Issue No. 49

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EXPERT PAIN REPORTS

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Listed on the UK Register of Expert Witnesses, an APIL expert, Member of Society of Expert Witnesses and Expert Witness Institute.

Dr Adedokun accepts instructions from Claimants, Defendants and as a Single Joint Expert. He covers Manchester, Liverpool, Leeds, Birmingham and London. Other locations and Domiciliary visits can be arranged.

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I have been involved in medico legal work for over 15 years, producing medical reports for around 40 to 50 cases per year, mainly in cases involving clinical negligence.

The majority of my medico legal work is on behalf of claimants although I am willing to perform defence work.

Depending on the complexity of the case, I can usually produce reports within 3 - 6 months of instruction.

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contents

IN THIS ISSUE

16

12

19

7 ***Opening Statement***

NEWS

8 Expert panel will review family courts
8 Video extended to abuse injunctions
8 Probation service to be centralised
11 Massive fine following offshore gas incident
11 RICS offers guidance for experts
11 RICS consults on new standard
11 Lawyers welcome conveyancing rules

FINANCE & ACCOUNTANCY

12 Understanding business accounts – what to look out for
14 What if an expert changes his opinion?

FOCUS ON SCOTLAND

16 Scotland's lawyers celebrate reaching platinum
17 Age of responsibility change puts Scotland in the lead
17 Technology aims to protect vulnerable witnesses

CHOOSING THE CORRECT EXPERT

19 How do I find the right expert?

TRAINING FOR EXPERTS

20 Training: just being an expert is no longer enough
21 Consent and litigations – an expert witness's perspective

A to Z WEBSITE GUIDE

15 Our A to Z guide to the websites of some of the country's leading expert witnesses.

EXPERT CLASSIFIED

51 Expert Witness classified listings
54 Medico-legal classified listings

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2YWC

MEDICAL ISSUES

23 *Medical Notes*

NEWS
25 CQC 'sorry' for abuse uncovered in BBC programme
25 Panel firms announced for new GP negligence scheme
27 NHS boosts care funding for those with learning disabilities
27 BMA fumes as records are misfiled

PAIN MEDICINE
28 Opioid labelling initiative welcomed by pain doctors
28 Neuro-pain medicines reclassified as controlled

VARICOSE VEIN SURGERY
29 Will 2019 see the fading out of traditional varicose vein surgery?

PHYSIOTHERAPY
30 Chartered body has its own medico-legal register
30 New guidelines confirm need for early mobilisation post-stroke
31 Physios' lawyer stresses importance of early rehab
32 How physiotherapists can assist in expert witness work

ORTHOPAEDICS
33 Study reveals failures of hip screening in babies
34 Societies respond to joint failure press report
35 Complications after trauma – acute compartment syndrome in orthopaedics
36 Waiting time increase flagged up by orthopaedic association
37 This trauma expert witness is a real high-flyer

TOXICOLOGY
38 Pharmacists call for ban on 'deadly' weight loss drug

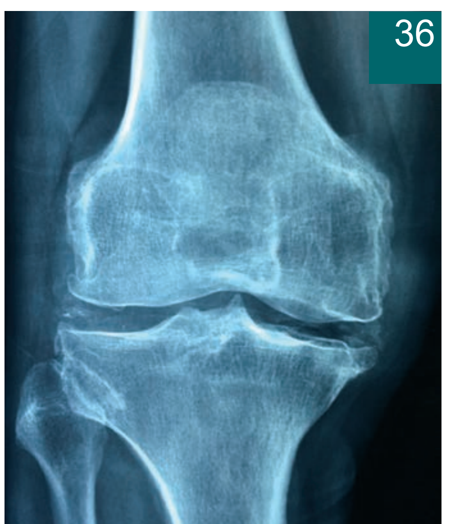
DENTISTRY
39 Dentists echo NAO call for clarity on charges
40 Potential for conflict between counsel and expert witness

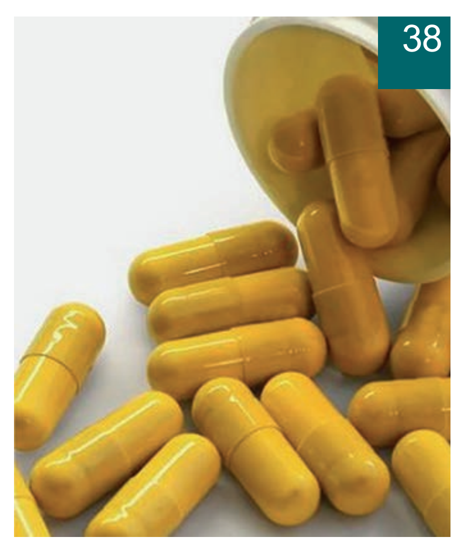
PSYCHIATRIC & PSYCHOLOGICAL ISSUES
43 New capacity law still raising concerns
43 Reality TV inquiry welcomed by profession
45 Assessing malingering, lying and deception for reports

OPHTHALMOLOGY
47 Research could help reduce misdiagnosis of dementia-related visual problems
47 RCOphth issues lens alert

PLASTIC, RECONSTRUCTIVE & HAND SURGERY
49 Reality TV seen as driver in liposuction growth
49 Surgeons urge caution in declining funding

OBSTETRICS & GYNAECOLOGY
50 Special measures follow maternity report


36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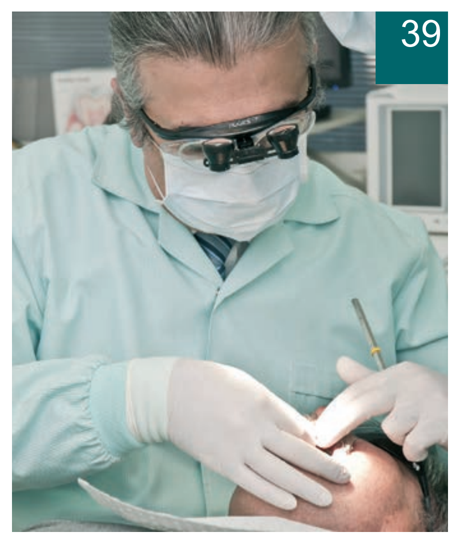
39

Dr Linda Monaci

Consultant Clinical Neuropsychologist

Medico-legal assessments for suspected or known brain injury and/or brain dysfunction in Personal Injury and Medical Negligence claims

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Medico-legal services: Instructions from Claimants, Defendants and as a Single Joint Expert. Appointments usually within 2 to 4 weeks, and reports produced in a further 2 to 4 weeks. Assessments can be carried out in Italian. Dr Monaci also has a good knowledge of the Swedish language and has experience of working through interpreters.

Clinical services: Clinical neurorehabilitation.

Dr Monaci has completed the Cardiff University Bond Solon Expert Witness Certificates (Civil and Criminal Law).

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Opening Statement

THIS YEAR SEES the 70th anniversary of The Law Society of Scotland. Given that the legal systems in Scotland and England have been famously different for centuries, it seems perverse that the country's lawyers only acquired their own representative body less than one of those centuries ago. In fact the principal was established in 1933, but the little matter of World War Two got in the way of its implementation.

Nevertheless, a platinum anniversary is something to be celebrated and Scotland's advocates are determined to do just that: especially as it coincides with the centenary of the Sex Disqualification (Removal) Act, which paved the way for women to become solicitors for the first time.

• One of the traditional differences between English and Scottish law has been that of the age of criminal responsibility. In fact the discrepancy only dates from 1963, when the age was raised in England and Wales but left at age eight in Scotland.

In a landmark decision, the Scottish Parliament has voted to raise the age of criminal responsibility there to 12. There are debates on-going in England to do the same.

• Another area of law in which there are differences between England and Scotland is that of the role of the expert witness. Whichever jurisdiction an expert works in, these days training is needed to be able to fulfil the necessary criteria and abide by the relevant procedures.

There are many sources of training – some leading to formal qualification – but what they all have in common is that they make it easier for instructing solicitors to know what they are getting.

• One of the organisations that provides expert witness training is the Royal Institution of Chartered Surveyors – the professional organisation representing property specialists. And the property industry has been undergoing a series of changes to tighten up practice and improve what has not always been the best of images.

The changes include moves to promote greater transparency in the buying and selling process, announced by the government in May. The measures, which include guides for consumers explaining the process, have been endorsed by the Law Society of England and Wales.

A further proposal is for new mandatory standards for home surveys, which would be enforced by the RICS itself. The institution is currently consulting with both its members and – commendably – the public.

• Experts of a different kind will be looking into the protection offered to children and families by the family courts in cases involving alleged abuse. The expert panel has been assembled by the Ministry of Justice and includes senior members of the judiciary, leading academics and charities.

The move is in response to concerns raised during the government's domestic abuse consultation. There are even claims that abusers have been abusing the court process itself – using it to inflict a kind of secondary abuse and re-traumatise their victims.

• Technology is a way of mitigating the trauma experienced by abuse victims, such as the use of so-called fully-video to process applications for injunctions against abusers. A scheme that was trialled in Manchester met with approval from many corners and is set to be extended. The fully-video system allows two-way communication between the applicant and the court and has led to a reduction in stress felt by victims.

• General approval was also given to another step forward in the treatment of vulnerable people: the re-centralising of the probation service. Justice Minister David Gaulke announced that all probation activities will now be carried on under the aegis of the National Probation Service.

This being the government, they couldn't go the whole hog and bring all provision in-house, but having a central authority overseeing provision can only lead to improvement. ❑

Ian Wild, Director of Business Development
Your Expert Witness

Expert panel will review family courts

A PANEL OF EXPERTS is to review how the family courts protect children and parents in cases of domestic abuse and other serious offences. The three-month project – launched on 21 May – aims to ensure that the family court works first and foremost in the explicit interests of the child, such as their safety, health and well-being. The MoJ-chaired panel will consist of a range of experts including senior members of the judiciary, leading academics and charities.

The move follows responses received through the government's domestic abuse consultation in which concerns were raised around the family courts' response to potential harm to children and victims. In addition to calls for better protection for children, some claim that domestic abusers are using the court system to re-traumatise their victims.

Justice Minister Paul Maynard said: "Some of the most vulnerable in our society come before the family courts, and I am absolutely determined that we offer them every protection.

"This review will help us better understand victims' experiences of the system, and make sure the family court is never used to coerce or re-traumatise those who have been abused. Its findings will be used to inform next steps so we can build on the raft of measures we have already introduced to protect victims of domestic abuse."

The project will examine the courts' application of Practice Direction 12J, examine the application of 'barring orders' which prevent further applications being made without leave of the court, and gather evidence of the impact on the child and victim where child contact is sought by someone alleged to have, or who has, committed domestic abuse or other relevant offences.

The panel will consider how the family courts handle a range of offences, including rape, child abuse, assault, sexual assault, murder and other violent crime, with the government committed to ensuring the right protections are in place for victims and their children. ❑

Video extended to abuse injunctions

DOMESTIC ABUSE VICTIMS may seek injunctions more easily and with less stress as part of a test into the use of fully-video court hearings. A trial at Manchester Civil Justice Centre has led to vulnerable people appearing before the court using a video link from a computer in their solicitor's office, avoiding the distress of appearing in court at an already difficult time.

This has been used in six cases so far and feedback from those involved has been positive. Testing will continue in the family and civil courts during the coming months and is being independently evaluated.

Jane Campbell, a partner at family law solicitors Makin Dixon, who is representing a female client, said: "Accessing the hearing has made a real difference to our client; she was a referral from victim support, who commented how convenient it was for the client. The victim was too scared to go home last night and doing this over video has really made a positive impact."

The video hearing has the gravitas of a court room. The interview suite is set up with all the necessary tools to swear in a witness and the client gets to see the judge and observe the process. ❑

Probation service to be centralised

THE PROBATION SERVICE is to be brought back under central control, it has been announced. Justice Secretary David Gauke revealed on 16 May that all offender management will be brought under the aegis of the National Probation Service (NPS), although the private and voluntary sectors will still have a role.

The reforms are designed to build on the successful elements of the existing system, Transforming Rehabilitation, which led to 40,000 additional offenders being supervised every year, along with the introduction of fresh ideas and innovative new rehabilitative services from private and voluntary providers.

David Gauke said: "Delivering a stronger probation system, which commands the confidence of the courts and better protects the public, is a pillar of our reforms to focus on rehabilitation and cut reoffending. I want a smarter justice system that reduces repeat crime by providing robust community alternatives to ineffective short prison sentences - supporting offenders to turn away from crime for good.

"The model we are announcing today will harness the skills of private and voluntary providers and draw on the expertise of the NPS to boost rehabilitation, improve standards and ultimately increase public safety."

Plans to bring forward legislation to implement a statutory regulatory framework that will hold probation officers to the same professional standards as doctors and lawyers will also ensure that probation staff feel respected and empowered to deliver this important service.

The MoJ will work closely with providers, stakeholders and staff to finalise the proposals, ready for the new model to come into effect in spring 2021. ❑

Joanne Caffrey, Expert Witness

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Massive fine following offshore gas incident

MARATHON OIL UK LLC (MARATHON) has been fined £1,160,000 following an HSE investigation into a high-pressure gas release on its Brae Alpha offshore platform on Boxing Day 2015.

Aberdeen Sherriff Court heard that, on 26 December 2015, an eight-inch diameter high pressure pipework in Module 14 of the platform suffered a catastrophic rupture as a result of 'corrosion under insulation', allowing over two tonnes of high-pressure methane gas to be released almost instantaneously.

The force of the high-pressure blast caused significant and widespread damage within Module 14. The incident occurred while most of the 100 personnel on the platform were gathered in the accommodation block, in readiness for their Boxing Day meal and away from the source of the blast.

An investigation by HSE found that Marathon Oil had failed to undertake any suitable and sufficient inspection of the pipework that would have allowed the company to identify the risk and prevent the hazard from materialising. The failures resulted in personnel on board the Brae Alpha platform being exposed to an unacceptable risk of serious personal injury or death from fire and explosion, and also led to HSE serving an Improvement Notice on Marathon Oil in January 2016, requiring the company to implement an effective hydrocarbon pipework inspection and maintenance regime.

On 20 May Marathon pleaded guilty to breaching Regulation 4(1) of the Offshore Installations (Prevention of Fire and Explosion, and Emergency Response) Regulations 1995 and Section 33(1) of the Health and Safety at Work Act 1974, at Aberdeen Sheriff Court.

HSE inspector, Ahmedur Rezwan, said: "This incident is a further reminder of the ever-present hazards in oil and gas production that, if not rigorously managed, can easily result in a potentially life-threatening event.

"Corrosion under insulation is a well-known risk and this incident should not have occurred. During any normal period of operations personnel could easily have been working in, or transiting through, Module 14 – and they would almost certainly have been killed or suffered serious injury. The timing of the incident and fact that the gas did not ignite was fortuitous." ❑

RICS offers guidance for experts

ONE OF THE MOST obvious places to seek expert opinion in property and construction disputes is the office of a chartered surveyor.

The Royal Institution of Chartered Surveyors (RICS) offers one of the most respected dispute resolution services and also publishes guidance for its members who provide expert evidence to be relied upon in civil proceedings before a wide range of tribunals.

The guidance:

- Explains the need for clear instructions and terms of engagement
- Gives guidance on what to do in situations of conflict of interest
- Outlines the written report format
- Clarifies the differences between the roles of expert and advocate
- Helps remove pressure upon experts to support their clients' cases irrespective of their honest professional opinion.

It is one of a series of documents produced by RICS to aid its members in providing dispute resolution. Another deals with independent expert determination. According to RICS, the guidance 'is designed primarily to assist those who are appointed either by the president of RICS or directly by the parties to a dispute, to act as an independent expert to determine their dispute.'

A further guidance note deals with mediation. It is aimed at helping surveyors represent their clients at or before mediations, with or without lawyers. It is not aimed at surveyors acting as mediators.

A fourth document, *Conflicts of Interest for Members Acting as Dispute Resolvers,* covers the appointment of surveyors as arbitrators, independent experts, mediators, adjudicators and other dispute resolvers.

That guidance was updated in June 2013 to include a Scottish Addendum. ❑

RICS consults on new standard

THE RICS has launched an industry and public consultation on the proposals for a new mandatory Home Survey Standard. It hopes that the proposals will deliver a new best practice standard to improve the homebuying and selling process and enhance consumer confidence.

The consultation consists of an industry questionnaire and a public questionnaire.

RICS worked with industry to create the proposed new standard and plan to make it simpler for consumers to understand what is checked, the different surveys on offer and the level of service delivered by RICS members.

RICS would also like to ensure consistency in the types of survey offered. They say that the changes have been made in response to a changing marketplace, updated technology and consumer needs.

