Written evidence submitted by Bolt Burdon Kemp (NLR0054)

Who we are

Bolt Burdon Kemp is a firm of solicitors. We specialise in acting for those who have suffered serious injury as a result of medical negligence, personal injury or abuse. The firm is based in London, but represents clients nationwide.

We are in a position to provide anonymised case studies throughout our response to illustrate the points we make.

Executive Summary

This response to the call for evidence confirms our views about:

- An alternative to the current system – a no-fault, fully compensated scheme for anyone who has sustained an injury at the hands of the NHS
- How to improve the current system including:
    - Cultural changes that need to be implemented across the NHS
    - Learning from other areas of industry and practice
    - Highlighting areas which are working well
- Case studies of real patients, and their experiences of the current system - good and bad
- The position of conflict that exists between the State (NHS) and individuals (injured patients) and the need to keep this in sight.

We agree wholeheartedly with the former Secretary of State for Health, Jeremy Hunt, who encapsulates the problem and the solution in what he said on 9th March 2016[1]:

> *"But still we make too many mistakes. Twice a week in the NHS we operate on the wrong part of someone's body and twice a week we wrongly leave a foreign object in someone's body. The pioneering work of Helen Hogan, Nick Black and Ara Darzi has estimated that 3.6% of hospital deaths have a 50% or more chance of being avoidable, which equates to over 150 deaths every week…*
>
> *No change is permanent without real and lasting culture change. And that culture change needs to be about 2 things: openness and transparency about where problems exist, and a true learning culture to put them right…*
>
> *Too often the fear of litigation or professional consequences inhibits the openness and transparency we need if we are to learn from mistakes…*
>
> *An NHS that learns from mistakes. One of the largest organisations in the world becoming the world's largest learning organisation - that is how we will offer the safest, highest quality standards of care in the NHS."*

[1] https://www.gov.uk/government/speeches/an-nhs-that-learns-from-mistakes

The measures he introduced are welcome, and, in our opinion need to be further developed to achieve the aims the call for evidence sets out.

Response

- ***What is the impact of the current cost of litigation on the financial sustainability of the NHS and the provision of patient care?***

We cannot answer this question. Clearly, it makes sense for the NHS to reduce the costs of litigation. Just as it makes sense for society to reduce the number of needless injuries as a result of NHS negligence. It can do this in two ways:

1. A fully funded no fault compensation system.

If the NHS and the government wish to eliminate costs of claims and legal fees for both parties involved in litigation, then creation of a no-fault compensation scheme, which prioritises compensating anyone who suffers an injury whilst receiving NHS treatment, would ensure access to justice for everyone and enable everyone to live their best lives, adapt and heal from their injuries. However if the Government is looking to spend less not more, this would not be a viable option. Evidence indicates that only 2% of those who experience negligence bring a compensation claim[2]. So, whilst legal fees will be eliminated, the cost of compensating all claims will increase to include the other 98% of claims which are not being made.

2. Sticking with the existing system and making savings by improvements including:-

- Learning from mistakes so they aren't made again. This has to be the number one priority.
- Reviewing and improving supervision and training to medical staff.
- Increasing staffing levels and reducing the length of shifts for medical staff – mistakes are made when staff are tired, overworked and under pressure.
- More investigations when things go wrong, such as carrying out a post mortem following every death that occurs in NHS care and disseminating learning points.
- Tackling the dysfunctional culture: by rewarding people who speak out rather than penalising them; adapting to change; greater transparency; reviewing the seniority / hierarchy / status models currently employed.
- Funding early rehabilitation for those injured in NHS care. Getting people back on their feet faster means quicker recovery times and fewer damages and legal costs to pay.
- Reviewing the NHS legal panel for clinical negligence and their "defend at all costs" approach. We have seen time and again situations where legal costs increase as a result

[2] NHS England data confirms that there were 647,542 reported patient safety incidents resulting in any degree of harm that occurred in 2020/21. By way of contrast, NHS Resolution (see page18 of hyperlinked document) received just 12,629 clinical negligence claims in 2020/21. This suggests that roughly 2% of patient safety incidents which cause harm result in a clinical negligence claim against the NHS.

of this approach, despite the NHS having clearly gotten it wrong. Instead, promote greater engagement and cooperation with patients and their representatives / families and comply with and uphold the duty of candour.

