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Managing clinical negligence claims and HM Coroners' Inquests: a Consultant's perspective

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Introduction

- Partner in Healthcare Regulatory Advisory team.
- Over 12 years' experience working for NHS organisations.
- General Counsel at Liverpool University Hospitals NHS Foundation Trust.
- Head of Legal Services at Wrightington, Wigan and Leigh Teaching Hospitals NHS Foundation Trust.
- Managed legal services within the NHS for over 10 years, working collaboratively with clinical teams.
- Director of Liverpool Law Society.
- Trustee for the UK Clinical Ethics Network.

Managing Clinical Negligence Claims

Clinical Negligence Claims: CNST

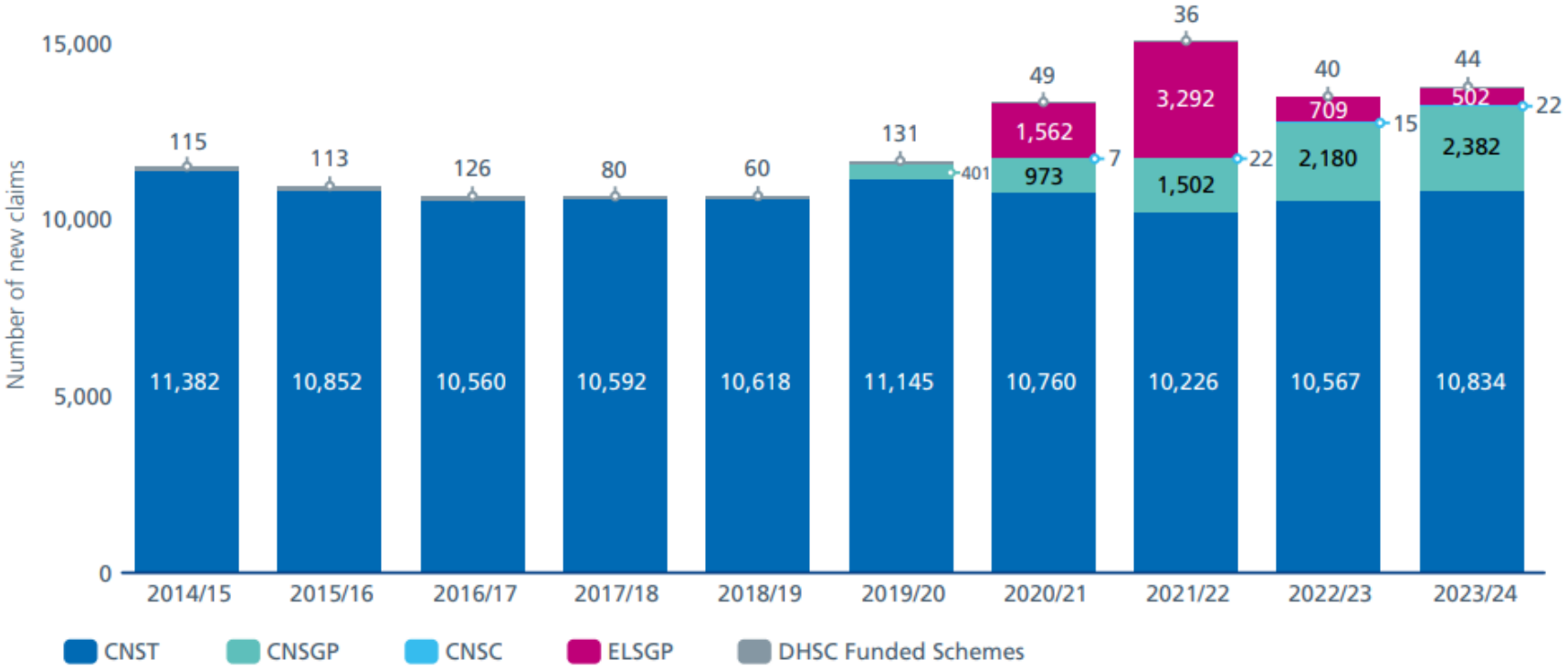
- Administered by NHS Resolution (NHSR)
- All clinical negligence claims are managed under the Trust's CNST scheme (Clinical Negligence Scheme for Trusts)
- All NHS Trusts, ICBs and GP practices are Members of the CNST.
- There is no other insurance provider.