The questions cover home surveys and valuations. Topics where views from solicitors would be particularly useful include the document's clarity, structure and content, and omissions.

Solicitors who carry out residential conveyancing work may want to respond to the consultation, which closes on 29 July. ❑

Lawyers welcome conveyancing rules

KEY GUIDANCE on buying and selling properties unveiled by the government in May has been endorsed by the Law Society of England and Wales, which called for greater transparency in the conveyancing process.

"Consumers need to know more about the process for homebuying and selling, including understanding the information they should be looking for," said Law Society president Christina Blacklaws.

"The Law Society is committed to making the process more open, transparent and efficient. We are working with government and other stakeholders to make improvements – including contributing to the creation of the guides.

"Having a common point of reference for consumers will help them navigate successfully what can often be a complicated and stressful process. Professionals and consumers can now refer to the same standardised set of guidance."

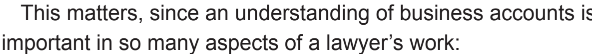
The guides include detailed steps on how to complete a property transaction, where to find further information, and the organisations which can help. ❑

Understanding business accounts – what to look out for

By CHRIS MAKIN ***Chartered Accountant, Civil Mediator and Expert Determiner***

LAWYERS ARE GOOD with words and accountants are good with figures. What a pity they don't talk the same language! Now meet an accountant who *is* good with words. As an experienced expert witness, I have to be – which means that I must be weak with figures. True? Not really!

It's a pity that so many people, some lawyers included, are frightened of figures, because the principles really are quite simple – they have to be, for me to understand them! Many accountants like to keep the mystique of business accounts to themselves, but I am happy to share. So here is my contribution to the sum of legal knowledge.



This matters, since an understanding of business accounts is important in so many aspects of a lawyer's work:

- A self-employed man is seriously handicapped after an operation went wrong. What would he have earned but for his disabilities?
- A company director is killed in an RTA. But for his death, how much of his earnings would his dependents have received for what would have been the remainder of his working lifetime?
- A couple seek a clean break divorce, so the matrimonial 'balance sheet' must be drawn up. The husband has a limited company, so what is it worth, and what cash could be withdrawn to assist in the settlement?
- A factory burns down. What would the future profits have been?
- A factory burns down, and a false claim is suspected. Was the business *really* earning as much as claimed? Was there a motive for arson, revealed by close analysis of past trading results?
- The directors of a company can't get on, and a Section 994 claim is made. How much should the court order that the unfairly prejudiced shareholder receives for his shares?

In all these situations, and more, you the lawyer need to know what the past business accounts show, how reliable they are, and how they may be used as a basis for projecting future profits or for valuing the business.

How do you begin? Well, you could of course instruct an accountant to advise on every case where business accounts are involved; but in these days of stringent costs, that can't happen. So how do you gain an understanding of which cases do indeed need an expert accountant's help; and which ones you, as a wordsmith but perhaps not a figuresmith, can handle yourself?

The first thing is to get a simple guide to business and company accounts. I can help. For some years up to the death of David Kemp QC I had a short chapter (9 pages) in Kemp & Kemp which gave this guidance. After Mr Kemp's death the work was re-written, and my simple guide is subsumed in the work of others. So it is out of print, but still highly relevant to lawyers dealing with all the kinds of cases that I list above, and not just personal injury. I am happy to send a copy, without charge,

to whoever asks for it – and this offer has been gratefully accepted by many lawyers.

The second is to have a relationship with a friendly forensic accountant who will perform an initial review of any case and give you his views and a fee estimate – without charge if not appointed. I do this frequently; I don't sulk if not appointed, and tell you if I consider that an expert accountant is *not* needed.

This is good business for both of us. I am appointed only on worthwhile cases, and you have the assurance that someone who understands business accounts, and their relevance to your case, has considered them. If nothing else, it saves you negligence claims!

Thirdly, let us have a very brief look at what to watch out for when you first receive that mysterious bundle of business accounts. Once you have my Kemp & Kemp chapter you will be halfway there. But I will finish with some quick tips on what to look out for in limited company accounts:

- The audit report: does it use standard wording for a 'clean' report, or is the auditor trying to tell you something?
- A qualified audit report: no 'true and fair view' or a true and fair view 'except' is serious. Beware of what the auditor clearly is trying to tell you!
- If there is no audit report, it may simply be because the company is too small to require one. In fact that applies to the vast majority. But then there can be no assurance that a qualified accountant has looked at the books independently.
- Even then, good accountants would not put their name to accounts which they knew to be wrong, so speak to someone who knows the good or bad reputation of the accountant.
- Look at the profit and loss account. Are dividends being paid even if a loss is suffered? Does that lead one to believe that matters are not so bad as the directors would have us believe?
- Look at the balance sheet, and remember that the total shareholders' funds is *not* the worth of the business. If that comes as a surprise, I will explain if you give me a ring when you have a spare half hour!
- Is net current assets a positive or a negative figure? If the latter, is there a fear that the company will not be able to pay its debts as they fall due?
- Ensure that you receive a copy of the detailed trading accounts, usually headed 'Trading and Profit & Loss Account for Management Information Only'. These do not form part of the statutory accounts but they are essential to an understanding of the business.

  I insist on seeing these for several years and I always start by charting them in Excel, to see whether turnover is going up or down, the rate of gross profit, whether expenses have any 'quirks', and so on. Seek explanations, or use an experienced forensic accountant who can ask *intelligent* questions!
- Consultancy fees are usually interesting. What assistance was given? Was it to someone close to the directors? Was it at a market rate? Will the benefit of the consultancy be reflected in future profits? Or is it just a tax fiddle, or an attempt to reduce profits artificially?
- Directors' remuneration: has it varied much? With a family company, the proprietors will take out salary, fees, benefits in kind, pension contributions and dividends in a tax-efficient way. The salary will seldom be at a commercial rate.
- If this remuneration were to be replaced by reasonable management remuneration, what would that do to the reported profits (or losses)?
- Depreciation: have the rates changed? Is there a suspicion that this is to increase (insurance claim) or reduce (divorce) profits?
- Fixed assets: after depreciation are they shown at a realistic value? Remember that fixed assets are to be shown at historic cost (unless revalued) less depreciation, which can give a false indication of the value of the company. Is freehold property undervalued?
- Have fixed assets been revalued? Professionally, or just by optimistic directors? Is this just an artificial device to prop up a creaking edifice of a company?

There is more – much more – but in this short article I trust I have provided something of value, so that you can decide, for your many and varied cases, when a forensic accountant is needed and when not to waste his time.

But as a final point, if you wish to send me your key documents for a free initial review without obligation, that would *never* be a waste of *my* time! ❑

Chris Makin

Chartered Accountant
Accredited Civil Mediator
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He is also an accredited civil and commercial mediator and an accredited expert determiner. Over the last 30 years, he has given expert evidence over 100 times on a vast range of cases and conducted over 100 mediations.

For CV, war stories, videos and much more go to the website www.chrismakin.co.uk. ❑

What if an expert changes his opinion?

By* DAVID BUNKER*, Chartered Accountant, Arbitrator and Mediator

AN EXPERT is traditionally regarded as a pillar of reliability and strength of opinion: someone to rely upon in the course of a dispute, an investigation or a court case. So it is an extremely rare event for an expert to change his opinion – but it is not unknown – and in this article I will consider the circumstances in which that rare occurrence may happen and the outcome as regards the other parties involved in the process.

I will start by reminding readers that, although an expert may be appointed as an independent expert by the person convening proceedings, the more traditional appointment is that of party expert. In that case the expert is part of a team appointed by, and presumably supporting the position of, a third party.

That expert will have been hired because the party has ascertained that the expert's opinion on a particular issue, or one part of that issue, coincides with that of the party hiring them. If that expert's opinion did not coincide, then quite simply, they would not have been hired. However, to make the position clear, the expert's ultimate responsibility is not to the person hiring them, but to the court or other body they are reporting to. That is a clear ethical and professional position which is clearly understood by every expert I have come into contact with.

The most obvious circumstance giving rise to a change of opinion is the subsequent realisation by the expert that their conclusion was wrong. There are, unfortunately, times when we all look back with the benefit of hindsight and see that our previous opinion was either mistaken or simply too categorical. It may be simply as a result of further reflection, or prompted by some subsequent event that casts doubt on our previous opinion.

The obvious but unpleasant duty of the expert is clear: they must notify not only their client, who is likely to be disconcerted at best, but more importantly the convener of the tribunal to which they are reporting.

In my experience, that kind of 'Road to Damascus' change of opinion is very rare. What is far more likely is some measure of shift in position or emphasis. In most cases where a party expert is appointed there will be a point at which the two experts will meet to try to arrive at a common position. In my experience, those kinds of meeting rarely result in the kind of face-to-face disagreement where each side flatly contradicts the other. What generally happens is that each expert discovers that they have been given a fairly specific brief to examine a situation from a very prescribed point of view. In effect, both experts may discover that they are both right; but they are simply providing opinions on differing aspects of the same situation.

The conclusion as to how to proceed in that situation seems to me to be less clear cut. In an ideal scenario both experts would work together to produce a combined report that puts the work of both in a broader context, while enabling each to continue to endorse their slightly narrow opinions on the matters that their respective clients have commissioned. What is more likely, however, is that each expert will report back to their respective party, and that party will then rely on their own legal team to argue for the significance of their expert's opinion over those of others.

Finally, an expert must be wary of slippage, whereby they start to provide an opinion for their client on something upon which they are well qualified to report, but because of pressure from the client or their team they find their opinion is sought on other aspects upon which they are less well qualified to comment. The expert risks the wrath of the judge if they proceed down that foolish path. If at any time they realise that they have got out of their depth, they are best advised to report the fact to the judge at the earliest opportunity. ❑

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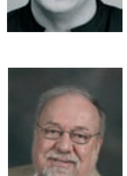

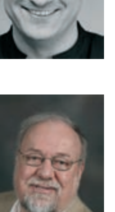

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Scotland's lawyers celebrate reaching platinum

THIS YEAR SEES the 70th anniversary of the Law Society of Scotland – its platinum anniversary: and the lure of the precious metal forms the backdrop to a number of activities, including a series of special blogs by notable figures in the society.

Reflecting on the anniversary, the society said: "Our 70th year is an opportunity to showcase the fantastic work of the Scottish legal profession, reflect on how the law and practice has progressed as well as looking to the future."

The differences between Scots and English law has been summarised by the Scottish Centre for Crime and Justice Research at the University of Glasgow thus: "The Act of Union 1707 between Scotland and England permitted Scotland to retain its separate legal system, which continued to be administered in Scotland. This meant that, prior to devolution, the Scottish justice system had its own court system, its own police forces, its own prosecution service and its own prison and criminal justice social work services.

"The 1998 Scotland Act devolved a range of powers from Westminster to the reconvened Scottish Parliament, which included legislative powers to administer the Scottish legal system.

"Scots Law is divided into two main categories: civil law and criminal law. Civil law (also referred to as 'private law') is, broadly speaking, about the rights and obligations of individuals and organisations (and not the state), and has been derived from the principles of Roman law."

One of the main functions of the society's policy team is to analyse and respond to proposed changes in the law, to ensure that new laws – or changes to existing ones – are clear and will work in practice.

Part of this process involves commenting on consultations from the Scottish Government, Scottish Parliament, UK Parliament, Scottish Law Commission and Europe. Plus, the society carries out consultations of its own.

This year is an extra special year for the legal profession because it is 100 years since a change in the law permitted women to become lawyers for the first time. The Sex Disqualification (Removal) Act in 1919 paved the way for women to build a career as a solicitor.

To mark the anniversary, we report on two new legislative initiatives. ❑

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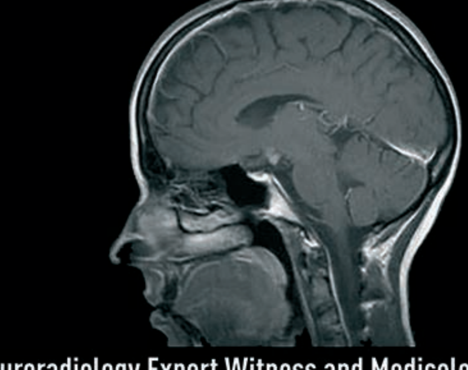

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Age of responsibility change puts Scotland in the lead

PRIMARY SCHOOL-AGED CHILDREN will no longer be arrested and treated as offenders in Scotland, following the passing of the Age of Criminal Responsibility Bill. The Bill raises the age of criminal responsibility in the country from eight to 12.

Scotland had traditionally the lowest age of criminal responsibility in the UK. The Children and Young Persons Act 1933 raised the age from seven to eight across the UK, where it stayed in Scotland despite changes in England and Wales.

Now, Scotland is leading the way by increasing the age of criminal responsibility to the highest in the UK – with plans to raise it further within three years.

Children's Minister Maree Todd said: "Today is an historic day. This groundbreaking law delivers a bold, progressive, child-centred approach that will make a real difference to children's lives.

"We can be proud that Scotland is leading the way in the UK. This new law means that no child under 12 will ever again be arrested or charged with an offence in Scotland. But the Bill also ensures that serious harmful behaviour will be investigated appropriately and victims will continue to get the support they need.

"Currently young children can be left with criminal records that can follow them into adulthood and affect their chances of getting training or a job. The measures in the Age of Criminal Responsibility Bill will end that.

"I have sought to achieve the right balance with this Bill. This legislation forms a key part of our wider approach to children's rights and youth justice. By getting this right we will demonstrate that in Scotland we don't just say things differently, we will show it by doing things differently."

Harmful behaviour will continue to be recognised and investigated with victims respected and responded to appropriately and the Scottish Government has taken steps to bring elements of the new legislation into force as quickly as possible.

Ms Todd also announced a new Advisory Group to take forward a review of the legislation. The group – whose membership will include stakeholders and agencies working with children and young people – will consider whether the age should be raised to higher than 12. ❑

Technology aims to protect vulnerable witnesses

LEGISLATION TO ENSURE more child witnesses are able to pre-record evidence ahead of jury trials has been passed unanimously by the Scottish Parliament.

The Vulnerable Witnesses (Criminal Evidence) (Scotland) Bill will minimise distress and improve the quality of evidence given as it will be recorded at an earlier stage in proceedings for the most serious offences. Once in place, the changes are expected to benefit hundreds of children each year.

Community Safety Minister Ash Denham said: "This is a milestone in Scotland's journey to protect children as they interact with the justice system, and a key part of our wider work to strengthen support for victims and witnesses.

"Children who have witnessed the most traumatic crimes must be able to start on the path to recovery at the earliest possible stage and these changes will allow that, improving the experiences of the most vulnerable child witnesses, as far fewer will have to give evidence in front of a jury.

"We are committed to ensuring these significant reforms are implemented in a considered, effective way and we have already provided the Scottish Courts and Tribunal Service with more than £2 million to upgrade technology and create hearings suites that will support child and vulnerable witnesses to give their best evidence." ❑

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Mr William Stuart Hislop
BDS MBChB FRCSEd FFSTEd FDSRCSEd FDSRCPS
Consultant Oral and Maxillofacial / Head and Neck Surgeon

Mr Hislop has been a Consultant Oral and Maxillofacial surgeon at Crosshouse Hospital, Kilmarnock since 1994 and is now also at the regional Maxillofacial Unit at the Queen Elizabeth University Hospital in Glasgow. He has been an Honorary Clinical Senior Lecturer at the University of Glasgow since 1995.

He specialises in head and neck ablative and reconstructive surgery for malignancy, salivary gland surgery and facial aesthetic and cancer surgery. He is experienced in dealing with facial trauma and also undertakes routine oral surgery.

Mr Hislop is currently carrying out approximately thirty medico-legal reports per year for both defence and prosecution.

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Dr Sheela Shah MBBS MD FRCP

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Dr Sheela Shah acts as an expert witness, including the preparation of medico legal reports and appearing in court, in cases relating to all fields of acute hospital medicine involving adults of all ages – including cerebrovascular disease and neurology, cardiology, gastroenterology, chest, hepatobiliary and metabolic medicine.

Dr Shah takes instructions on behalf of either claimant or defendant or as a Single Joint Expert.

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Broomfield Hospital, Court Road, Broomfield, Chelmsford, Essex CM1 7ET

Professor Charles Davis MBBS FRCS

Consultant Neurosurgeon

Professor Charles Davis acts as an expert witness in cases relating to neurosurgery, including the preparation of medico-legal reports and appearing in court.

His specialist areas of expertise include:

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Dr Lars Davidsson MRCPsych MEWI

Consultant Psychiatrist and Accredited Mediator

Dr Lars Davidsson is a consultant psychiatrist of almost 30 years standing. Over the past ten years he has provided more than 1,200 medico legal reports and attends court as an expert witness on a regular basis.