ANONYMISED CASE STUDY ONE – LUCIA'S CASE

Lucia suffered a catastrophic brain injury in her early 20s due to a delay in diagnosis of turberculous meningitis. She was left with permanent blindness, hemiplegia, a significant cognitive deficit and can no longer communicate her needs. She is mother to two children, one of whom was a premature newborn in another hospital at the time of injury (the other was a toddler). Their lives changed beyond recognition.

The Defendant NHS Trust raised a limitation defence, which we fought rigorously with a forensic examination of the evidence dating back several years. Our robust response led to the defence being withdrawn shortly before the trial of this issue. Following this, the defendant denied liability for negligence, before a 98% liability agreement was reached, days before trial on this issue.

Had the NHS Trust engaged more proactively with the litigation, the costs incurred in arguing about limitation and then subsequently, liability, would and could have been avoided, or indeed seriously limited.

After securing a liability agreement, we engaged leading experts to report on Lucia's injuries and needs in order to value the claim. We secured a large interim payment of damages to set up a care regime and move the family to greatly improved accommodation to meet her needs as well as an extensive private care and treatment package, prior to settlement being reached. This was created around the family's requirements, including their particular cultural and religious needs. The claim settled for a capitalised eight-figure sum.

Lucia experienced negligence with far-reaching and serious consequences. Her family then had to battle with a Trust to establish liability for her claim, whilst also raising two young children, coming to terms with the extent of her injury and worrying about how to survive.

This case took 18 years from the date of the negligence to conclude, having been fought at each stage.

- ***What are the key changes the Government should consider as part of its review of clinical negligence litigation? In particular:***

- ***What changes should be made to the way that compensation is awarded in clinical negligence claims in order to promote learning and avoid the same problem being repeated elsewhere in the system?***

The question being asked here does not make sense. No changes are needed to "the way compensation is awarded" in order for learning to take place and to avoid repeated mistakes. That has to do with culture, with transparency, and with resources to investigate problems and disseminate solutions.

Insurance in private practice

The NHS are in a unique position in being insured by the State for any negligence on their part. We suggest that closer scrutiny is given to organisations in private practice and how they and their insurers operate. It is standard practice for an insurer to cover reasonable conduct. If an insured party repeatedly commits acts of negligence, an underwriter might decide to take one of several courses of action – increasing premiums; placing limits on future cover to exclude claims that demonstrate a repeated course of conduct; or cancel a policy. An insured party who refuses to improve their systems will then be subject to seeking cover with high-risk providers, penalised with higher premiums and more limited terms of cover. In contrast, for NHS providers, there is only one indemnity provider.

- ***How can clinical negligence processes be simplified so that patients can receive redress more quickly?***

The Serious Injury Guide: Emphasise importance of early rehabilitation

The Serious Injury Guide promotes early rehabilitation for those involved in an accident. If a defendant is not a signatory to the guide then the Rehabilitation Code 2015 enshrines similar aims in enabling claimants to access rehabilitation. In the sphere of personal injury, there is increasing collaboration between parties to work together to ensure results. However, the Serious Injury Guide does not cover clinical negligence claims and there is no parallel agreement in place to cover such claims. There should be.

Whilst there is an expectation under the Rehabilitation Code 2015 for the parties to consider rehabilitation, in our experience NHS Resolution are not often willing to engage in any form of rehabilitation until liability has been established. This can often mean a delay of years, during which time our clients' rehabilitation will be limited to that which is available solely on the NHS. This is limited and being provided by the very tort-feasor which has allegedly caused or worsened the injury.