Is there a compensation culture?

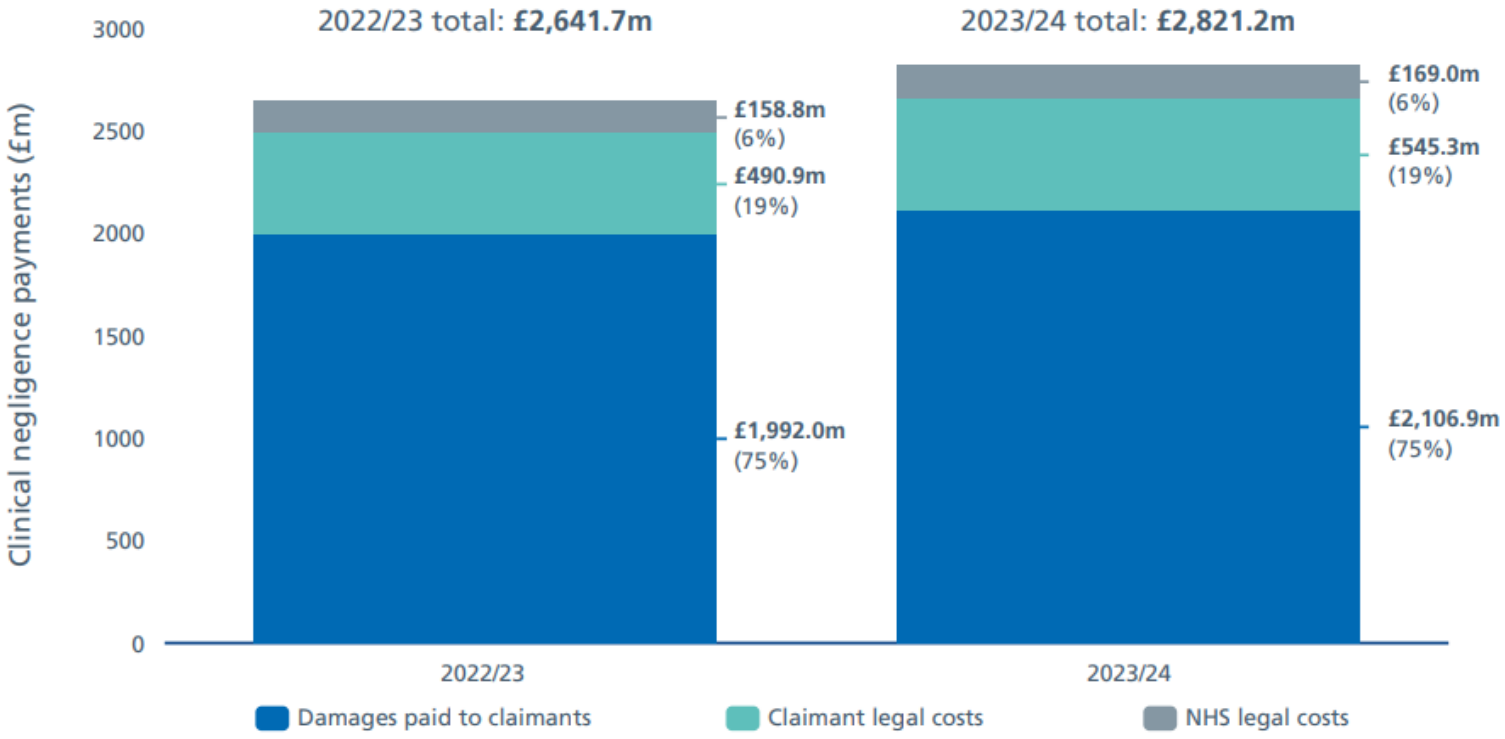
Number of claims and incidents reported to NHS Resolution:

2019/2020: 11,677
2020/2021: 13,351
2021/2022: 15,087

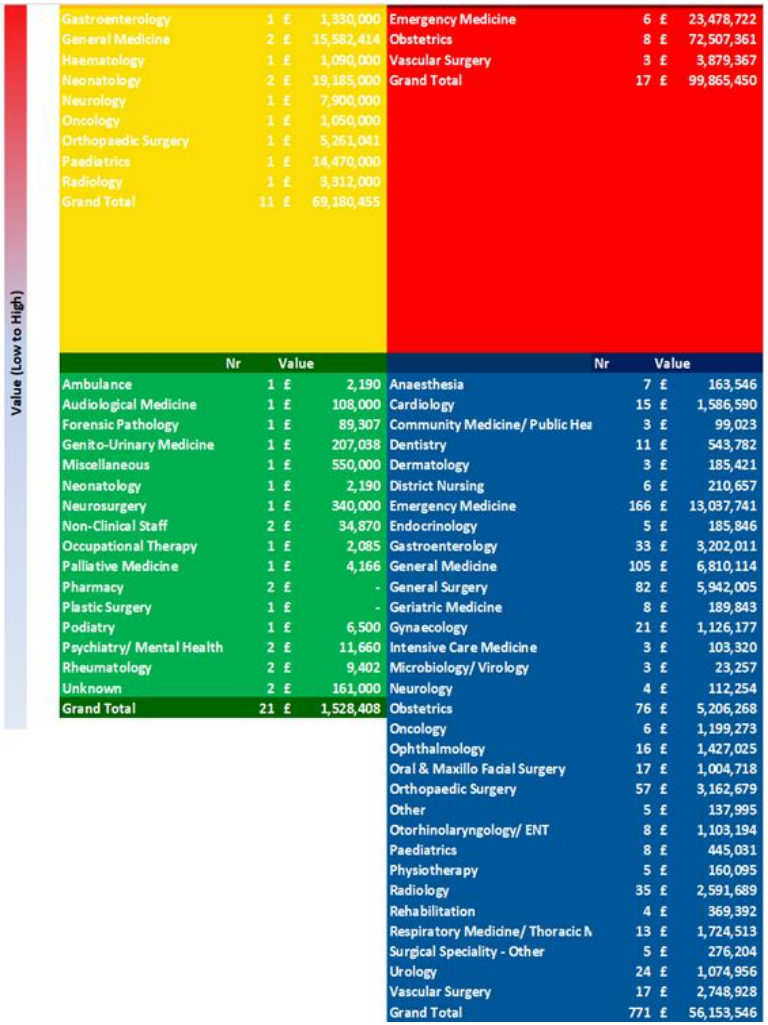
2022/2023: 13,511
2023/2024: 13,784



Clinical Negligence Payments



Example NHSR Scorecard



Gastroenterology	1	£ 1,330,000
General Medicine	2	£ 15,582,414
Haematology	1	£ 1,090,000
Neonatology	2	£ 19,185,000
Neurology	1	£ 7,900,000
Oncology	1	£ 1,050,000
Orthopaedic Surgery	1	£ 5,261,041
Paediatrics	1	£ 14,470,000
Radiology	1	£ 3,312,000
Grand Total	11	£ 69,180,455