With almost 10 years' experience from his local Criminal Justice Mental Health Team, Dr Davidsson has a special interest in anxiety and trauma, including as a result of road traffic accidents. He has also written an increasing number of reports for employment tribunals.

He is experienced in giving evidence at the Magistrates Court, Crown Court and County Courts (mainly for family matters) as well as Military Tribunals. He also attends professional hearings as an expert witness for GDC, NMC and GOC.

Dr Davidsson has undergone continuous formal training in report writing and court appearance and is a member of The Expert Witnesses Institute.

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- Leukaemia
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Dr Keenan has experience of working with barristers and being cross examined in court. He keeps his reports relatively short, focused on the legal instructions, with all scientific and medical language and the basis of any opinions explained and referenced as required.

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How do I find the right expert?

EXPERT WITNESSES HAVE BECOME an increasingly-important element in the judicial process over recent decades – helping the courts and other bodies to reach decisions in ever-more complex areas of law. They produce reports and statements or give evidence in a variety of forums: criminal, civil and family courts and the full range of tribunals, as well as in judicial inquiries and professional misconduct and fitness to practice hearings.

So what is an expert witness, how do you find one and how do you choose between them?

The Expert Witness Institute (EWI) acts as a voice for the expert witness community, supporting experts from all professional disciplines and lawyers who use the services of experts. It functions to encourage, train and educate experts and to improve and maintain their standards and status.

The EWI defines an expert witness thus: "To be an expert witness, you need to be an expert. This may seem obvious, but note that an expert is not the same as an expert witness.

"An expert offers special expertise in a particular field. As an expert witness, however, he or she needs to offer additional skills and abilities – courtroom skills and report writing, for example – which can be enhanced by training and developed over time.

"When in court, the expert witness methodically presents opinion evidence based on evidence of fact. The subsequent report – which the expert witness also prepares – would be written within a specified time scale in compliance with specific legal guidelines."

Fundamental to the role of the expert is that their overriding responsibility is to the court. Gone are the days of 'hired guns' putting forward the expert opinion most suited to the party that appointed them.

Dr Jan Wise, chair of the medico-legal committee of the British Medical Association (BMA) writes: "The expert's duty is to the court. This overrides any obligation to the person who is instructing or paying them. This means that they have a duty to act independently and not be influenced by the party who instructs or pays them.

"The main trait of expert evidence is that it is opinion evidence. However, the expert is expected to take care not to express opinion that strays beyond the limits of their personal expertise.

"Where opinions cross the boundaries of expertise, the expert is expected to respect and where appropriate defer to the opinions of experts in those other areas of expertise."

That principal is set out by the Civil Justice Council (CJC). In its *Guidance on the Instruction of Experts in Civil Claims*, the CJC states: "Experts always owe a duty to exercise reasonable skill and care to those instructing them, and to comply with any relevant professional code. However, when they are instructed to give or prepare evidence for civil proceedings they have an overriding duty to help the court on matters within their expertise (CPR 35.3). This duty overrides any obligation to the person instructing or paying them. Experts must not serve the exclusive interest of those who retain them."

The modern expert witness, however, also needs to offer a range of organisational skills suited to the modern justice system. In the introduction to its expert witness courses, well-known training company Bond Solon explains: "Solicitors now look for experts who can demonstrate that they are able to meet deadlines, produce court-compliant reports, have credibility in the witness box and have a thorough understanding of the relevant procedure."

Finding and choosing an expert witness depends on the type of expert needed and the preferences of the instructing solicitor. The most obvious starting point is to ensure they have the required level of expertise in the relevant practice area. Most professional bodies maintain a register of their members qualified and willing to undertake instruction as an expert. The Institute of Chartered Accountants of England and Wales and the Royal Institution of Chartered Surveyors are two such. The Expert Witness Institute has a more broadly-based register.

When instructing medical experts the sheer range of specialties can be bewildering. The Royal Colleges confer specialist qualifications that can be of help in determining specialist knowledge.

Some cases require a team of experts across various disciplines. In a recent issue we reported on a case handled by Girlings Solicitors in Kent that involved experts in emergency medicine, orthopaedic surgery, neurology and neurosurgery, together with a psychiatrist, a urogynaecologist, a colorectal surgeon and a care expert.

A useful starting point could be the array of experts in many fields to be found in this publication and its associated website at www.yourexpertwitness.co.uk. ❑

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Training: just being an expert is no longer enough

HAVING ESTABLISHED the need for an expert opinion in a particular case – and having determined the area and level of expertise required – how do you determine that the individual you engage has the necessary abilities to apply that expertise as an expert witness?

These days there is a great deal of training available for both established and prospective expert witnesses to ensure they have the background knowledge of what is required of them. As well as giving confidence to the instructing solicitor, such knowledge can protect the expert themselves from making costly errors.

Leading training provider Bond Solon explains: "Important changes to both the Civil and Family Procedure Rules and the Supreme Court's decision to abolish expert witnesses' immunity from suit has resulted in solicitors being more careful than ever when assessing the suitability of an expert.

"Solicitors must adhere to the Protocol for the Instruction of Experts and ensure the expert has training appropriate to the value, complexity and importance of the case."

Bond Solon's own training course can lead to the Expert Witness Certificate – in civil, criminal or family law – which is offered in conjunction with Cardiff University. The Cardiff University Bond Solon Expert Witness Certificate is regarded as the gold standard in expert witness training and is highly regarded among law firms and other instructing parties.

To date over 1,500 experts from a wide variety of professions have completed, or are in the process of completing, one of more of the three certificates, which can be delivered through a public course or on an in-house basis.

> *"Before becoming an expert it is essential to do your groundwork"*

Training is also offered by a number of professional bodies, which is tailored to the professional expertise of their members. The Royal Institution of Chartered Surveyors has its own Expert Witness Certificate, while the Institution of Civil Engineers offers an Advanced Professional Award in Expert Witness Evidence. The Institute of Chartered Accountants' Forensic and Expert Witness Community also offers training courses throughout the year.

For medical expert witnesses the British Medical Association has a medico-legal committee, which is responsible for advising on legal matters affecting doctors who undertake work as an expert or professional witness. For psychologists training is available from the British Psychological Society.

The various expert witness organisations also provide training for both their members and non-members. The Expert Witness Institute (EWI) offers a variety of courses, including a valuable introductory seminar for those professionals who are considering taking up the role.

The EWI says: "Before becoming an expert it is essential to do your groundwork and this seminar will provide everything you need to know about becoming an expert, what is expected from you, how demanding this additional career could be and how fulfilling it can be."

Even if a professional does not wish to pursue the role of expert witness, but is involved in a case that requires them to act as a witness, knowledge of procedure can be of benefit. Here, again, Bond Solon can be of assistance with its Witness Familiarisation Service.

Having acquired the relevant training, it is more important than ever to keep abreast of changes. Recent changes to the Criminal Procedure Rules regarding disclosure demonstrate the need for constant updating. The theme of this year's EWI Annual Conference in September sums up the requirement: *Nothing stays the same; is everything changing?* ❑

Dr Philip Barber FRCP
Consultant Respiratory Physician

Dr Philip Barber is a Consultant Respiratory Physician at the Manchester University NHS Foundation Trust.

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- emphysema
- mesothelioma
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Consent and litigations – an expert witness's perspective

General, Upper GI and Laparoscopic Surgeon Mr ASHOK BOHRA offers a viewpoint with regards to consenting patients for clinical procedures

SOME OF THE MOST complex negligence litigations I have been asked to report on over the past decade have been related to alleged poor consenting. My own expertise covers general surgery, laparoscopic surgery, upper gastrointestinal cancer and bariatric surgery. Common pitfalls for clinicians are:

- Failure to understand what is 'material' to the patient: ie a reasonable person in the patient's position would attach significance to the particular risk.
- Misconception that it is all about bombarding percentages and every possible risk, rather than focussing on relevance, magnitude and importance to the patient.
- Misassumptions about 'what the patient needs to know'.
- Failure to explain alternative treatments or the option of no treatment.
- Failure to understand that a signed consent does not guarantee immunity (*Jones v Royal Devon and Exeter NHS Foundation Trust*).
- Paucity of time
- Poor documentation

The big variable is the patient's priorities and their ability to understand and retain complex information. In a digital world it is not uncommon to see patients having pre-conceived notions, inaccurate or irrelevant information and impractical expectations. It is difficult, if not impossible, to glean all of the above as well as provide detailed, tailored information with proper documentation in a busy clinic. In a litigious environment, consent is as important as the procedure itself.

Snapshot of GMC guidance most commonly applicable

The GMC states: "You should tailor your approach to discussions with patients according to their needs, wishes and priorities; their level of knowledge and understanding of their condition, prognosis and treatment options; the nature of their condition; the complexity of the treatment and nature and level of risk associated with the investigation or treatment.

"Give the patient time to reflect, before and after they make a decision, especially if the information is complex or what you are proposing involves significant risk."

Regarding discussing the complications, the GMC recommends: "The amount of information about risk you should share with patients will depend on the individual patient and what they want or need to know. Your discussions with patients should focus on their individual situation and the risks to them.

"You must tell patients if an investigation or treatment might result in a serious adverse outcome, even if the likelihood is small. You should also tell patients about less serious side effects or complications if they occur frequently, and explain what the patient should do if they experience any of them."

Regarding documentation, the GMC recommends: "Patients can give consent orally or in writing, or they may imply consent by complying with the proposed examination or treatment." However, the guidance also states: "You must use the patient's medical records or a consent form to record the key elements of your discussion with the patient."

It is the responsibility of the instructing solicitors to guide the expert on the relevant laws in the particular case. The expert's role is to provide factual, impartial scrutiny and comments pertaining to their expertise in the field, and consider the efforts made by the clinician in the consent process. The expert needs to understand that assessment of negligence is a purely legal concept and it is up to the solicitors to decide if the expert's opinion is enough to infer negligence as defined by the law. A working knowledge of the relevant laws is important for all medicolegal experts.

In my experience the common rulings often referred to are *Bolam v Friern Hospital Management (1957)*, *Montgomery v Lanarkshire Health Board (2015)* and *Bolitho v City & Hackney Health Authority (1997).*

The *Montgomery* ruling is the most significant to consider when it comes to advice and consent to treatment. For most other aspects of clinical management, it is the 'reasonable skills and care' and *Bolam* which is still relevant. The GMC is looking to update its guidance on consent later in the year. ❑

Ashok Bohra
General & Laparoscopic Surgeon

Mr Ashok Bohra MS MPhil MFSTEd FRCSEd FRCS(GenSurg)

With 28 years of surgical training and practice, and thousands of successful operations under his belt, Mr Ashok Bohra has an active interest in medico legal work.

He has almost 10 years experience acting as an expert witness in general and gastrointestinal surgical cases involving personal injury and clinical negligence claims.

Mr Bohra is aware of the requirements of Part 35 and Practice Direction 35, the Protocol for the Instruction of Experts to give Evidence in Civil Claims and the Practice Direction on pre-action conduct. He obtained the 'Bond Solon Civil Procedure Rules for Expert Witnesses Certificate' to evidence his understanding and compliance with the above requirements.

Mr Bohra can take instructions on behalf of either claimant or defendant or as a Single Joint Expert.

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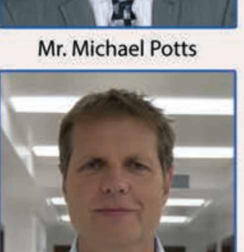

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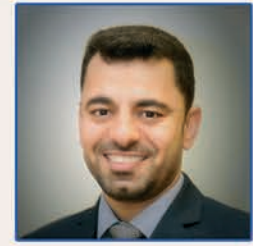

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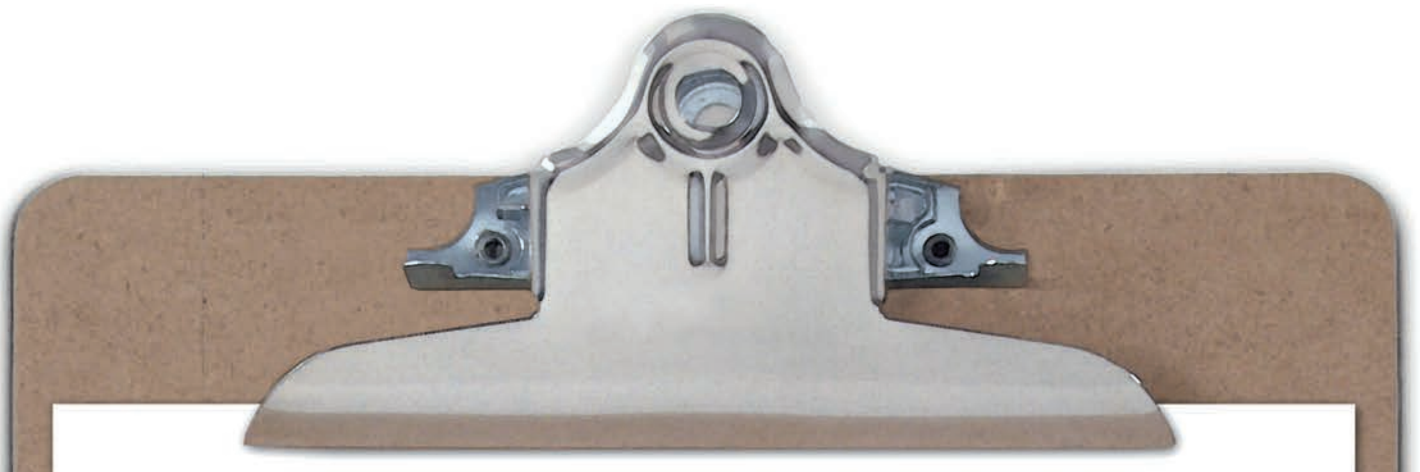

MEDICAL NOTES

TELEVISION ITSELF HAS been making headlines in the health sector over the past month or so. Reality TV in particular has been under the spotlight, with the announcement that the Commons Select Committee on Digital, Culture, Media and Sport is to conduct an inquiry into the genre, looking at the extent to which production companies have a duty of care to participants. The inquiry follows the deaths of participants in two shows – *The Jeremy Kyle Show* and *Love Island*.

The inquiry has been welcomed both by psychology professionals and by mental health charities.

• Reality TV has also had the finger pointed at it by plastic surgeons. The annual audit carried out by the British Association of Aesthetic Plastic Surgeons (BAAPS) has revealed that shows such as *Love Island* are driving an upsurge in liposuction procedures. All well and good for plastic surgeons you may think, but former BAAPS president Rajiv Grover has warned of a concomitant commoditisation of the procedure, leading to people undergoing liposuction without thinking it through. You can't take it back for a refund, as Mr Grover pointed out.

• Television redeemed itself with the harrowing report of grotesque abuse at a privately-run mental hospital in County Durham. Whorlton Hall has been closed down and arrests have been made. The CQC issued an immediate apology. Its deputy chief inspector of hospitals and lead for mental health, Dr Paul Lelliott, was interviewed for the *Panorama* programme and apologised personally for the failure of CQC to pick up on the abuse.

The official view was that all such hospitals should have been closed down years ago as better facilities came available, but that it had not happened. It is astonishing that there should be a presumption that, as long as such institutions exist, there will be abuses such as those filmed undercover at Whorlton Hall.

• Another investigation – of a different kind – was also announced into events at the Gosport War Memorial Hospital. A fourth police investigation is being opened into the deaths of hundreds of patients to determine whether they were caused by the inappropriate administration of opioid painkillers.

While idly looking through archived copies of *Your Expert Witness* I came across a story headlined *Gosport hospital deaths: families 'not satisfied'*. The issue was dated May 2009: exactly 10 years ago.

• Archives are also, it seems, the place for GPs to look if they want to find their patients' records – 160,000 of them. The records were archived instead of being transferred to GPs' surgeries. It was, according to the BMA, the latest in 'a litany' of errors by outsourcing provider Capita.

• It's not all doom and gloom in the world of medical expert witnesses, though. We profile a real-life 'flying doctor' (yes, I am old enough to remember the Aussie TV series) who also manages to find time to act as an expert witness. Mr Aswinkumar Vasireddy is a member of the Helicopter Emergency Medical Service team. A consultant orthopaedic trauma surgeon in his day job, he flies to the scene of major incidents during his off-duty to provide pre-hospital emergency care for seriously-injured patients in road accidents, train accidents or on building sites.

It means that high levels of care can be given during the 'golden hour', together with faster transport to a trauma centre.

• Early intervention is also the key to better recovery from any accident. The principal of rehabilitation was reiterated recently by a specialist lawyer from Thompsons Solicitors, who urged all his colleagues to adopt an early intervention approach to establish liability and begin rehabilitation.