The National Institute for Health Research, amongst others, confirms their view that early intensive rehabilitation aids recovery and improves outcomes for people who have suffered injury. So not only would early rehabilitation benefit patients, it would likely lessen the damages and compensation the NHS are paying to those who have received negligent treatment.

NHS Resolution aims to reduce litigation and unnecessary costs but there is no mention of the impact rehabilitation could have on these goals. The World Health Organisation say[3]:

[3] https://www.who.int/news-room/fact-sheets/detail/rehabilitation

"*Rehabilitation is an investment, with cost benefits for both the individuals and society. It can help to avoid costly hospitalization, reduce hospital length of stay, and prevent re-admissions. Rehabilitation also enables individuals to participate in education and gainful employment, remain independent at home, and minimize the need for financial or caregiver support."*

Fully funded no fault compensation system

Creation of a fully funded, no fault compensation system for all – which compensates everyone who has suffered an injury, without application of any criteria as to whether the injury was avoidable or not, would create a fairer system for everyone, remove all costs of litigation on both parties sides and support a learning culture.

Changing the NHS approach to litigation

The NHS should switch from their current adversarial approach to one which focusses on early admissions, early disclosure, cooperation, with parties working together, agreeing mediation in suitable cases, apologies when mistakes have been made, and a commitment to upholding the duty of candour. This would transform the way in which litigation is conducted and ensure patients' needs are prioritised.

- ***How can collaboration between legal advisors be strengthened to encourage early and constructive engagement between parties?***

By having a clinical negligence equivalent of the Serious Injury Guide or Rehabilitation Code 2015, parties could work collaboratively to put in place early rehabilitation for injured patients, which would ultimately mean that they could reach their best possible prognosis and quality of life, reducing the cost of compensation claims.

The government should find a way to create such a system for patients who have experienced clinical negligence.

Mediation

We are seeing increased use of mediation in clinical negligence cases. In the right claim, we believe this can be a helpful approach to litigation and settlement. Provided it is employed with flexibility we believe this is a useful tool to achieve this aim.

ANONYMISED CASE STUDY TWO – MARGARET'S CASE

We represented Margaret after the death of her late husband, Felix. The case centred around negligent care following dental surgery, which left Felix with chronic and unresolved pain. His condition deteriorated and he showed signs of psychosis and planning his suicide. He was assessed several times but discharged without being seen by a psychiatrist. He very sadly committed suicide, when their two children were both under 5 years old.

The Trust never responded to our letters before claim. Court proceedings were issued. Whilst breach of duty was admitted, causation remained in dispute. A date for mediation was agreed, and a week prior to this, the Trust set out their case as to loss.

The mediation started with Margaret sharing her feelings about her loss, and showing photographs of her with her late husband and their children. This set the

What role could an expanded Early Notification scheme play in improving transparency and efficiency system-wide?

We consider that, with greater transparency and checks and balances in place, the ENS could play a welcome role in improving the current system.

In our experience, the current ENS is not transparent.

ANONYMISED CASE STUDY THREE – NADIA'S CASE

Nadia underwent a lengthy delivery before being having an emergency caesarean section. After birth, her child was floppy and unresponsive and had to be cooled. Nadia raised allegations of negligent care resulting in a brain injury to her newborn child. After receipt of her complaint, the Trust confirmed that they were investigating her delivery but no further information was forthcoming. After Nadia instructed us to pursue a claim, the NHS Trust then confirmed, some months later, that they had entered Nadia into the ENS without her knowledge. Despite confirming that investigations would be concluded within 4 months, they are still awaited – some three years later. This does not speak well as to the current transparency of the system and needs to be rectified.