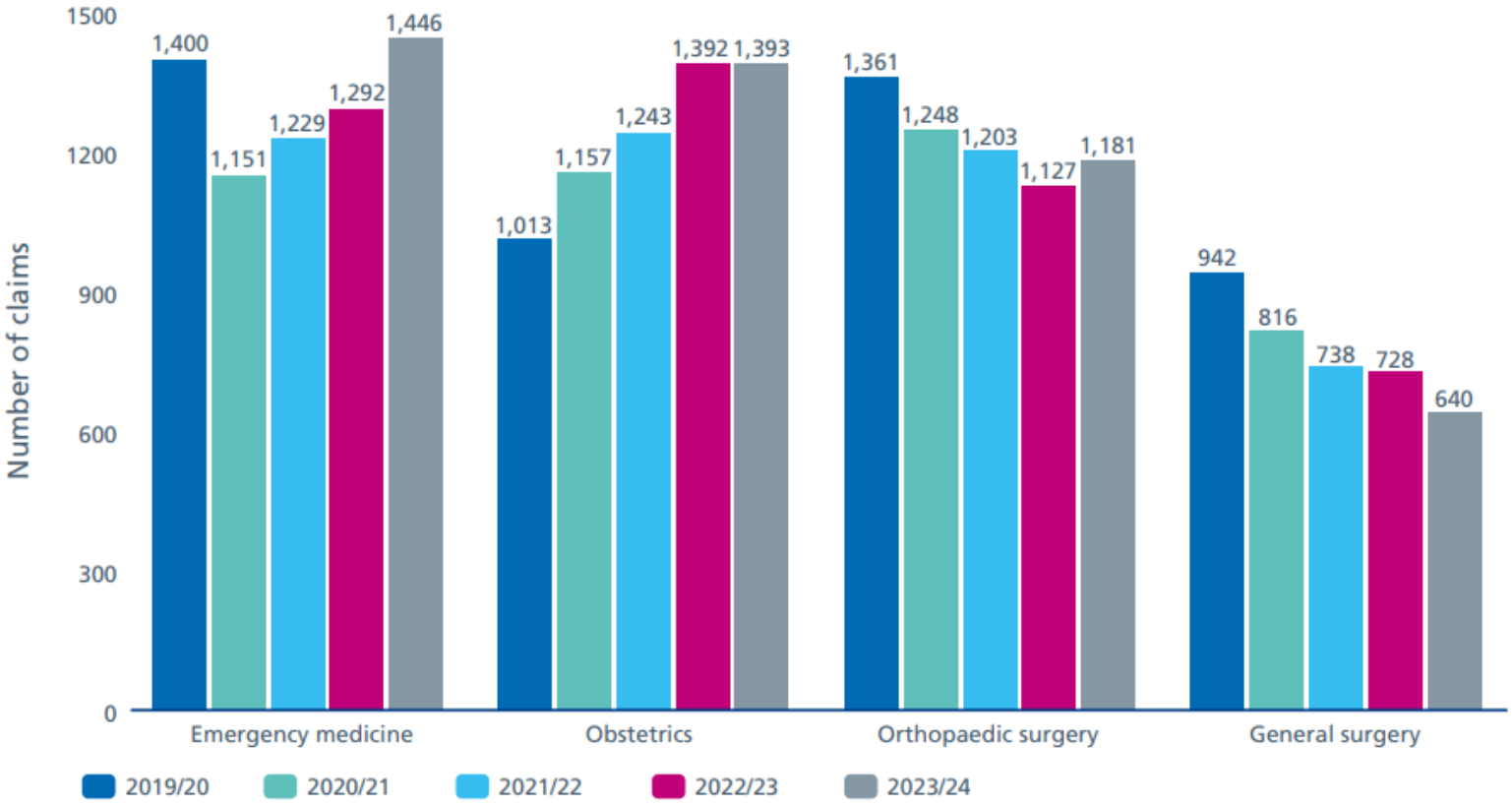
Emergency Medicine	6	£ 23,478,722
Obstetrics	8	£ 72,507,361
Vascular Surgery	3	£ 3,879,367
Grand Total	17	£ 99,865,450

	Nr	Value
Ambulance	1	£ 2,190
Audiological Medicine	1	£ 108,000
Forensic Pathology	1	£ 89,307
Genito-Urinary Medicine	1	£ 207,038
Miscellaneous	1	£ 550,000
Neonatology	1	£ 2,190
Neurosurgery	1	£ 340,000
Non-Clinical Staff	2	£ 34,870
Occupational Therapy	1	£ 2,085
Palliative Medicine	1	£ 4,166
Pharmacy	2	£ -
Plastic Surgery	1	£ -
Podiatry	1	£ 6,500
Psychiatry/ Mental Health	2	£ 11,660
Rheumatology	2	£ 9,402
Unknown	2	£ 161,000
Grand Total	21	£ 1,528,408

	Nr	Value
Anaesthesia	7	£ 163,546
Cardiology	15	£ 1,586,590
Community Medicine/ Public Hea	3	£ 99,023
Dentistry	11	£ 543,782
Dermatology	3	£ 185,421
District Nursing	6	£ 210,657
Emergency Medicine	166	£ 13,037,741
Endocrinology	5	£ 185,846
Gastroenterology	33	£ 3,202,011
General Medicine	105	£ 6,810,114
General Surgery	82	£ 5,942,005
Geriatric Medicine	8	£ 189,843
Gynaecology	21	£ 1,126,177
Intensive Care Medicine	3	£ 103,320
Microbiology/ Virology	3	£ 23,257
Neurology	4	£ 112,254
Obstetrics	76	£ 5,206,268
Oncology	6	£ 1,199,273
Ophthalmology	16	£ 1,427,025
Oral & Maxillo Facial Surgery	17	£ 1,004,718
Orthopaedic Surgery	57	£ 3,162,679
Other	5	£ 137,995
Otorhinolaryngology/ ENT	8	£ 1,103,194
Paediatrics	8	£ 445,031
Physiotherapy	5	£ 160,095
Radiology	35	£ 2,591,689
Rehabilitation	4	£ 369,392
Respiratory Medicine/ Thoracic M	13	£ 1,724,513
Surgical Speciality - Other	5	£ 276,204
Urology	24	£ 1,074,956
Vascular Surgery	17	£ 2,748,928
Grand Total	771	£ 56,153,546