He reported how a client who had been injured in a road accident benefitted from such an approach. ❑

Mr Graham R Dow BSc MbChB FRCS

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Mr Dow is a neurosurgeon who has been practising in Nottingham for over 10 years. He manages all aspects of general adult neurosurgery, with particular subspecialty expertise in pituitary, vascular and skull base neurosurgery.

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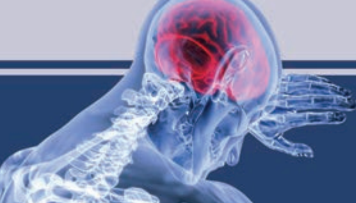

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Mr Luke Meleagros is a consultant surgeon at North Middlesex University Hospital, where he specialises in gastrointestinal and general surgery.

He has extensive experience as a medico-legal expert, completing on average 2 to 3 expert reports per month in medical negligence and personal injury cases.

Mr Meleagros is instructed mainly by solicitors on behalf of NHS Trusts and the NHS Resolution, but he also acts on behalf of claimants in medical negligence cases.

His expert reports cover a wide range of cases of alleged negligence, in particular those involving abdominal and colorectal surgery. He has reported extensively on cases involving abdominal laparoscopy surgery and hernia surgery.

In the past two years he has appeared in court and given evidence as expert witness in eight cases of medical negligence.

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Dr Michael Bone BSc (Hons) MB DCH FRCP

Consultant Physician

Dr Michael Bone has been a Consultant Physician (General Internal, Respiratory and Clinical Allergy) for over 30 years and still provides supervision of acute unselected medical intake at one of England's consistently top performing NHS Trust Hospitals.

Over the years he has acted as clinical lead in asthma and COPD, lung cancer, tuberculosis and interstitial lung diseases and critical care medicine. He ran a pleural diseases service, initiating medical thoracoscopy in 1985 and inaugurated a joint rheumatological lung clinic in the early 1990s. With early training in paediatrics and immunology, he ran a joint allergy and asthma service for 16 years and remains an active member of the northern paediatric allergy group.

Dr Bone has been engaged in medico-legal assessments and reporting since 1982. He has had extensive experience with occupational asthma and hypersensitivity reactions, such as farmers lung and industrial dust diseases, from his time at the MRC pneumoconiosis unit in South Wales and later in the Midlands. Over the last 18 years in the North East he has acquired extensive experience with asbestos related lung diseases.

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CQC 'sorry' for abuse uncovered in BBC programme

THE UNDERCOVER REPORT by the *Panorama* programme of abuse of patients at a privately-run hospital for people with autism and learning difficulties, broadcast by the BBC on 22 May, drew an immediate response from the Care Quality Commission.

Dr Paul Lelliott, deputy chief inspector of hospitals and lead for mental health at the CQC, said: "The footage captured by *Panorama* shows sickening abuse of vulnerable people. As soon as the BBC told us that they had evidence of abuse we alerted the police and they are now investigating.

"Working with the local authority and NHS England we have acted urgently to protect the people living at Whorlton Hall. Sixteen members of permanent staff were immediately suspended and CQC inspectors, NHS England, a safeguarding team from the local authority and clinical staff from the local NHS mental health trust have all been on site to ensure that people are safe."

The firm which runs the unit, Cygnet, said it was 'shocked and deeply saddened'. The company took over the running of the centre at the turn of the year and said it was 'co-operating fully' with the police investigation. All the patients have been transferred to other services and the hospital closed down, Cygnet said.

The programme revealed that the unit had been given a 'good' rating by the CQC when it was inspected in 2017, although subsequent inspections had raised concerns.

Dr Lelliott continued: "When we last inspected Whorlton Hall, in March 2018, we did so as a result of whistleblowing concerns. Our inspectors identified concerns around staffing: staff sometimes worked 24-hour shifts, agency staff were not receiving appropriate training and not all staff were receiving individual supervision. We found the provider in breach of regulations and told them to address the issues.

"It is clear now that we missed what was really going on at Whorlton Hall, and we are sorry. The patients we spoke to during this inspection told us they felt safe and had not experienced aggression towards them.

"We also spoke to health care professionals who had formal caring roles for patients at the hospital, but who were independent of the hospital. They did not raise any concerns. This illustrates how difficult it is to get under the skin of this type of 'closed culture' where people are placed for long periods of time in care settings far away from their communities, weakening their support networks and making it more difficult for their families to visit them and to spot problems.

"When you add staff who are deliberately concealing abusive behaviour, it has the potential to create a toxic environment.

"We will urgently explore ways in which we can better assess the experience of care of people who may have impaired capacity, or even be fearful to talk about how they are being treated because of the way that staff have behaved towards them. We must do all we can to lift this cloak of secrecy."

Dr Lelliott stressed that the majority of people with a learning disability and/or autism are receiving good care from caring, professional staff. However, he conceded: "I know that seeing this footage will be particularly shocking for people with a learning disability or autism and those who have family members who are being cared for in a hospital for people with a learning disability or autism.

"We are sorry that we did not identify the abusive practices at Whorlton Hall – but we do act on concerns from members of the public every day. Over the past three years we have placed seven hospitals for people with a learning disability and/or autism into special measures, leading to closure in three cases." ❑

Panel firms announced for new GP negligence scheme

NHS RESOLUTION – formerly the NHS Litigation Authority – has appointed a panel of seven legal firms to assist it, if necessary, in managing claims presented under a new Clinical Negligence Scheme for General Practice (CNSGP).

CNSGP is the indemnity scheme administered by NHS Resolution on behalf of the Secretary of State for Health and Social Care. It provides comprehensive cover to all GPs and their wider practice teams for clinical negligence relating to NHS services occurring from 1 April provided by general practice.

NHS Resolution has extensive expertise in clinical negligence, having operated state schemes such as the Clinical Negligence Scheme for Trusts (CNST) for over 20 years. A similar panel provides support to NHS Resolution to manage claims, if necessary, under the CNST.

The seven firms on the CNSGP panel are Bevan Brittan, Capsticks, DAC Beachcroft, Hempsons, Hill Dickinson, Kennedys and Weightmans. ❑

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Consultant Oto-Rhino-Laryngologist

Christopher Raine has vast experience in the preparation of medico-legal reports in cases involving clinical negligence in his specialist area.

Producing written reports since 1986 and currently completing over 100 cases per year covering aspects such as medical negligence, personal injury and noise induced hearing loss, he is happy to take instructions from both claimant and defendant and also to act as a Single Joint Expert.

All reports are issued in accordance with the new Civil Procedure Rules.

Independent cases can also be prepared for NHS tribunals for malpractice cases both for the patient and medical attendant.

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Dr Duncan S Dymond is a consultant cardiologist who has been undertaking expert witness and medico-legal work for more than 8 years completing 1-2 reports a week for personal injury and medical negligence cases.

He has also completed expert witness work for the General Medical Council, the Medical Defence Union and the Crown Prosecution Service as well as accepting private instructions directly from solicitors.

Dr Dymond is extensively published with more than 100 scientific articles to his name. He has been Consultant Cardiologist at St Bartholomews Hospital for 31 years, now holding the title of Consultant Emeritus, and is in practice in central London.

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Chris Dawson MS FRCS LLDip

Consultant Urologist

Mr Dawson is a Consultant Urologist with over 22 years experience. He has received formal training in personal injury and medical negligence reporting and completed the Bond Solon Cardiff University Expert Witness Course in 2006. In 2008 he completed a Diploma in Law at the College of Law in Birmingham.

Mr Dawson has 15 years experience of medico legal report writing and expert witness work and has completed over 1,050 reports. He also regularly completes Fitness to Practice reports for the General Medical Council.

He is the author of the *ABC of Urology*, now in its 3rd edition, and also co-edited *The Evidence for Urology* which won first prize in the urology section of the BMA Medical Book Competition in 2005.

Mr Dawson is happy to accept instructions for personal injury, clinical negligence and condition and prognosis reports.

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NHS boosts care funding for those with learning disabilities

THE NHS HAS announced an additional £5m in funding to improve care for people with a learning disability and committed to renewed national action to tackle serious conditions. The programme to review the deaths of everyone with a learning disability is being expanded to speed up the spread of best practice.

The NHS has also committed itself to taking action to tackle the major killer conditions among people with a learning disability, based on lessons learned from reviews. They include:

- Pneumonia – efforts will focus on increasing the uptake of the flu vaccine among people with a learning disability alongside other at risk groups, through a targeted awareness campaign.
- Respiratory – The NHS will commission an independent review into the deaths of people with a learning disability due to respiratory conditions to address inequalities among the patient group.
- Constipation – the NHS will launch a national campaign to promote awareness around the risk of constipation, including how it can be prevented, recognised and treated to better support families, carers and staff who work with people with a learning disability.
- Sepsis and deterioration – Earlier this year NHS England took action to help ensure hospital staff spot and treat the killer blood condition within an hour to save thousands more lives.
- Cancer – the uptake of screening to ensure early diagnosis of cancer is a priority for the NHS with a focus on people with a learning disability in the national screening review. The NHS is prioritising making reasonable adjustments for screening including the roll out of easy-read information.

The reviews into deaths of people with a learning disability have led to hundreds of local innovations. They include the widespread introduction of hospital passports so all staff have everything they need to know about a person with a learning disability, learning disability champions in GP surgeries with specialist skills, and training to support carers spot the signs of deteriorating health.

Ray James, national director for learning disabilities at NHS England and NHS Improvement, said: "Significant progress has been made over the past year and the renewed commitment today will ensure we continue to drive important learning and ensure widespread improvements in the care and treatment of people with a learning disability.

"I want to pay tribute to the contribution that many bereaved families have made to this important work. Their courage, constructive challenge and willingness to share their experiences for the benefit of others has helped the NHS locally and nationally to improve care and save lives."

Sheila Handley, bereaved family carer and expert by experience, said: "My son Richard died in 2012. Since then, I've been keen to help push for changes to make the avoidable deaths of people with a learning disability a thing of the past.

"At last there is a drive to not only understand the cause of premature deaths but, far more importantly, to take the actions needed to improve care and save lives. There's still a long way to go, but this a big step in the right direction." ❑

BMA fumes as records are misfiled

ON 20 MAY NHS England wrote to GP practices to inform them that 160,000 patient records had been mistakenly archived, rather than transferred to surgeries. It was, the British Medical Association said, "the latest error from the Primary Care Support England programme". The programme is being delivered by outsourcing giant Capita.

Dr Richard Vautrey (pictured), the BMA's GP committee chair, said: "One hundred and sixty thousand patients' records wrongly archived rather than forwarded to practices is just the latest major error; and while it is shocking we cannot say we are surprised.

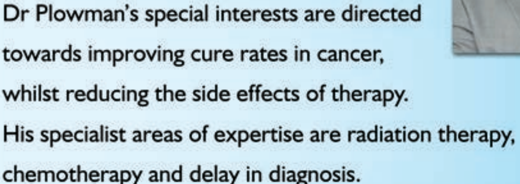
"And while NHS England tells us that they do not believe any patients have come to any harm, this assertion is based on a sample from just one area of the country, which may not be enough to back up such claims. Patients cannot be allowed to be put at risk because of the incompetence of one supplier, and NHS England must offer support to anyone affected.

Dr Vautrey added the error was just the latest in a 'litany' by the provider. "Even if no patient has been harmed, we find ourselves having the same conversations about a new Capita failing, and it is completely unacceptable that this is being allowed to happen again.

"Ultimately, it will be GP practices, already under-pressure from heavy workloads, who bear the brunt of sorting out the mess left behind by Capita, and NHS England must ensure surgeries also receive the support and resources needed to do so." ❑

Dr Nick Plowman MA MD FRCP FRCR
Consultant in Clinical Oncology

Dr Nick Plowman is the Senior Consultant in Clinical Oncology at St Bartholomew's Hospital, London (adults) and The Hospital for Sick Children.



Dr Plowman's special interests are directed towards improving cure rates in cancer, whilst reducing the side effects of therapy.
His specialist areas of expertise are radiation therapy, chemotherapy and delay in diagnosis.

Dr Plowman has over 20 years experience acting as an expert witness, including the preparation of medico legal reports and appearing in court, in cases involving negligence and delays in diagnosis relating to all of his areas of experience.

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Opioid labelling initiative welcomed by pain doctors

THE UK GOVERNMENT has announced that all opioid medicines are to carry prominent warnings to inform people about their potentially addictive properties.

According to the Department of Health and Social Care, while opioids can be highly effective, there is increasing evidence of overuse and misuse. Some opioids – such as codeine-based painkillers – are available at pharmacies over the counter: these are weaker, but can also cause addiction if used excessively.

Announcing the plans, Health Secretary Matt Hancock said: "I have been incredibly concerned by the recent increase in people addicted to opioid drugs. Painkillers were a major breakthrough in modern medicine and are hugely important to help people manage pain alongside their busy lives; but they must be treated with caution. We know that too much of any painkiller can damage your health, and some opioids are highly addictive and can ruin lives like an illegal drug.

Under the government's plans the Medicines and Healthcare Products Regulatory Agency (MHRA) will have the power to insist that opioids carry warnings, following recommendations from the UK's Commission on Human Medicines opioid expert working group.

The move has been supported by both the Faculty of Pain Medicine (FPM) of the Royal College of Anaesthetists and the Association of the British Pharmaceutical Industry (ABPI).

In a statement, the FPM said: "All stakeholders in the initiative agree that improving clarity for patients and healthcare professionals on the risks is an important step in the better use of these medicines across the health sector and continues to demonstrate the importance of good education for all on opioids."

Sheuli Porkess, deputy chief scientific officer at the ABPI said: "When opioids are prescribed as part of managing a patient's pain, the packaging and labelling should be clear and convey the risks of dependency. Pharmaceutical companies have recommended that clearer warnings are included on packaging, so these changes are welcome and have our full support." ❑

Neuro-pain medicines reclassified as controlled

FROM 1 APRIL, gabapentin and pregabalin have been classified as Schedule 3 controlled drugs under the Misuse of Drugs Regulations 2001, and Class C of the Misuse of Drugs Act 1971.

Both are established treatments for neuropathic pain, as well as for epilepsy.

According to online healthcare resource Cochrane: "Neuropathic pain comes from damage to the nervous system. It is different from pain messages that are carried along healthy nerves from damaged tissue – for example, from a fall or a cut, or from an arthritic knee. Neuropathic pain is often treated by different medicines (drugs) from those used for pain from damaged tissue, which we often think of as painkillers."

The drugs have been classified as controlled following concerns over a growing number of deaths from overdoses. It means that additional requirements are needed on the prescription; for example, the dose must be clearly defined – 'As directed' is not acceptable.

A patient leaflet has been issued by the Department for Health and Social Care for issuing by GPs to patients who take the medicines. ❑

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Dr Aglan can act as an expert witness in cases involving his specialist areas of expertise:

- Assessment of personal injury
- Work-related accidents
- Road traffic accidents
- Chronic disability assessment
- Anaesthetics-related accidents
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Will 2019 see the fading out of traditional varicose vein surgery?

by **PHILIP COLERIDGE** ***SMITH DM MA BCh FRCS***
Consultant Vascular Surgeon, Medical Director of the British Vein Institute and Emeritus Reader in Surgery at UCL Medical School

IN RECENT YEARS there has been a considerable change in surgical practice in the field of varicose veins surgery. The original methods of treatment date back more than 2,000 years, but were improved in 1905 and 1908 by the introduction of 'varicose vein stripping' – in which the diseased veins were removed in their entirety. The treatments were performed under general anaesthesia, leading to significant post-operative pain and a recovery period of about one month. The long-term outcome of treatment was satisfactory.

In the past 15 years a number of new treatments have been introduced which can be accomplished under local anaesthetic. They include thermal ablation methods, where a tube is passed along the diseased vein for a distance of 20-50cm. The tube contains a heating method, which may be a laser fibre optic, an electrically-heated catheter or used to deliver super-heated steam. The vein is anaesthetised and the heat applied to destroy it without removing it.

An improved method of injecting varicose veins, known as 'ultrasound guided foam sclerotherapy', has been popularised. In this method, injections of foam created from a sclerosant drug are made into the diseased saphenous veins and associated varices under ultrasound guidance. Local anaesthesia is not required for this treatment except at the point of injection.

The efficacy of these treatments is very similar and comparable to the ability of surgery to treat varicose veins. The main difference is that those treatments have a greatly reduced post-operative recovery time compared to 'stripping' operations, with most patients experiencing little post-treatment discomfort. Return to work is usually with 1-3 days, in contrast to much longer periods of recovery following surgery.

