLA admitted that there was a negligent failure to make a diagnosis of septic arthritis, it denied that, but for the negligence, the seeding of the spine with infection and all that followed from that would have been avoided. The NHSLA asserted that Mr H's spine and lungs would have been seeded with infection in any event; that he would have been left with the severe curvature of the spine in any event, which would naturally impact on his ability to ambulate, care for himself and work for a living in any event.

Following issue of proceedings, the parties were each given leave to rely on the evidence of their own consultant orthopaedic surgeon and their own Consultant Microbiologist in relation to liability issues. The parties were also given leave to rely upon separate care reports.

- The NHSLA continued to defend the claim until September 2013, five years after the patient had been injured by the NHS's negligence.
- On 7 October 2013 the NHSLA finally made an offer to settle the claim for a global figure of £1.5 million, which was accepted the following day. The defendant had also made an initial offer of £200,000 to settle the claim, at an earlier stage in the proceedings, which was rejected.

The settlement of £1.5 million can be apportioned as follows:

Compensation Recovery Unit:	£65,000
General damages	£150,000
Past loss of earnings	£40,000
Past gratuitous care	£10,000
Other past losses inc contrib to Local Authority care:	£10,000
Adapted accommodation	£500,000
Future loss of earnings	£50,000
Future care costs	£500,000
Future equipment/adaptations	£100,000
Future transportation costs	£75,000

Case studies 4 a & b – the Welsh Redress Scheme

a Ms H and the Cardiff & Vale University Health Board

- **Liability denial – claim left redress scheme**
- **Additional costs due to denial of liability**

This case related to a lady who suffered a four-day delay in diagnosis and treatment for her fractured neck. The Health Board denied qualifying liability and refused the claimant solicitor's suggestion to jointly instruct a liability expert under the Redress scheme.

As a consequence, a conditional fee agreement with ATE insurance was entered into and an expert's liability report was obtained. The claimant made a Part 36 Offer to the Health Board, paraphrasing the negligence identified in the earlier liability report. The Part 36 offer was in the sum of £1,250. After four months, the Health Board accepted the offer.

- If this case had settled under the Redress Scheme, the NHS could have paid £1,920 costs (fixed fee of £1,600 plus VAT) plus £1,250 damages to the patient. Instead they paid £1,250 in damages to client and £11,775.90 to her solicitors for legal costs and expert fees incurred.

b Ms W and the Aneurin Bevan University Health Board – ongoing

- **Failure by health board to engage within the Redress Scheme**

Letter of claim sent to the Health Board in January 2014, but 18 months later no response has been received. As a result, the claimant has had to instruct counsel and is looking to

obtain evidence on condition and prognosis with a view to issuing proceedings. Extra fees for counsel, medical records and reports mean that the costs and disbursements may be as much as £20,000, exclusive of the ATE insurance premium which has yet to be obtained.

- Ends -

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