- Data over 10 years
- 820 claims (01/04/2014 – 31/03/2024)
- Split into 4 categories
- Shows reserved costs for each clinical speciality

Top Four Categories of Claims



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Elements of a claim

In order to successfully establish a claim for clinical negligence a patient (or 'claimant') must prove three things:

1. A **duty** of care was owed
2. There was a **breach** of that duty
3. The breach **caused** injury, loss or damage

Breach of duty

The ***Bolam*** test:

"[a doctor] *is not guilty of negligence if he has acted in accordance with a practice accepted as proper by a responsible body of medical men skilled in that particular art…*

Putting it the other way round, a man is not negligent, if he is acting in accordance with such a practice, merely because there is a body of opinion who would take a contrary view."

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Causation

- The Court must be satisfied that the breach of duty complained of caused the Claimant injury, harm and/or loss.
- The Court applies the following tests:
    1. The *'but for'* test
        - But for the negligence would the patient have suffered any injury?
    2. The '*balance of probabilities test*'
        - If something has a greater than 50% chance of happening, then the Court will conclude that it would have occurred (and vice versa).

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How are breach of duty and causation established?

- The patient's records
- Incident reports, Rapid Review Reports, RCAs,
- Response to the complaint
- Reports submitted ahead of an inquest
- Evidence given at the inquest
- Written statements from the clinicians who provided the care
- Independent expert evidence
- The role of the judge

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Injury, Loss and Damage

- The patient must prove they have suffered injury, loss and/or damage through:
  - Expert medical evidence (condition and prognosis)
  - Documentary evidence (e.g. wage slips, invoices, receipts etc.)
- The injury, loss and/or damage is then **quantified** (valued) to determine the compensation that is to be paid with the aim of:

  "as nearly as possible [getting] that sum of money which will put the party who has been injured, or who has suffered, in the same position as he would have been in if he had not sustained the wrong for which he is now getting his compensation…"

Time Limits of a Claim (1)

- There are time limits for bringing clinical negligence claims which are set out in the Limitation Act (1980).
- The time limits are as follows:

Claimant	Time Limit
Adult (with capacity)	3 years from incident / knowledge
Child	21st birthday (i.e. 3 years from adulthood)
Patient Lacking Capacity	Unlimited (no time limit)
Deceased Patient	3 years from date of death / knowledge

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Time Limits of a Claim (2)

- The **date of knowledge** is when a person became aware of or reasonably ought to have been aware of a potential claim for clinical negligence:
  - Think about if / when a complaint was raised with the Trust
  - Risk management reports e.g. SUI's shared with the family

- If the time limit for issuing a claim is missed then it may not succeed as it is **statute barred** (out of time), but the Court can exercise discretion (s.33)

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The Role of the Regulators

HM Coroner
Police
CQC
GMC / NMC / HCPC

- Grounds for referral – high bar
  - Dishonesty
  - Gross negligence or recklessness about a risk of serious harm to patients
- Reflection, openness, learning
- Duty of Candour – Government review and consultation

General Medical Council

Care Quality Commission

Life cycle of a claim

Claimant's Request for records – 40 days to comply

Letter of Claim

- Summary of facts, allegations and value
- 24 hours to notify NHS Resolution and 14 days to provide full documentation (e.g. SUI report, witness details forms)

Letter of Response – 4 months from receipt of Letter of Claim

- Admit? Deny? Partial admission?
- Request for clinician's comments **(invaluable!)**
- Independent expert evidence sought

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Proceedings

Claim Form issued by Court

Proceedings served – Particulars of Claim

Acknowledgement of Service – 14 days to send to Court

Defence – 28 days from receipt of Particulars of Claim (if AoS served)