The National Institute for Health and Care Excellence (NICE) publishes advice on which treatments are accepted as safe and effective for use in the NHS. NICE Clinical Guideline 168 (July 2013) offers advice on the relative efficacy of modern treatments. Thermal ablation methods are recommended as the first-line treatment, if it is feasible to use one of those techniques. Otherwise, ultrasound guided foam sclerotherapy is recommended.

Where none of the modern methods of treatment is considered to be feasible, conventional surgery is recommended. The information confirms that all currently-used treatments are acceptable forms of management, but emphasis is placed on the modern methods which permit rapid recovery and avoid complications associated with conventional surgical treatment.

Changes in practice

Detailed information on NHS treatments is collected and published as Hospital Episode Statistics. In 2000 almost all patients with varicose veins were managed surgically. In 2014/2015 32,700 treatment episodes were provided: of those, surgical treatment was used in 23%. Thermal ablation procedures were used in half of all treatments and foam sclerotherapy in 18% – some in combination with thermal ablation methods.

In 2016 the Health and Social Care Information Centre published the results of a study on patient reported outcome measures (PROMs) amongst varicose veins patients. PROMs have become the main outcome measure of treatments provided by the NHS – and many healthcare providers in other countries. They provide an estimate of efficacy of treatments for conditions which curtail lifestyle rather than life expectancy. In general, similar results were obtained from all treatments, although slightly more patients reported improvement after surgical treatment than the less invasive treatments.

The complications reported by patients were also studied, including wound problems and bleeding. In all, 31% of patients reported one or more complications after surgery, 16% after thermal ablation and 11% following foam sclerotherapy. That reinforces the view from earlier work that surgical treatment is associated with a higher level of post-operative complications than the more modern treatments.

Implications for clinical practice: what can go wrong?

The increasing complexity of modern methods of varicose veins treatment means they require substantially different surgical skills compared to varicose vein stripping techniques; and some surgeons may still be in the conversion phase of their training. Modern treatments require skills in ultrasound imaging and ultrasound guided injection. Not all vascular surgeons have so far achieved full competence in these areas.

Adverse events after surgery include: wound problems (bleeding, infection, healing, scars), post-operative pain and bruising, damage to adjacent structures (cutaneous nerves, motor nerves, major arteries and veins, lymphatic vessels) and problems related to general anaesthesia. As noted above, a study of patient reported outcomes recorded the greatest frequency of adverse events following surgical treatment.

Given that NICE guidance indicates that the first-line treatments are thermal ablation and foam sclerotherapy, I consider there can be little justification for using surgical stripping of varicose veins: a treatment devised in the first decade of the 20th century. In the past decade I have found that, in all cases of varicose veins that I have treated, surgery was not required to achieve a good outcome.

I have advised a number of patients who have experienced significant adverse events following surgical treatment of varicose veins. The nerves at the back of the knee are at risk of damage during treatment of varicose veins arising in this anatomical region. The veins run very close to the nerves and care has to be taken to avoid accidentally cutting or removing the nerve in mistake for a vein. I have advised claimants who have suffered partial paralysis of the limb following surgical errors of that type.

In the groin region, where the veins run close to the lymphatic vessels which drain interstitial fluid from the limb, surgical exploration of the region in order to remove varicose veins may damage the lymphatic vessels. That may lead to a number of complications following surgery, including a leak of lymph (clear fluid) from the groin incision or a cystic accumulation of fluid in the groin, which can be felt as a lump or swelling in the groin. In addition, lymphoedema (permanent swelling of the limb) may occur when major lymphatic vessels have been damaged during surgical treatment.

I have advised two claimants who suffered severe and extensive infections of the limb following surgical intervention. Protracted infection led to a long recovery period and permanent and extensive scarring of the affected limb.

In the longer term, recurrence of varicose veins may also occur. That is a problem common to all varicose veins treatments. However, a particular instance is varicose veins which have recurred after surgical treatment. A number of publications show that poor results with early recurrence occur when surgery is used as the treatment in this type of varicose vein. However, when ultrasound-guided foam sclerotherapy is used, the frequency of recurrence is the same as that for veins which have never been treated.

The complications mentioned above are almost completely avoided by the modern endovenous treatments. Since NICE has advocated these as first-line treatments, I consider that, where patients have received surgical interventions and suffered serious adverse events, these may be attributable to substandard care. ❑

Chartered body has its own medico-legal register

THE Medico Legal Association of Chartered Physiotherapists (MLACP) is a professional network for chartered physiotherapists and others who have a special interest in medico-legal work.

According to the MLACP: “In broad terms, physiotherapy is concerned with human movement performance and function. Physiotherapists use a range of physical, cognitive and other interventional approaches to restore, maintain, improve or manage the planned decline of movement and activity in individuals caused by ageing, disease, injury and/or disability.”

The titles ‘physiotherapist’ and ‘physical therapist’ are protected, and only those listed on the relevant register held by the Health and Care Professions Council (HCPC) may practise using the protected title. Some physiotherapists may also prescribe prescription only medicines (POMs) for their patients, including some controlled drugs. A physiotherapist prescriber must have an additional annotation against their HCPC registration.

Chartered physiotherapists who can demonstrate that they are currently educated, trained and competent in medico-legal report writing are eligible for inclusion in the MLACP’s *Directory of Members*.

MLACP members cover a broad range of physiotherapy disciplines: they may act in cases involving injuries sustained at work or as the result of an accident, or they may report in negligence cases.

One member with a long experience both as a practicing physiotherapist and expert witness is Dr Nicholas Clark. He sees the ability to present complex medical facts in a way that is understandable as a key skill. He describes his report-writing as: “Translating all relevant sources of clinical evidence to plain language explanation and meaning, in order to give a clear picture of a neutral and justified expert opinion focused on the critical clinical issues of the case.

“Reports are uniquely structured in a way that is quick to navigate, easy to read, and clearly links all critical clinical information so that clients can find what they need as quickly as possible.”

Some MLACP members offer unique areas of expertise. Elizabeth Beckerlegge (pictured) is the founder of Riding for Rehab and is the only hippotherapist on the register. Her specialist knowledge of the potential benefits of riding in treating injuries enables her and her team to offer a unique rehabilitation package.

Says Elizabeth: “After a thorough assessment, we’ll put together a bespoke riding or hippotherapy programme, with frequent reassessment and resetting of aims and goals plus regular updates to the case managers and solicitors involved.

“We accept instructions as treating therapist for clients requiring hippotherapy or riding therapy during the litigation process and provide treatment post settlement of a compensation claim.” ❑

RIDING
FOR REHAB

Elizabeth Beckerlegge is the UK’s only physiotherapist working in hippotherapy to have qualified as an expert witness.

She’s an active member of the Medico Legal Association of Chartered Physiotherapists (MLACP), demonstrating that she’s educated, trained and competent in the relevant justice standards, qualified in medico-legal report writing and maintaining CPD relevant to hippotherapy and riding therapy practice at the highest level.

Able to advise for both claimant and defendant, Elizabeth’s expert witness work includes short advice notes, desktop reports, condition and prognosis reports (Quantum) and physiotherapy needs reports in relation to hippotherapy and riding therapy.

Recent cases include adults with spinal cord injuries, children with cerebral palsy, victims of road traffic accidents and people with musculoskeletal conditions.

Although based in Yorkshire, instructions can be undertaken throughout England and clients are typically seen at a riding facility convenient to their own home.

Tel: 07726 592728 Email: ridingforrehab@gmail.com
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New guidelines confirm need for early mobilisation post-stroke

NEW RECOMMENDATIONS for early mobilisation for people with acute stroke have been made by the National Institute for Health and Care Excellence (NICE) following new evidence being made available.

The Association of Chartered Physiotherapists in Neurology (ACPIN) has welcomed the change as being particularly important for physiotherapists working with people in the initial 48 hours after the onset of stroke symptoms.

In recent years patients have been assessed and mobilised much earlier by physiotherapists following stroke. Mobilisation can refer to any ‘out of bed’ activity, such as sitting out of bed, standing or walking, with the aim of reducing the complications associated with immobility and promoting functional recovery.

The previous guideline suggested that people with acute stroke should be mobilised as soon as possible as part of an active management programme on a specialist stroke unit, and that they should be helped to sit up as soon as possible. However, the impact of early mobilisation on mortality and morbidity was unclear and there was limited evidence available to guide when, and how early after stroke, mobilisation should take place.

ACPIN board member for public affairs Dr Jonathan McCrea explained that since the previous guideline, a large international randomised controlled trail (AVERT) was published which prompted a further review of the evidence.

The guideline team included a total of eight studies in their review, six of which used very early mobilisation and two used early mobilisation.

Dr McCrea said: “ACPIN very much welcomes this carefully considered evidence-based guideline recommendation. It will aid physiotherapists working with patients in the initial 48 hours after onset of stroke symptoms.” ❑

Physios' lawyer stresses importance of early rehab

A SOLICITOR AT Thompsons Solicitors, the largest trade union law firm in the UK and the firm that provides support to members of the Chartered Society of Physiotherapy (CSP) and their families, has urged lawyers who represent seriously injured people to be aware of their rehabilitation needs, as well as their legal rights.

Matthew Hall told the society's journal *Frontline* that specialist serious injury lawyers need to consider not only the legal merits of their clients' cases, but also their immediate rehabilitation needs – as this could have an impact on both their long-term health and the outcome of their case.

"In practical terms, that means making early contact with the responsible party's insurer, setting out a client's case and requesting that they fund treatment and rehabilitation," he explained. "A proactive and engaged approach to litigation can make a real difference not only to the outcome of a case but also to the long-term health of the client. If insurers can be persuaded to recognise their liability and responsibility early on or are forced, through tactical litigation, to face up to it, it can make a tangible difference."

The journal reported a recent case where Thompsons Solicitors handled a claim for a CSP member's relative who suffered life-changing injuries following an accident.

In that case, the injury occurred when a driver lost control of a tractor and collided with a set of traffic lights, causing the pole to bend and hit their client on the head.

"Their injuries included a serious head injury, orthopaedic injuries and a profound psychological injury, which left them extremely anxious around roads and in public," Matthew Hall told *Frontline*. "They ended up unable to return to work, needing help both around the house and when going out.

"In this particular case, our approach secured an early admission of fault and the insurer agreed to fund rehabilitation."

Interim payments from the insurer also allowed the solicitors to put a multidisciplinary team in place, which included a brain injury case manager, a physiotherapist, a consultant neuropsychologist and an occupational therapist.

"The team considered not only our client's injuries and treatment needs, but also their employment, interests and hobbies, leading to a bespoke plan, taking into account both short and long-term goals," said Matthew Hall. "Working together, they saw significant improvements in our client's cognitive skills, mobility, independence and psychological wellbeing. And with their help, she has made excellent progress and is now in much better health moving into the future."

He added that Thompsons' specialist lawyers always take an active role in the rehabilitation process by attending multidisciplinary meetings with the treating team.

"Effective rehabilitation not only helps our clients to return as far as possible to their pre-accident life, but it also provides the treating team with opportunities to more accurately and more quickly assess long-term needs and prospects for recovery." ❑

Dr Nicholas Clark PhD MSc MCSP MMACP CSCS

Consultant Chartered Physiotherapist, Physiotherapy Expert Witness

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Instructions are accepted in musculoskeletal physiotherapy, orthopaedics, sports and dance injuries, occupational health, and military injuries. Opinion is provided on matters for the lower back, hip, knee, ankle, and foot.

Please feel free to get in touch if you would like me to assist you with your case:
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How physiotherapists can assist in expert witness work

by SARA DICKINSON *MCSP*

MANY EXPERIENCED PHYSIOTHERAPISTS undertake expert witness work related to their area of clinical practice. Physiotherapists are experts at assessing, treating and preventing musculoskeletal problems, ie those related to human movement. The problems may be insidious in their onset, or related to accidents, sporting injuries or the workplace.

Physiotherapy expert witnesses undertake two types of assessment reports: face-to-face assessments of the claimant for quantum purposes and desktop reports for liability purposes. Other reports include fitness to practice (FtP) reports, usually at the request of the Health and Care Professions Council – the profession's regulatory body. Occasionally, there are requests for reports which will form part of a criminal case.

Liability reports may be in the form of a non-CPR compliant screening report, which provides the solicitor with an overview of the physiotherapy-related issues in the case. They may assist in formulating a Letter of Claim or Response.

Full liability reports are more detailed and include the relevant chronology, a statement of the standards expected and a discussion of the material event, with clear conclusions articulating the physiotherapist's opinion. Full reports will be CPR compliant.

Increasingly in clinical practice, a physiotherapist may be the first clinician to assess or triage a patient. Some examples of issues that may present as a case against a physiotherapist include:

- Possible breaches during assessment and treatment in an outpatient setting, such as a failure to act upon so-called 'Red Flag' signs and symptoms. This is commonly seen in patients presenting with spinal conditions, and in particular those with suspected cauda equina syndrome.
- Missed diagnosis of a fracture, for example of the scaphoid bone in the wrist, or other soft tissue injuries such as ruptured tendons or ligaments.
- Whether or not the physiotherapy treatment was too intensive resulting in injury or re-injury.
- Falls or injury on hospital wards and during inpatient rehabilitation: it may be alleged that the physiotherapy contributed to the fall or injury, that treatment was negligent or there was use of inappropriate equipment.

For physiotherapists who are expert witnesses, it is a very different challenge to that of their clinical practice and requires an analytical approach to the forensic nature of the work. ❑

• Sara Dickinson (Grad Dip Physiotherapy) MCSP is a senior physiotherapist with expertise in trauma, orthopaedics, cauda equina, chronic pain, elderly care and general surgery. She is an associate trainer for physiotherapy experts at Somek and Associates.

Study reveals failures of hip screening in babies

SELECTIVE SCREENING introduced in 1986 to identify hip problems in babies in England has 'failed' to prevent late diagnoses, according to research carried out by doctors at Southampton Children's Hospital and published in *The Bone and Joint Journal*.

Currently, babies receive an ultrasound only if potential developmental dysplasia of the hip (DDH) is found on physical examinations around the time of birth or at six weeks, or if the infant has specific risk factors. If detected early in infancy, the problem can be treated by a removable splint worn for two to three months to stabilise the position of the hips and help them develop normally, with 95% success rates.

However, if diagnosed after three months, it is associated with an increased number of invasive operations, longer hospital stays, greater healthcare costs and long-term complications.

The research carried out at Southampton found the incidence of late-diagnosed DDH remains similar to the figure recorded 35 years ago prior to the introduction of the current national selective screening programme.

"Hip dysplasia is a significant public health issue which, untreated, represents the single largest cause for arthritis and total hip replacement in young adults," said Alexander Aarvold, a consultant orthopaedic surgeon at Southampton Children's Hospital and study lead. "Detection in children over one year of age remains a persistent reason for referral to paediatric orthopaedic units.

"This is despite the introduction of selective screening introduced in England in 1986 as part of the Newborn and Infant Physical Examination programme, so there are searching questions for Public Health England regarding the impact, if any, of selective screening on the prevention of late diagnoses."

The study of almost 15 million patients, the largest population study on DDH and the first to use linked primary and secondary care records, examined national records of all children from 1 January 1990 to 1 January 2016 who were diagnosed between one and eight years old.

The overall incidence of late diagnosis within England of 1.28 per 1,000 live births is greater than previously reported 37 years ago in Southampton (0.47) from 1965 to 1978 and 34 years ago in Bristol (0.39) from 1970 to 1979.

Tim Theologis, president of the British Society for Children's Orthopaedic Surgery, commented: "This study has provided evidence that the current selective screening for neonatal hip dysplasia is ineffective and the percentage of infants diagnosed late is unacceptably high.

"There is a pressing need to present convincing evidence to policy makers for the neonatal hip screening guidelines to change and BSCOS will fully support this effort." ❑

Mr Sameer Singh MBBS BSc FRCS

Consultant Orthopaedic Surgeon

Personal Injury and Medical Negligence Expert

Mr Sameer Singh is an experienced expert witness in personal injury and medical negligence cases relating to his specialist areas of expertise. These include:

- All aspects of trauma – soft tissue and bone injuries • Sports injuries
- Upper and lower limb disorders and injuries • Whiplash injuries

His clinical practice covers all aspects of upper and lower limb trauma. There is a speciality interest in Shoulder, Elbow and Hand disorders. Expert witness for work related disorders and repetitive strain injuries.

Mr Singh completes over 200 medico legal reports per year and offers an efficient turnaround within 10 days from receipt of all relevant documentation. He can take instructions for cases on behalf of either claimant or defendant.