Improving the ENS system

The current scheme has several flaws which need addressing before it can be adopted more widely:

- *Speed at which claims are assessed leaves claimants at risk of being under-compensated:* Brain injuries are incredibly complex. They evolve over time, they develop and they manifest in a variety of ways. Given the technological limitations of brain imaging, some injuries caused at or after birth are often not apparent until months and years later, often when a child starts to lag behind their peers. Subsequently, it can be very difficult to accurately assess the true nature and extent of a child's injury, how it will impact their life and consequently, what the child's care, therapy, education, housing and equipment needs will

be, until the child reaches adolescence or in some cases early adulthood. In some cases, until the child reaches these stages, it is impossible to properly quantify how much compensation will be required to meet the child's needs for life. There is a clear risk that the child's compensation claim will be under-settled through the scheme if there is an attempt to settle the case in its entirety at an early stage. In other words, they will not receive the right amount of compensation they need to flourish, heal and adapt post-injury.

- *Lack of complete expert evidence to properly assess a claim:* NHS Resolution are not instructing neuro-radiologists or neurologists to assist them with their liability investigations but instead are solely relying on the opinions of experts in midwifery, obstetrics and neonatology. Whilst these expert opinions will be helpful, their understanding of the medicine is limited to their specific areas of expertise, and they will be unable to provide a view from all aspects.

- *Not consistently taking evidence from families*: Failures to take evidence from, and involve, treating staff and the patient's family will mean the experts examining the case will not have all of the information required to investigate what has happened. To make the most of the opportunity for learning, the involvement of both should be integrated into the process. It is our experience that this does not happen consistently.

- *Limited review of evidence:* Cutting corners by reducing the volume of medical records disclosed to experts, not obtaining key opinions from experts and detailed statements from witnesses and limiting complex matters to a single 90 minute conference will almost certainly mean that crucial elements of a case will not be thoroughly reviewed and at worst, could be missed.

- *Conflict*: As solicitors we have a duty to act in our client's best interests. Solicitors representing the NHS have a duty to act in the best interests of the NHS, not in the injured child's best interests. There is an inherent conflict in the scheme being run by the NHSR, representatives of the tort-feasor, with no independent advice being made available for the parents of the injured child. Signposting, when it does occur, simply isn't enough.

- *Need for independent approval of settlements for vulnerable claimants, including those who lack capacity:* When litigation involves children and protected parties, the courts must approve any settlement agreement. Such 'checks and balances' must be replicated and we suggest the courts should be involved in approving compensation awarded to a child, and indeed, to any injured person involved in such a scheme.

    - ***The Government has reiterated its intention to extend fixed recoverable costs, which limit the amount that can be paid out to meet legal costs, to clinical negligence cases with settlements of less than £25,000. At what level should these fixed recoverable costs be set, and are there any circumstances in which they should not apply to low value clinical negligence cases?***

We believe that exceptions should be made in respect of the following cases:

- Fatal cases
- Stillborn babies
- Vulnerable parties. See Practice Direction 1a – Participation Of Vulnerable Parties Or Witnesses of the Civil Procedure Rules.

These claimants are those who require extra care and support through the legal process, so it is simply not appropriate to limit the resources and legal advice available to them.

- ***To what extent does the adversarial nature of the current clinical negligence system create a "blame culture" which affects medical advice and decision making?***

In short, we don't know.

We appreciate doctors and nurses who are facing allegations about competence must be in a very difficult position. The NHS is staffed by people, and we all make mistakes – that is human nature. We have a great deal of sympathy for over-worked junior doctors who are subject to target and performance pressures. Accepting liability at an early stage in a case where the NHS recognises that failings have led to an adverse health outcome for a patient will not only put patients first but it will also result in lower costs.

We believe that most people in the NHS do their best to help the patient when things go wrong and learn lessons. We are well aware that most, if not all, NHS staff want to do their best. A lack of training, supervision and openness all drive people to make mistakes. An entire change of culture is required so that those working in the NHS who make a mistake can openly hold their hand up and admit to it. This would mean the focus could be on making things right, and the organisation learning from those experiences. It is not okay, however, to see the same mistakes made repeatedly, with no learnings being drawn from those experiences.