CCMC

Court directions to trial

Standard Disclosure

Factual witness statements

Expert evidence

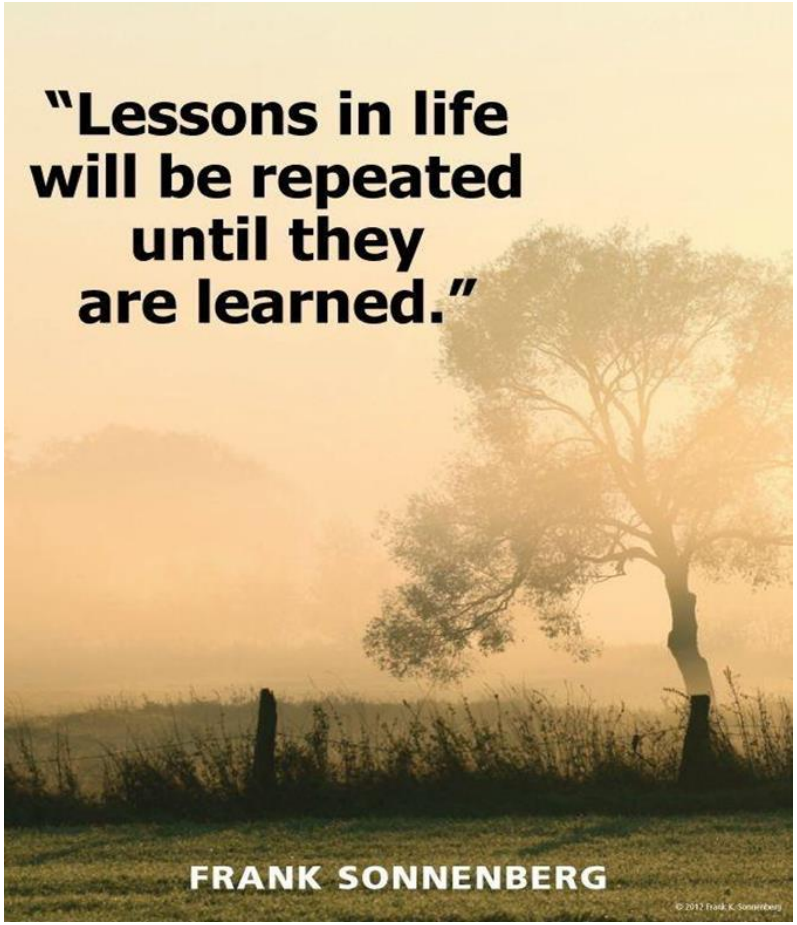
Expert discussions

Trial

Main messages for New Consultants:

The claim is not against you	Lots of support available	Don't take it personally
Less than 1% of clinical claims end up at Trial	Without the input of those who delivered the care, we cannot usually defend claims	The support is ongoing