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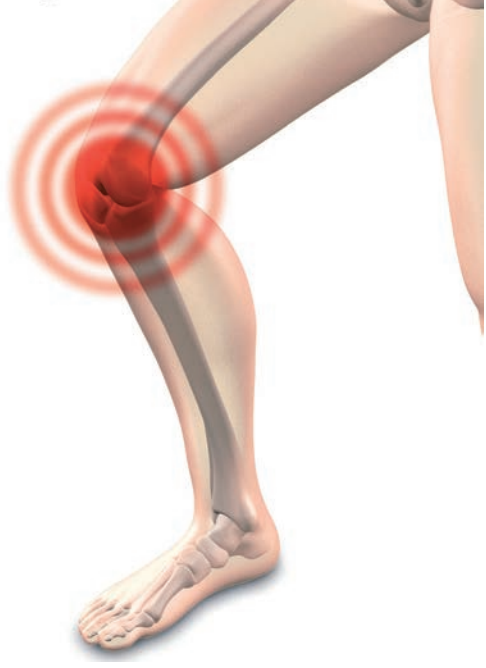
Societies respond to joint failure press report



IN MAY the British Orthopaedic Association (BOA), British Hip Society (BHS) and British Association for Surgery of the Knee (BASK) issued a joint statement in response to an article in the *Daily Mail* regarding implants used for hip and knee replacement surgery.

The article, published on 30 April, reported on research carried out by a team from Bristol University comparing the performance of different brands of hip and knee joint replacements. It revealed the brands that performed least well compared to the accepted benchmark for failure of 5% after 10 years.

The article also stressed that the vast majority of devices – 89% of knees and 96% of hips – performed better than the benchmark.

In the joint response, the BOA, BHS and BASK said: “The *Daily Mail* is reporting on two research papers published in the *BMJ Open*, which is a peer-reviewed medical journal. The research has used data from the National Joint Registry (NJR), which is a dataset about joint replacements in England and Wales that began in 2003.

“Research like this is really important to help surgeons know more about the results of different implants, and for patients who are considering having this surgery it can help them to discuss with their surgeon the implants they intend to use.”

The article stressed that patients with specific concerns or queries should discuss them with their GP or orthopaedic surgeon.

The statement continued: “We would like to highlight to patients that:

• Around 160,000 hip and knee replacements are carried out in England and Wales every year. These are two of the most common surgical procedures performed in the NHS.

• The overall likelihood of needing revision surgery following hip and knee surgery is low. The most recent NJR annual report shows that for hip replacement the failure rate after 10 years is 4.99%, while for knee replacement the failure rate after 10 years is 4.36%. Therefore, in both cases, for every 100 people having surgery, five or fewer would have a further operation within 10 years.

• There is no single implant or implant combination in this study (or in others previously) that outperforms all others. Different implants are typically used by surgeons in different types of patient, for example depending on their age. The surgeons will have knowledge and experience of which implants are expected to perform better in which types of patients. You could ask your surgeon about this if you are currently considering surgery.”

The report concludes by outlining the view of the BOA.

“As an organisation, our position in relation to devices and their regulation overall is as follows:

• We support high standards of device regulation.

• We support high-quality surveillance of implants once they have started to be used clinically and the need for registries to track the patients in whom they are used – this is an area where the BOA, supported by the orthopaedic specialist societies, has had significant involvement.

• The UK already has a highly successful National Joint Registry and the BOA supports mandating similar programmes for all other orthopaedic implants as a priority.

• Each year tens of thousands of patients in the UK undergo an operation that involves an orthopaedic implant and the vast majority of these will have excellent outcomes from these procedures.

• We recognise that implants wear and fail, sometimes unexpectedly, and we understand the importance of investigating and explaining why this may have occurred.” ❑

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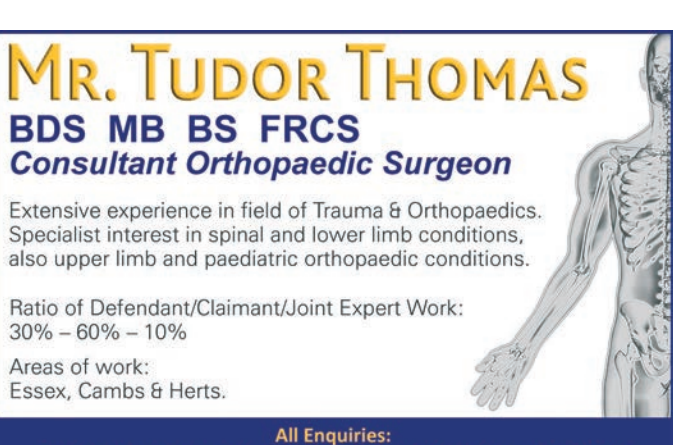
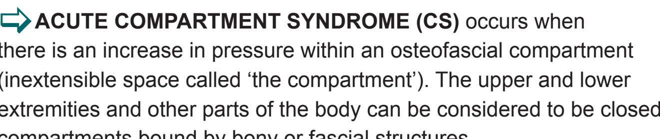


Complications after trauma

Acute compartment syndrome in orthopaedics

by* MR NIKHIL SHAH, *consultant trauma and orthopaedic surgeon at the Wrightington Hospital in Wigan



ACUTE COMPARTMENT SYNDROME (CS) occurs when there is an increase in pressure within an osteofascial compartment (inextensible space called 'the compartment'). The upper and lower extremities and other parts of the body can be considered to be closed compartments bound by bony or fascial structures.

When pressure within a compartment increases, it compromises the blood flow to that part of the body. This may cause damage to the nerves, muscles and tissues leading to permanent loss of function, especially if left untreated. It can even lead to loss of limb or life.

It can occur in the compartments of the leg or the forearm. It may also affect other compartments less commonly such as the thigh compartment, foot or gluteal compartments, and even the abdominal cavity.

Trauma is the most common etiology of compartment syndrome. Other causes include dressings, splints or casts which are too tight; lying in a particular position for long time; malfunctioning sequential compression devices; intramuscular or intracompartmental injections; bleeding into compartments; intraoperative use of pressurised pulsatile irrigation; and military anti-shock trousers.

However acute CS can be difficult to diagnose. At present there are no established pathognomonic diagnostic procedures. History is critical in establishing the etiology and likelihood of compartment syndrome. Clinical observations, such as pain or paralysis and even compartment pressure monitoring, are often unreliable determinants of the presence of the syndrome.

The most sensitive clinical symptom of compartment syndrome is stated to be severe disproportionate pain. However pain can be masked by the use of opioid analgesics, in alcohol intoxication, head injury or unconsciousness. Pain on passive stretching can be an important clinical sign. The intense ischemic pain of acute compartment syndrome can be difficult to discriminate from the pain related to an associated fracture.

Diagnosis can be supplemented by compartment pressure measurements. Perfusion within a compartment is only present when the diastolic blood pressure exceeds the intra-compartmental pressure. Various thresholds of pressure measurement have been suggested to guide surgical treatment of CS. There are proponents who advocate continuous pressure measurement and those who would measure pressure intermittently.

However there can be problems even with this. As the compartment is a large enclosed space, the value of the pressure can be influenced by where it is measured and when it is measured. Whether absolute or differential pressure should be considered to guide surgery is also a matter of some debate. If the patient's blood pressure is low due to hypotension, or raised due to any reason, then such measurements may become unreliable. Pressure measurements are said to be helpful in unconscious or obtunded patients. Dependence on pressure measurements alone is not sufficient.

Diagnosis therefore largely relies on the severity of the injury as well as the experience of the clinician. The indication for fasciotomy should be supported by a high index of suspicion, clinical findings (neurologic deficits) and supplemented by pressure measurement where indicated. The most important step in diagnosing a compartment syndrome is the surgeon's awareness of this complication and appropriate clinical examination.

The treatment is surgical, consisting of early and large decompressive fasciotomy. A fasciotomy is an operation where all the constricting boundaries of the compartment are released surgically to decompress the compartment and release the pressure. Complete fasciotomy of all affected compartments is urgently required to reliably normalise compartment pressures and restore perfusion to the affected tissues. Early fasciotomy can prevent long-term nerve, muscle or tissue injury. Fasciotomy itself is not without its own morbidity and is associated with complication rates of infection, scarring and pain.

There are NICE guidelines in relation to assessment and management of complex fractures that also describe the management of compartment syndrome. The prognosis depends on the aetiology, diagnosis and time from injury to intervention. Late diagnosis leads to irreversible necrosis and permanent muscle and nerve damage, chronic pain, nerve palsy and Volkmann's contracture.

It is essential that an immediate diagnosis is made in acute cases, followed rapidly by proper surgical treatment to prevent further sequelae. Missed compartment syndrome is unfortunately still a recognised cause of litigation after trauma surgery. ❑

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Mr Nikhil Shah can act as an expert witness in personal injury and clinical negligence cases, taking instructions from either claimant or defendant or as a Single Joint Expert.

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Waiting time increase flagged up by orthopaedic association

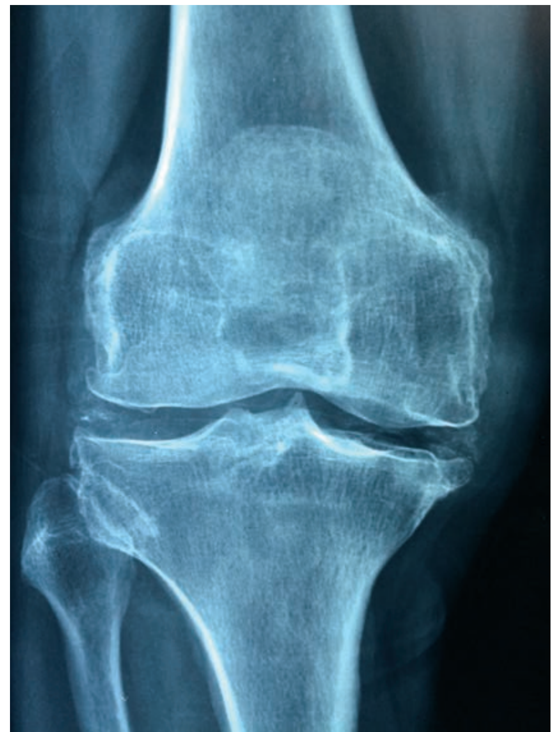
THE BRITISH ORTHOPAEDIC ASSOCIATION (BOA) has expressed itself 'very concerned' about increasing waiting times for patients with orthopaedic conditions across England.

The BOA said it is alarmed and dismayed to see the gradual backwards transition to the long waiting lists of the past for what the NHS are wrongly interpreting as 'optional' surgical procedures. Elective surgery is not optional surgery, the BOA says: many patients suffering with arthritis and other musculoskeletal conditions are in significant pain, which severely affects their quality of life and their ability to perform the simple activities of daily living. Leaving patients waiting in pain for treatment longer than is clinically necessary is not acceptable. Arthritis is common and often dismissed, but it is life changing, threatening patients' independence, their ability to earn a living and care for their loved ones.

Figures issued by the BOA show a steady increase in the number of patients waiting more than 18 weeks over the past four years – from 4,000 in January 2015 to more than 8,000 in January this year.

The BOA said: "We recently prepared some data on the numbers (rather than percentages) of people who are waiting more than 18 weeks for treatment, and this has deteriorated markedly. Each of these people is an individual experiencing pain, limited mobility or other effects on their day to day functions. We consider this unacceptable and call on the NHS to put the necessary resources in place to ensure those needing orthopaedic surgery such as hip and knee replacements are not continuing to suffer needlessly.

"We have particularly highlighted the deterioration in waiting times that has occurred during winter 2017/18, when 'winter pressures' resulted in the widespread cancellation of elective surgery as beds were filled to capacity with acutely ill patients. We are concerned that an efficient and timely elective orthopaedic service is not possible where such measures are taken for prolonged periods."❑



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This trauma expert witness is a real high-flyer

A uniquely-qualified 'flying doctor' has recently joined the team of experts at Medicolegal Partners. Mr Aswinkumar Vasireddy BSc (Hons) MBBS FRCS acts in his capacity as consultant orthopaedic trauma surgeon; but he is not a 'run-of-the-mill' expert witness by any stretch of the imagination.

⇨**MR VASIREDDY'S** day job is working as a full-time, fellowship-trained consultant orthopaedic trauma surgeon, based at King's College Hospital in London – one of London's four Major Trauma Centres – where he treats as a matter of course patients with the most urgent, life-threatening injuries. He qualified at Guy's, King's & St Thomas' School of Medicine, completing his orthopaedic training on the prestigious London South East Thames Rotation.

He specialises in the management of complex open and closed pelvic, acetabular, upper limb and lower limb fractures and amputations. He is also one of a small group of surgeons – and the only contemporary orthopaedic trauma surgeon in the UK – who works as a Helicopter Emergency Medical Service (HEMS) air ambulance pre-hospital care doctor.

HEMS provides an advanced trauma team which consists of a doctor and paramedic, who rush to the scene of an incident via helicopter during the day or fast response car at night. Mr Vasireddy's training extends quite uniquely to delivering advanced medical interventions, such as rapid sequence induction of anaesthesia, to injured patients in order to better improve their outcome.

The service provides the unique opportunity to treat patients in time-critical, life-threatening situations: often in hostile environments, for example under trains or lorries and in the middle of roads and building sites.

The well-established theory of the 'golden hour' advocates that major trauma patients should be transported as quickly as possible to a specialist trauma centre following a traumatic injury, to give them the highest likelihood of surviving. Medical responders in a helicopter or fast response car with optimum training and skills can provide a higher level of care at the scene and faster transportation to a trauma centre. In addition, by starting treatment at the scene, many patients can receive this optimal care within this golden hour.

The training to be a part of this elite team – on top of the extensive medical training to qualify as a surgeon – includes separate secondments in emergency medicine, anaesthesia and intensive care medicine. Joining any HEMS service is an incredibly competitive process. Once a doctor is accepted – after completing the additional training in the form of secondments – and starts working for the service, there is a further intensive six-week training course culminating in a continuous 12-hour assessment during a clinical shift.

An example of a hostile scene with numerous safety issues but where timely extrication and clinical management of the patient is imperative

Some aspects of the course can be very stressful, even more so than the studying required to be a surgeon. During training, all shifts are supervised by senior colleagues and all 'missions' are debriefed in a 'very open and blunt fashion' to help audit and continually improve performance. Many seminal articles from journals need to be committed to memory – including the results of the studies as well as their limitations – so that the clinicians understand the evidence that underpins the interventions provided by the service. Additionally, there are more than 50 standard operating procedures (SOPs) that need to be learnt. There are other associated documents that need to be read and committed to memory, including many Major Incident Protocols.

The air ambulance service has become a critical part of the amazing treatment and care we are privileged to have available to us in the UK. They are involved in the majority of major incidents we see reported on the news, including the 7/7 bombings and numerous railway crashes. Mr Vasireddy was one of the medics involved in treating the casualties from the Westminster terrorist incident in 2018 for example.

Some of the reading material that needs to be committed to memory!

All shifts are 12 hours long and run from 7am to 7pm or 7pm to 7am. The general routine (for which there is an SOP!) involves the doctor and paramedic preparing and checking equipment prior to taking a handover from the previous team – and ensuring checklists are complete. Duplicate equipment is present in both the car and aircraft, so that both transport options are available depending on the incident location. Upon arriving at an incident, two packs are carried containing all the necessary drugs and medical equipment they might need. Once all medical interventions are completed, such as anaesthsia, surgical procedures and blood transfusions, the patient is escorted to hospital via land or air.

Clinical governance is a crucial part of the service, with twice-weekly meetings in which clinical cases are discussed. There is also a monthly Clinical Governance Day – open to all outside the organisation – at which clinical cases are audited. An open culture is key in order to highlight areas of improvement. Guest speakers also lecture on their particular areas of interest, which include clinical and non-clinical topics. ❑

• Mr Vasireddy is an orthopaedic and trauma surgeon and expert witness. He specialises in a range of areas including claimants who have sustained high-energy injuries. With his unique level of training and expertise he is able to provide a range of comprehensive reports and review all aspects of a patient's treatment. He can be instructed via Medicolegal Partners by calling 020 7118 0650, emailing info@medicolegal-partners.com or visiting the website www.Medicolegal-partners.com

Pharmacists call for ban on ‘deadly’ weight loss drug

THE ROYAL PHARMACEUTICAL SOCIETY (RPS) has called on the government to ban the chemical 2,4-Dinitrophenol, known as DNP, which it labelled a ‘deadly diet drug’.

RPS president Ash Soni and its chief pharmacist Gino Martini have written to the Home Secretary, Sajid Javid MP, requesting a ban on the drug.

DNP is an industrial chemical unfit for human consumption, which is marketed illegally online to often vulnerable people to promote extreme weight loss. There have been at least 21 deaths related to DNP since 2013. It is a yellow powder usually made into tablet or capsule form before being sold via websites, social media accounts or by people at gyms.