Reforming the existing system of legal redress won't change the culture in the NHS. This approach is back to front!

- ***How important is it that any clinical negligence system encourages lesson learning and commitment to change as the result of any action?***

It is vitally importance that the system encourages lessons to be learned. We have seen the same mistakes in the NHS repeated time and again – for example the maternity care scandals across the country.

We have been impressed with the HSIB's reports and recommendations and consider this to be a good way to effect positive change, and learning, across the NHS.

We would also highlight the valuable work carried out by coroners, which provides valuable insight into failings and lessons to be learned.

- ***What changes should be made to clinical negligence claims to enable a move away from a blame culture and towards a learning culture in the NHS?***

Learning from the Aviation Industry – no blame

Closer consideration of the aviation industry and their accident investigation system may also prove insightful. By studying accidents, airlines are able to determine responsibility, educate new and inexperienced pilots so they learn from previous mistakes and prevent future accidents. Those investigating aviation accidents accept that there is rarely one single reason for an accident to have occurred. Rather, it is the result of a chain of events which lead up to an accident – an error chain – and that when individual links of the chain combine, they create the circumstances in which an accident can happen. By identifying all contributory factors that lead to the accident, elimination of one of these factors could have avoided the accident. The Air Accidents Investigation Branch make Safety Recommendations[4], defined as:

> *"A proposal of an accident investigation authority based on information derived from an investigation, made with the intention of preventing accidents or incidents and which in no case has the purpose of creating presumption of blame or liability for an accident or incident."*

The NHS could learn a lot from this system of review and education to understand all the causal factors which lead to negligent medical care, to enhance learning (all qualified medical staff require ongoing CPD training) and improve healthcare.

Use of black-boxes

We think that the NHS could make use of the black boxes used in aircraft to record events within a clinical setting, so that there can be a better understanding of what has gone wrong. All GPs, theatres and delivery rooms could have a black box installed, to end the culture of denial and cover up and stop people and departments passing the blame elsewhere, by allowing a completely transparent, unequivocal account of what events have led to an allegation of negligence.

Whistle-blower protection

The NHS should provide protection for and listen to whistle-blowers. The NHS, and managers within each Trust, should not view whistle-blowers as 'disloyal' for speaking up about systemic and repeated failings, but rather as people promoting positive change. An atmosphere of personal responsibility needs to be instilled so that staff are encouraged to "do the right thing" and "speak up" when they see things of concern, without fear of repercussions on their careers and relationships. They need to be given a 'safe space' from which to report their concerns without impacting their career.

- ***How can the Healthcare Safety Investigation Branch work to improve short term responses to patient safety incidences and therefore reduce the number of those who are forced to pursue litigation as a means of obtaining non-financial remedies?***

Whilst the work carried out by HSIB is incredibly valuable, they are not the right people to be involved in the early conversations with patients who have experienced sub-standard care. Short term responses are for the clinicians treating the patients to provide.

In our – admittedly anecdotal - experience, many of our clients say that had they received an apology, and a full explanation of what went wrong they would not have pursued litigation against

[4] https://www.gov.uk/government/publications/what-is-a-safety-recommendation/what-is-a-safety-recommendation

the NHS. Sometimes, the motivation for bringing a claim is based on a client's need to seek answers, with a wish that staff learn from mistakes so no one in the future needs to go through what they went through.

- ***What legislative changes would be required to support these changes?***

There is already a statutory duty of candour – it needs to be enforced.

The Parliamentary and Health Service Ombudsman currently lacks clout to effect positive change. Consideration should be given to giving the Ombudsman more powers, particularly where the duty of candour has not been complied with, so that they can hold NHS Trusts to account. Expansion of the role of the Patient Safety Commissioner could be an effective way to resolve this lacuna, to broaden their remit to all medical treatment. The currently proposed remit relating to devices and products represents a lost opportunity.

Bolt Burdon Kemp

For further information or follow-up please contact Sonita Hayward

Oct 2021