Learning Lessons

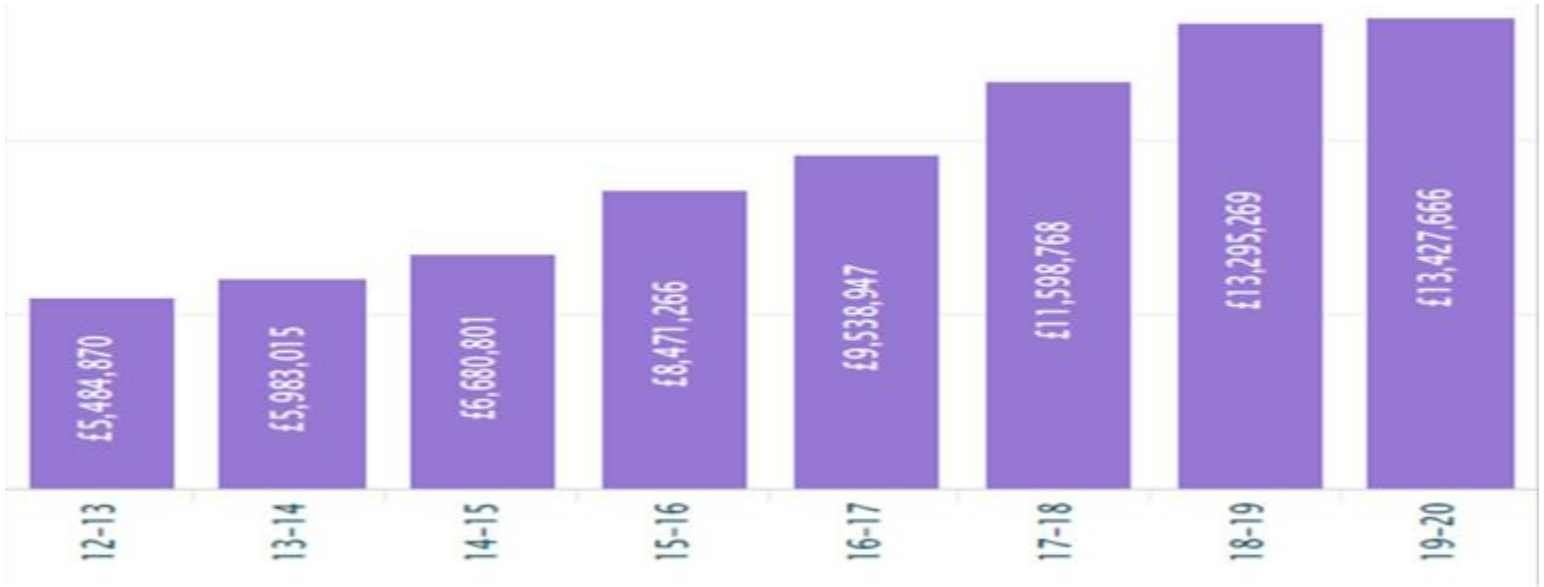


Financial Contributions

Payments for resolving clinical claims in 2023/24 compared with 2022/23

£2,821.2m 2023/24

£2,641.7m 2022/23



2024/25: £15,758,008

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Crossover between clinical negligence and inquests

- Inquests often investigate deaths that may arise from medical errors or omissions
- Findings from inquest may reveal basis for a claim
- Evidence given at inquest from lay or expert witness can be pivotal in subsequent clinical negligence claim
- Conclusion can serve as foundation for establishing negligence

HM Coroners Inquests

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What is an Inquest?

- A legal investigation to establish the circumstances surrounding a person's death. Its purpose is to answer the following four questions:

- Who the deceased was.
- When the deceased died.
- Where the deceased died.
- How the deceased came by their death.

- An inquest is a fact-finding inquiry!

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What an inquest is not . . .

- To apportion blame.
- To apportion culpability.
- To establish criminal or civil liability.
- For the Coroner to express an opinion on any matters outside who, where, when and how the deceased came by their death.
- Cross examination of witnesses.
- TV style drama…

2024 Death Certification Reforms

- With effect from 9 September 2024.
- Require an independent review to be carried out for all deaths in England and Wales, without exception.
- This will either be provided by independent scrutiny by a medical examiner or by investigation by a coroner.

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Medical Examiners Role

Under the Medical Examiners Regulations, they:

- Provide independent scrutiny of causes of death.
- Give bereaved people an opportunity to ask questions and raise concerns with someone not involved in providing care to their loved one.
- Review medical records and work with doctors to complete the MCCD to ensure this is accurate and to highlight any concerns about the care provided.

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MCCD Regulations 2024 – Doctor Responsibilities

As soon as practicable after becoming aware of a death, an attending practitioner must–

(a) review health records, any physical examination of the body and any other relevant information with a view to establishing the cause of death to the best of the practitioner's knowledge and belief;

(b) Either prepare and sign an attending practitioner's certificate; or where they are not able to establish the cause of death, refer the death to the relevant senior coroner.

MCCD 2024–ME Responsibilities

- The appropriate medical examiner must, as soon as practicable, make whatever enquiries the examiner considers necessary (including possibly examining the body and discussing the case with the attending practitioner)

- Where the appropriate medical examiner is satisfied with the cause of death, they must confirm the cause of death as stated on the attending practitioner's certificate by signing that certificate.

OR

- Refer the death to the relevant senior coroner where the examiner is unable to confirm the cause of death, or considers the death is unnatural, or the death occurred in state detention.

Referrals to HM Coroner:

A death will be referred to a coroner where:

- There is no attending practitioner;
- The attending practitioner cannot establish the cause of death;
- The medical examiner is unable to confirm the proposed cause of death; or
- The Notification of Deaths Regulations 2019 (NOD Regulations) apply.