In a statement, the RPS said: “We are working to raise awareness of the dangers of DNP, alongside the NHS, the National Food Crime Agency and others. We believe it should be banned as soon as possible to prevent further harm to human health.”

DNP accelerates the metabolism to a dangerously fast level. That increases body temperature, which can damage organs such as muscle, the kidneys and brain. The result can be seizures, coma, kidney failure, muscle damage and bone marrow failure. Once these effects have started to develop, they are very difficult to treat and death can occur in spite of the best medical treatment.

In the letter, Messrs Soni and Martini point out the difficulties posed to prosecution because DNP is ‘classed neither as a pharmaceutical product nor considered an illegal drug’. They suggest the chemical should fall within the scope of the Poisons Act 1972 and the Control of Poisons and Explosive Precursors Regulations 2015, adding: “While DNP has some commercial uses as a chemical, given continued health risks the Government should work with industry to find alternatives.”

They conclude: “We would urge the Government to immediately ban DNP to reduce the risk of harm, to commit to prosecuting those seeking to profit from it, and to encourage other countries to do the same.”

The RPS added that pharmacists can continue to play their part by making patients aware of the risks of buying weight loss remedies online and helping people with safe ways to maintain a healthy weight. ❏

New Gosport investigation could lead to serious charges

THE NEW INVESTIGATION being carried out by police into deaths at Gosport War Memorial Hospital in Hampshire – the fourth such – is a major development that will take many months to complete. In addition to the criminal investigation, the police have said they will be assembling an ‘expert medical panel’ to determine whether it is possible to prove that the administration of opioid painkillers caused the deaths.

It has been reported that the investigation will consider whether charges as serious as murder should be brought.

Ali Cloak, medical negligence lawyer on the inquest team at Royds Withy King, commented: “At the inquiry this question would have been considered on the ‘civil standard of proof’, in that they would have only had to consider whether it was more likely than not that the deaths were caused by the administration of the painkillers.

“However, in a criminal case this would have to be proved ‘beyond all reasonable doubt’, a significant change which is likely to have a bearing on any finding.” ❏

Specialist in Toxicology with particular emphasis on Drugs (both prescribed and illicit) and Alcohol.

Toxicological reports and interpretation provided for a wide range of criminal and civil investigations e.g. driving and alcohol/drug cases, child custody where drugs and poisons are involved, drug facilitated crime, workplace drug testing – medical reviews, interpretation of forensic toxicological analysis and forensic pathology reports.

Insurance reports prepared, personal injury and medical negligence cases dealt with.

I have more than 30 years experience as an expert witness in Coroners, Magistrates, County and Crown Courts.

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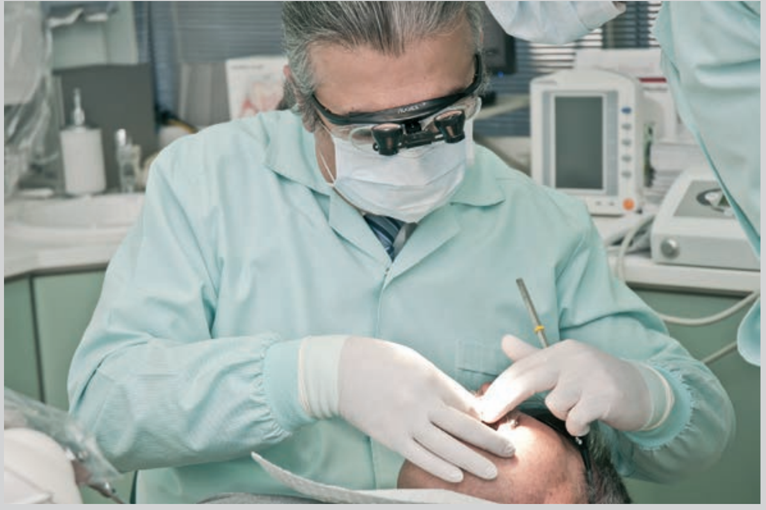
Dentists echo NAO call for clarity on charges



THE BRITISH DENTAL ASSOCIATION (BDA) has welcomed calls from the National Audit Office (NAO) for clarity on NHS penalty charges. The watchdog's new report revealed 30% of healthcare fines issued since 2014 – 1.7 million notices, with a cash value of £188m – were withdrawn because a valid exemption was confirmed to be in place following a challenge.

The NAO launched its investigation into fines covering NHS dental and prescription charges in response to a campaign by the BDA highlighting that 400,000 dental patients a year – including those on very low incomes, the elderly and those with learning disabilities – have received £100 fines, some for simply ticking the wrong box on a form.

The report identifies multiple sources of mistakes and confusion, including issues around Universal Credit and income-based Jobseeker's Allowance recipients, together with different criteria for eligibility for exemption between prescriptions and dental treatments. The report acknowledges that the NHS Business Services Authority (BSA) is unable to reduce the likelihood of vulnerable patients receiving fines, as it relies on recipients identifying themselves as vulnerable and challenging the fine, when many do not feel able to do so.

Dentists' leaders have expressed alarm over revelations in the NAO research that the BSA spent £1.6m on its *Don't Run the Risk* initiative, warning patients about misclaiming. The BDA has accused the campaign – which features messages like 'Don't assume you're entitled' – of simply discouraging patients unsure of their exemption status from seeking the help they need, rather than providing much-needed clarity.

The BDA has expressed deep concerns that the increasingly aggressive approach to penalty charges has fuelled a drop in attendance among low-income and vulnerable patients. Official statistics show a fall of two million treatments delivered to patients exempt from NHS charges since 2013/14: a fall of 23% in four years.

The BDA says at the very least NHS England must end its 'fraud first' approach to patient communications. Scotland and Northern Ireland do not operate on a presumption of fraud, with letters sent to patients querying their status should their entitlement to free care be in doubt.

In Scotland, Freedom of Information requests by the BDA demonstrate that it has effectively reduced the number of penalty charge notices issued for dental care by three quarters, with a large proportion of patients either confirming status or paying their treatment costs. Fines are sent to those who fail to respond to an initial letter. Income from those letters is higher than that secured from fines issued.

Charlotte Waite, chair of the BDA's England Community Dental Services Committee, said: "There can be no excusing the fact that innocent people, fully entitled to claim free care, have been slapped with over £180m in fines. Patients deserve real clarity when making a claim. Sadly, all the government has done is spend a fortune on campaigns simply discouraging them from seeking the help they need and are entitled to.

"England has a system built on a presumption of guilt, which offers few signposts and has left vulnerable patients chased by debt collection agencies. Other UK nations have chosen a different path. Change can begin by ending this blind 'fines first' approach, with a simple letter asking patients to spell out their entitlement." ❑

Dr. Joseph Fell BDS (UGlas)

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Dr Keith Marshall
PhD(Lond) BDS FFGDP MGDS RCS(Eng)
Specialist in Restorative Dentistry

Dr Keith Marshall undertakes instructions as an expert witness, including the preparation of medico legal reports, in cases involving facial and dental injuries.

His specialist areas of expertise include:

- General dentistry
- Odontology
- Restorative dentistry
- Interventional facial aesthetics
- Implantology

Previously a Senior Lecturer and Consultant at Kings College School of Medicine and Dentistry in London, and in a wholly private general and specialist practice in Surrey, he is now Postgraduate QI Tutor South West Wales for Health Education & Improvement Wales (HEIW) and member of the Clinical Advisor and Experts Panel at the General Dental Council.

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Potential for conflict between counsel and expert witness

By* TOBY TALBOT *BDS MSD (Washington) FDS RCS

TOBY TALBOT is a specialist in restorative dentistry, prosthodontics, endodontics and periodontics. He has over 20 years experience as an expert witness with a specific interest in dental negligence litigation claims. In this issue he shares his thoughts on dentistry and medico-legal matters at the coalface.

THE PROTOCOLS BETWEEN warring litigious parties are well established. Counsel represent their client, either acting for the claimant versus the opposing defendant, practitioner or health authority, or for the defendant in a claim for damages. The expert acts for the courts and must remain wholly non-partisan – a fact reiterated each time a report is formally addressed to the court. But, however clearly drawn the battle lines, there are several ways they can be so easily blurred.

Beware of any initial requests for a brief review of a case when only limited documentation has been made available as part of a scouting exercise. This usually means counsel is trying to determine whether a case has a favourable chance of success without spending any more money than necessary. It's effectively trying to do it on the cheap and exposes the expert if that opinion is not addressed to the courts. If at a later date counsel goes elsewhere for a more thorough report, the aforementioned expert can find themselves with a claim against them if that report contradicts their own. If any report is addressed to the court, only the court is able to act against the expert.

Don't compile reports unless you have sight of all the relevant original documentation. Summaries and transcriptions by legal and clerical staff are subject to typographical errors and omissions – not least because legal clerics don't understand medical and dental terms, except at the most basic level.

Many cases are now finding their way to my desk following the outcome of a conduct committee hearing conducted by a professional body. This invariably occurs when a case of Fitness to Practice has gone against the practitioner concerned. Although the patient has had their day in court, they still trot off to a solicitor to sue for damages.

What the patient may not appreciate is that Fitness to Practice charges are not the same as the Failure in Duty of Care – that has led to quantifiable damages – or Causation.

The doctor or dentist may have overlooked certain blood tests or diagnostic x-rays and is thus subject to criticism by the professional conduct committee, but unless this oversight has led to untoward consequences with subsequent harm or injury, there is no Causation and therefore no consequence of that omission.

It is also worth noting that although a professional body commissions an expert for guidance, that expert never examines the claimant. In my experience this can lead to misguided decisions against practitioners. When I have disagreed with the conclusions of conduct committees, I have often been told by instructing counsel that I am not permitted to contradict their findings. A wholly misinformed assumption.

Many an expert will find themselves instructed to provide only a Current Condition, Prognosis and Future Treatment Report after counsel have previously obtained a favourable Breach of Duty and Causation Report. Watch out for this one. It is invariably made by an expert who has made conclusions based on the documentation alone, without examining the patient. What counsel do not understand is that the details of the clinical records will invariably influence prognosis. If I review the records and conclude, after examining the patient, that patient compliance is so poor that the previous practitioner was not to blame, then this will invariably influence my own treatment recommendations for that patient.

As an example, let's take a patient who has been under the care of a general dentist for 20 years before they discover they have advanced periodontal disease with bone loss that will invariably lead to tooth loss. A review of their dental records shows limited documentation related to assessment of the gums, except intermittent advice to brush their teeth a bit more, and routine scaling every six months. When the patient attends another practitioner they suddenly feel shocked and aggrieved due to the 'failings' of the previous practitioner. Blame is apportioned and a visit to counsel ensues. An initial Breach of Duty Report follows after a review of the dental records, where the omissions are serially pointed out by the expert.

In the meantime, the patient (now client) trots off to a periodontist who reinforces the terrible state of the gums and the enormous costs of complex implant dentistry that is required to put things right. Due to the complexity of the proposed treatment, the former expert cannot provide an opinion as he/she is a general dentist with no specialist training. In addition, their report did not allow them to examine the patient.

I am then instructed to examine the client to provide the Current Condition, Prognosis and Treatment options perhaps 18 months after they attended the periodontist. At the consultation the client presents with ongoing severe active periodontal disease associated with abundant plaque deposits throughout. It is clear this patient has not taken a blind bit of notice, despite repeated visits to the periodontist, and is quite ill-suited to expensive dental implants. Not only do I consider that he/she is a candidate for conventional dentures, but also that he shows such a disregard for his own responsibility for optimum oral health that in all probability he is behaving as he did with the defendant, ignoring advice and failing to comply. In essence, the client is wholly culpable for their own tooth loss.

It may not surprise the reader that counsel are often furious with my conclusions and imply that I have ventured beyond their instructions for the Condition and Prognosis Report. Not so, I point out. My duty is to the court.

Their error is to assume that a second expert will always agree with the conclusions of a previous Breach of Duty Report. The only way to avoid contradictions between the two reports is to ensure only one expert is engaged.

In another case involving untreated periodontal disease I found in favour of the patient. Subsequent quantum of £3,600 was offered by the indemnity insurers which led me to file the records for archiving. Imagine my surprise when, three months later, I received a demand for £30,000 from the patient's agents as a consequence of my failure in my duty!

It transpired that during previous meetings with counsel, the client's solicitor had indicated to the client that he could expect a pay out of £35,000. As a consequence, the client issued instructions to the same solicitor who had instructed me to sue for the difference between what he expected and what he finally received. The author invites the reader to consider whether there is an integrity issue, and whether the solicitor should have referred the case to another firm.

This is not an isolated incident. Over the past 20 years I have received several instructions from one of the larger legal firms in my home city of Bath. They have a dedicated division handling medico-legal instructions. One bright morning my clinic doormat was graced with a letter from them representing one of my own patients pursuing compensation for treatment received. Not only did they not consider the possibility of any conflict, but the patient was a solicitor himself from Dorchester. The case was subsequently dropped. Needless to say, I have refused to accept any instructions from them since.

In my experience, the consequences of soured relations between expert and counsel are several and include:

• Deprivation – I have received no response after sending a report and the anticipated payment of my fee fails to arrive on time. Some firms have resisted paying my fees, which invariably leads to a claim in the small claims court and a complete breakdown in our relationship.

• Extension – One firm forwarded a list of 30 plus questions which they stated were necessary because they considered my report failed to clarify certain issues. Furthermore, they did not expect to pay extra for the responses which took more two hours of my time. It was clear from the questions asked that the solicitor had awarded himself an honorary degree in dentistry!

• Procrastination – Firms have asked for a precise breakdown of time allocated for the report and then quibbled endlessly about minor typographical errors.

• Omission – Several firms have asked me to omit certain paragraphs that weaken their case. When I refused, they complained that I had sent the report in pdf format and asked me to re-send the report as a Word document!

• Disqualification – Some firms have tried accusing me of venturing outside and beyond my area of expertise. It is to be noted that, as a former hospital consultant and a Fellow of the Royal College of Surgeons, my understanding of general medical and surgical issues is likely to be a little more than the general dental practitioner. I have been responsible for patients undergoing critical care, victims of severe road traffic accidents, and head and neck oncology patients. But I am a dentist!

This old lag isn't one to offer criticism without constructive advice.

To avoid many pitfalls for the office of counsel, I recommend due diligence is conducted by the solicitors to ensure that the selected expert can deliver the goods. If the case is simple and straightforward, and thus wholly within the remit of a general practitioner, you can commission a general dental practitioner.

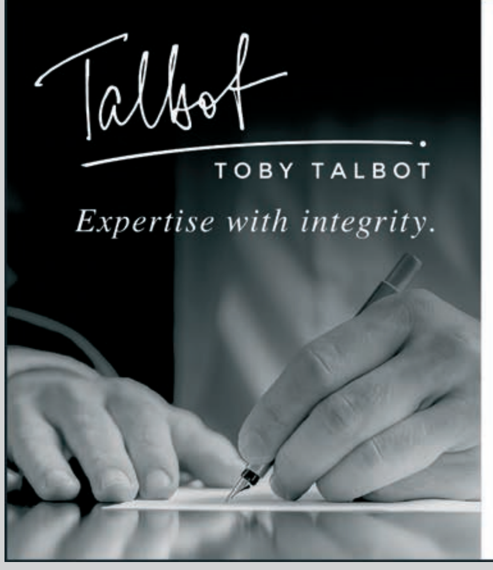
But you may need a dental expert. A maxillo-facial surgeon can give you a critical appraisal of a wholly surgical issue. He or she cannot give a dental opinion. If the problems relate to periodontal disease, find yourself a periodontist. If they relate to failed root canal treatments, find yourself an endodontist. Failed denture or crown and bridgework? Get yourself a prosthodontist. Is the case multifactorial and covers a broad range of dental problems? Get yourself a specialist in restorative dentistry. They are all dentists, *but* they're all different creatures.

Checkout whether the expert is still active at the coalface. The author attended a professional meeting in London quite recently and met a colleague who is very proactive as an expert witness. He had just celebrated his 85th birthday, having retired as a clinician 20 years ago. How on earth can counsel expect him to be up to date? He will invariably find himself giving evidence before a judge (in all probability and ironically of advanced years) only to be publicly humiliated when asked the ultimate question by the opposing QC – when did you last undertake a similar procedure?

Finally, the reader is reminded of the influence of the Wolfe Report a few years back. Partisan conduct, whereby former practitioners would consider it their mission to protect colleagues, has been stopped to reflect professional transparency and candour.

Gone are the days when senior retired medical/dental colleagues could dabble in report writing for a bit of pocket money without finding themselves humiliated in court, outed for being out of touch with current clinical practice. Court immunity has now become a thing of the past, resulting in a considerable reduction in our numbers. Professional training and registration of expert witnesses has culled the amateurs. May they RIP. ❑

• All the views and opinions expressed by the author are personal but I would welcome public debate on all the issues included.