Notification of Death Regulations 2019

- Poisoning, including by an otherwise benign substance;
- Exposure to, or contact with a toxic substance;
- Use of a medicinal product, the use of a controlled drug or psychoactive substance;
- Violence, trauma or injury;
- Self-harm;
- Neglect (including self-neglect);
- The person undergoing any treatment or procedure of a medical or similar nature; and
- An injury or disease attributable to any employment held by the person during the person's lifetime.

Witness Statements

Witness Statements

A statement is designed to assist the Coroner. Writing a statement does not mean you have done wrong, only that the coroner thinks you can help.

Can be viewed by police, CQC, coroner, patients/families, solicitors and Secretary of State for Health.

Drafting a Witness Statement (1):

DO:

- Keep it professional
- Stick to the facts
- Make clear the capacity in which you write the statement
- An honest reflection of your recollection
- Deal with any errors or omissions you have identified.

DON'T:

- Rush!
- Leave any tough questions for the day of the inquest
- Speculate or guess (interpretation of the facts is the Coroners job!)

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Drafting a Witness Statement (2):

- Use your in-house legal team (or solicitor) to support you, that is what they are there for!
- Take the time to review medical records, drug charts, test results, observation charts etc. Also review any relevant policies if you need to.
- Review and review again to make sure the contents are accurate.
- Send to your legal team to review – you do not have to accept their advice, this is your statement, but the legal team will be able to assist and support you.

Can you identify a ‘bad’ statement?

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Inquest before Mrs Timothy Brennand, 4 October 2018
Manchester Coroner's Court
Witness Statement of Mr Jones
Inquest of IS

This is a report regarding the death of Mr Smith who died on 11.12.17. I believe I met with Ilene on three occasions to discuss reversal of Hartmann's procedure.

We went through all the options that were available to Susan on each occasion i.e. the operation or just carrying on. I spoke about the procedure at length and exactly how it works and we both agreed that it was probably the best bet to go ahead. Even though I didn't put it in my note or the clinic letters, I definitely remember mentioning that she might die.

I asked one of the nurses to make sure Mrs Smith got the pre-op work-up she needed. This was important as it might show that her heart wasn't good enough for the op.

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Drafting a Witness Statement (3):

- Use unambiguous language.
- Explain medical terminology, acronyms, conditions and procedures in layman's terms.
- Be sensitive; check all personal details for the deceased are correct.
- When referring to other professionals use their full name and title.
- Stay within your area of expertise.
- Do not speculate.

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Attending Court

Preparing for Court:

- If you receive a summons, you must sign and return it – this should come through your Legal Department
- Re-read your written statement and take a copy with you
- Read the PSR/PSII Report and be familiar with any action plan
- Refresh your memory of other relevant documents e.g. medical records
- Arrange to attend a pre inquest meeting if one is offered to you – its purpose is to help and support you
- Plan your journey
- Plan to arrive early
- Ensure you have contact telephone numbers of your legal representative (if represented) or the Coroner's Court.
- Select a smart professional outfit (think job interview)
- Decide whether you want to swear an oath or give an affirmation

Giving Evidence (1):

- Address the Coroner as Sir/ Ma'am, not Your Worship, Your Highness.
- As long as you are not under oath you may speak to the family if appropriate – you may offer your condolences but do not discuss details of the inquest evidence
- Do not speak to the jury or the press
- Be professional at all times in and around the Court (there may be reporters and/or family members outside the building)
- Turn off your mobile phone or at least put it on silent (and do not disturb if you wear a smart watch!)

Giving Evidence (2)

- Take your time.
- Address the Coroner and speak loud enough for the family (or jury) to hear.
- Never ever become hostile or rise to aggressive opposition.
- Relax, keep calm and focused.
- Stand your ground if you need to – you do not need to change your answer even if you are asked the same question repeatedly.
- Remember your professional obligations.

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What happens next?

- Conclusion (short form or narrative)
- Regulation 28 – Prevention of Future Deaths
- Individual referral to a regulatory/governing body (very rare)
- Media attention
- Social media campaigns
- Complaint investigations
- Clinical negligence claim . . . . ?

Any questions?

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