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Dr Peter Corr is a Consultant Clinical Psychologist with over 20 years NHS experience and director of Bridge Psychology Services Ltd. He specialises in working with children and adolescents with learning disabilities, autistic spectrum conditions and other neurodevelopmental conditions, along with associated social and mental health difficulties.

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New capacity law still raising concerns

WITH THE COMING into law of the Mental Capacity (Amendment) Act, mental health charity Mind has expressed a raft of reservations, adding that there is 'more work to be done'.

Under the new law, Liberty Protection Safeguards (LPS) will replace the older Deprivation of Liberty Safeguards (DoLS) – a system widely criticised for being too complicated. A huge backlog of applications for DoLS left an estimated 125,000 people without legal protection.

As the new legislation made its way through Parliament, mental health charity Mind repeatedly called for changes to strengthen people's rights and empower them – or someone acting on their behalf – to question decisions about their care. LPS is meant to be more streamlined, but Mind remains concerned about the new process, fearing it could still leave vulnerable people without the protection they need.

Michael Henson-Webb, head of legal at Mind, said: "The long-awaited overhaul of Deprivation of Liberty Safeguards was an opportunity to fix a system that was not fit for purpose and left thousands of people, including those of us with mental health problems, without vital legal protection. We welcome some of the changes associated with this law, such as expanding the scope of the system and reducing the number of assessments required, potentially making the process work for increasing numbers of people.

"However, there are a number of missed opportunities. By streamlining the process, a number of important safeguards have been removed. In addition, recommendations made by the Law Commission and others to make sure those who lack capacity have more involvement in decisions made about their own care and treatment have largely been ignored.

"How this law will work in practice will rely heavily on what's included in the accompanying guidance. It is vital, therefore, that this code of practice is developed collaboratively with charities such as Mind, legal professionals, practitioners and those affected by the legislation. We want to see the views and experiences of people with mental health problems – in addition to those with dementia and learning disabilities – taken into account." ❑

Reality TV inquiry welcomed by profession

THE DIGITAL, Culture, Media and Sport Select Committee of the House of Commons is to conduct an inquiry into reality TV. The inquiry will consider production companies' duty of care to participants. The DCMS Committee's decision comes after the death of a guest following filming for *The Jeremy Kyle Show* and those of two former contestants in the reality dating show *Love Island*.

The committee's chair Damian Collins MP said: "Programmes like *The Jeremy Kyle Show* risk putting people who might be vulnerable on to a public stage at a point in their lives when they are unable to foresee the consequences, either for themselves or their families.

"This kind of TV featuring members of the public attracts viewing figures in the millions, but in return for ratings the broadcasters must demonstrate their duty of care to the people whose personal lives are being exposed."

The announcement of the inquiry was welcomed by the British Psychological Society (BPS). Its chief executive Sarb Bajwa said: "Broadcasters and producers have a responsibility to the people appearing on their shows, and the BPS will shortly be launching guidance aimed at informing television commissioners and producers of the best psychological practices when working with members of the public, especially vulnerable persons. We would be happy to contribute our expertise to this inquiry to help ensure that all programmes are produced in an ethically sound manner." ❑

Dr Kevin Wright BSc (Hons) MA MSc PhD
Chartered Counselling Psychologist

Dr Kevin Wright can act as an expert witness on behalf of either claimant or defendant and as a Single Joint Expert.

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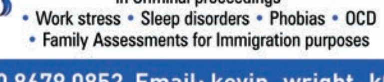

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Ψ DR THOMAS C M CARNWATH
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Assessing malingering, lying and deception for reports

By MR SIMON EASTON, *Chartered and Clinical Psychologist and Visiting Research Fellow, University of Portsmouth*

CLINICAL PSYCHOLOGISTS, medics and allied health professionals acting as expert witnesses draw upon their experience as clinicians when writing reports for the courts; but they can be less familiar with the literature relating to assessment of lying and malingering – for example *Resnick, 1995; Rogers, 1997; Drob et al, 2009; Vrij, 2000; Vrij et al, 2011*.

There is evidence that people are usually not good at detecting lies (*Vrij, 2000*) and experts, such as members of the Criminal Intelligence Agency, have been shown to perform only slightly better than most other people (*Ekman et al, 1999*).

The literature on lying tends to view dishonesty as active and clear cut: either what you say is wholly true or wholly untrue. In medico-legal settings, however, the detection of partial truth may be particularly relevant.

Resnick distinguished between pure malingering (feigning non-existent disease), partial malingering (exaggeration of existing symptoms) and false imputation (falsely ascribe real symptoms to unrelated cause). He later went on to suggest that the clinician might also attend to other factors in assessment of the validity of a claimant's reporting. That could include irregular employment and job dissatisfaction, previous claims for injuries, lack of co-operation at interview or psychological test results.

Rogers provided a list of factors a clinician might be alert to in interview:

- Rare symptoms – honest respondents might describe symptoms that a malingerer might not know about
- Indiscriminate symptom endorsement – claimant confirms presence of all symptoms asked about
- Obvious symptoms – observable signs of difficulty
- Improbable symptoms – unlikely difficulties in the context
- Presence of improbable combinations of symptoms
- Presence of symptoms of improbably extreme severity

In 1997 Lanyon suggested that, in assessing likelihood of malingering, an individual's accuracy of knowledge about a disorder is important. Investigators might usefully seek to identify whether or not someone is familiar with information which would not be readily known. The assessor might also consider whether someone presents information in a way which is consistent with common expectations for a disorder – but which does not actually reflect empirical validity.

There may be a wide range of other psychological factors that will affect assessment and prognosis. Ferrari et al, (1999) suggested that the prognosis for injuries in medico-legal settings can be affected by a range of aspects – such as blame, expectations and labelling, attention to symptoms, social factors, litigation and the sick role.

When preparing a report for the court, the clinician will usually have the opportunity to review other sources of information, such as medical records. Extensive and detailed questioning at interview will provide the opportunity to evaluate the validity of the informant's story in the light of that prior knowledge (*Vrij and Easton, 2002*).

Psychological tests can serve to alert the clinician to the possibility of inconsistency in presentation, but frequency of false positives and false negatives needs to borne in mind. Interpretation of psychometric test results requires care.

Maguire et al, (2001) reported that 'pure malingerers' (those inventing history of pain) tend to produce similar scores to those of 'real' pain patients on psychometric tests (eg a pain patient profile), while 'partial malingerers' (those exaggerating existing pain) tend to substantially over-endorse symptoms.

Faking psychological distress or pain is not difficult: Edens et al, for example, showed that successful malingerers asked to feign a mental disorder tended to endorse a lower rate of legitimate symptoms, avoid overly unusual or bizarre symptoms and/or base their responses on their personal experiences.

The opinion of an expert witness should be based on evidence cited in support of conclusions, and result from a comprehensive assessment. The structure of the interview, the relevance of the areas covered, the recognition of limits of expertise and the awareness and consideration of alternative interpretations of evidence must be taken into account when the court assesses the weight to be attached to an expert's report.

In the clinical setting, careful observation targeting the deception cues detailed above and extended interview probing – without revealing available information – together with such additional tests as may be appropriate, may increase the chance of detecting malingering. However, the only way to be confident about the veracity of a client's report is to thoroughly investigate the issue and search for collateral evidence – such as medical reports, statements of independent witnesses and forensic evidence – which supports or contradicts claims made.

Awareness of the relevant literature and/or formal training in the relevant techniques may be a requirement for expert witnesses. The expert assessor's attention to these key issues will assist both in the forming of opinions and the expert's expression of confidence in those opinions. ❑

Jeffrey S Hillman
ophthalmologist

Jeffrey Hillman is a Consultant Ophthalmic Surgeon with with special interests in cataract and intraocular lens surgery, glaucoma and trauma.

He is chairman and principal expert in the UK delegation to the ISO committee which sets standards for intraocular lenses.

Mr Hillman is a highly experienced medical expert witness and has prepared reports for both claimant and defendant in medical negligence and personal injury cases for over 30 years.

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Consultant Ophthalmologist with a special interest in Strabismus and Neuro-Ophthalmology

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He is Programme Director for Ophthalmology for Health Education North West and has had over 30 publications in peer-reviewed medical literature.

Medico-Legal Experience

Mr Durnian produces, on average, 70-80 reports a year with a claimant:defendant:joint work ratio of approximately 35:55:10.

He deals with clinical negligence and personal injury cases for all aspects of general ophthalmology, neuro-ophthalmology and strabismus. He has a particular interest in the visual problems that are often overlooked following brain injury.

Mr Durnian has successfully completed the Cardiff University/ Bond Solon Civil Expert Witness Certificate in Civil Law.

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Mr Kim Hakin
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Mr Kim Hakin has been providing medico-legal reports for over 20 years, providing around 200 reports per year and can provide a report within 2 weeks of receiving documentation.

Mr Hakin has produced many reports for the GMC, MDU, MPS, NHS Litigation Authority, and Welsh Health Legal Services as well as many legal firms and agencies.

To date he would estimate his ratio to be around 50% claimant to 50% defendant but is happy to work as a single joint expert. He is able to see patients in London or Taunton, or further afield with prior discussion.

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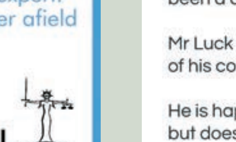

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Mr Luck has been actively engaged in medico-legal work throughout most of his consultant career.

He is happy to provide expert opinion in most aspects of ophthalmic surgery, but does have a special interest and expertise in corneal and external eye disease and refractive surgery including lens replacement and laser vision correction.

He has recent experience of giving expert evidence in the Crown Court, including lengthy cross examination.

Mr Luck can act on behalf of either plaintiff or defendant or as a Single Joint Expert and average waiting time for a report from instruction is four weeks.

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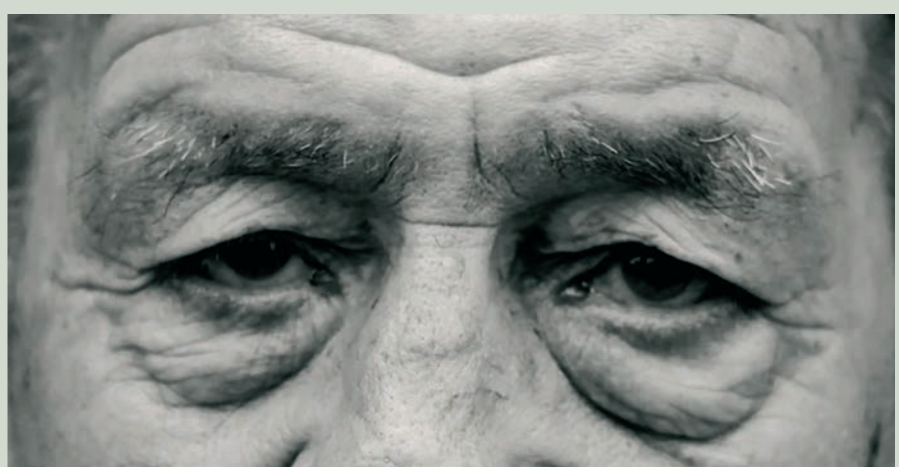
Research could help reduce misdiagnosis of dementia-related visual problems

THE COLLEGE OF OPTOMETRISTS has revealed the findings of research on the experiences of vision assessment for people living with a form of dementia that impacts vision.

The research, published in *BMJ Open*, focused on posterior cortical atrophy (PCA), which can result in unusual visual phenomena – such as finding it easier to read smaller fonts than larger ones – as well as visuospatial and perception problems. These can result in misdiagnosis unless health professionals know about, and test for, the condition specifically.



The project, undertaken with researchers at the Dementia Research Centre at University College London, guided three patients living with PCA through tests administered by three different health professionals: an optometrist, an ophthalmologist and a neurologist. The key finding was a quick and simple visual recognition test that showed some promise in helping clinicians to differentiate between vision problems with neurological origins, from those with optical/ocular causes.

The researchers also spoke to the patients, their carers and the health professionals about their experiences of vision assessment, and found that patients' priority was early diagnosis, while the health professionals valued further research and learning materials to raise awareness of the condition.

Michael Bowen, director of research at the College of Optometrists, said: "Although this project was limited in scope, it builds on the evidence from the college's NIHR-funded PrOVIDe project that there are vision assessments that people with dementia can complete, and that short and simple tests are preferable for this group of patients.

"It is important that optometrists, as the first port of call for those with vision problems, are aware of PCA, to ensure that patients are diagnosed as quickly as possible and can come to terms with the condition, which is why we have produced an online course for our members based on this project."

Professor Sebastian Crutch, professor of neuropsychology at University College London, added: "The experiences of people living with this condition can be truly mind-bending at first. Their eye care needs are the clearest example of how the visual system is as much to do with the brain as the eye, and their stoicism in the face of misdiagnosis is humbling. Hopefully this research will lead to further work that could verify the effectiveness of tests that can quickly identify PCA, and so help all health professionals in their practice." ❑

RCOphth issues lens alert

THE Royal College of Ophthalmologists has issued a safety alert to its members in which it stated it had been made aware of two ophthalmic units with a run of a small number of cases of fibrin membrane deposition in association with the Zeiss Lucia 611P intraocular lens.

The statement said: "In these cases, the patients presented from a few days up to six weeks postoperatively, with a painless white eye, very mild or no uveitis, associated with a fibrin membrane at the level of the anterior capsule incorporating the capsulorrhexis edge in front of the lens. This was sometimes quite dense, mistaken in some cases initially as intralens opacification and in a number of cases required tPA (tissue plasminogen activator) or occasionally surgery to remove the membrane and restore vision.

"A minority of those affected had some risk factors for postoperative inflammation, such as previous surgery or pathology, or small to medium pupils (not requiring iris hooks or expanders), but most of the patients had no specific risk factors."

In a statement issued on 8 April , Zeiss said: "Zeiss is intensely studying this issue, including the full scope of IOL testing and detailed analysis of clinical and surgical parameters. To date, no IOL associations have been observed. However, some cases have risk factors for a fibrinous anterior chamber reaction, such as intense postop uveitis and prior irradiation of the globe. The investigation is continuing with due haste." ❑

Ian Simmons BVSc MB ChB FRCOphth MBA
Ophthalmic Surgeon and Paediatric Ophthalmologist

Mr Ian Simmons has been a teaching hospital consultant ophthalmologist since 1999 and an Honorary Clinical Associate Professor since 2013. He specialises in paediatric ophthalmology, adult and paediatric neuro-ophthalmology (particularly involving tumours) and strabismus surgery.

He has co-written two textbooks on the complications of cataract surgery. He works in a major trauma centre and therefore co-manages patients with traumatic brain injuries and facial damage.

He has been in medicolegal practice since 2000 and prepares between 250 and 300 reports per year, split 70:30 Claimant to Defendant.

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Mr Brian Leatherbarrow

BSc MBChB DO FRCS FRCOphth

Consultant Ophthalmic, Oculoplastic & Orbital Surgeon

Mr Leatherbarrow has been preparing specialist expert witness reports since 1994.
He prepares over 150 reports per year, for both Claimants and Defendants.
Reports are produced within 4 weeks of receipt of all relevant information.

Mr Leatherbarrow has specialist expertise in:

- Complications of cosmetic eyelid surgery (blepharoplasty)
- Eyelid reconstructive surgery
- Ptosis surgery
- Eyelid and orbital tumours
- Eyelid and orbital trauma
- Loss of an eye / socket reconstructive surgery
- Thyroid eye disease
- Watering eye problems

Resumé

Consultant Ophthalmic, Oculoplastic & Orbital Surgeon Manchester Royal Eye Hospital 1992-2014.
He is now in full time private practice.
BOPSS Founder Member (President 2011—2014).
Cardiff University Bond Solon Expert Witness Certificate 2015.
BAAPS Inter-specialty member.
He has over 100 publications in the medical literature and 5 book chapters.
Single author of the text book Oculoplastic Surgery (3rd Edition due to be published in summer 2019).

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Reality TV seen as driver in liposuction growth

THE PAST YEAR has seen a rise of 9% in the number of liposuction procedures being carried out by members of the British Association of Aesthetic Plastic Surgeons (BAAPS), according to its annual audit published on 20 May.

Former BAAPS president Rajiv Grover, who compiled the audit, commented: “The rise comes at a time where the popularity of TV shows such as *Love Island* has driven the desire for a toned torso, as did the fashion for women’s athleisure clothing. The danger of cosmetic surgery becoming too closely linked to reality TV or celebrity endorsement is that it can make surgery seem like a commodity, which should never be the case. An operation is not something that can simply be returned to the shop if you have second thoughts.”

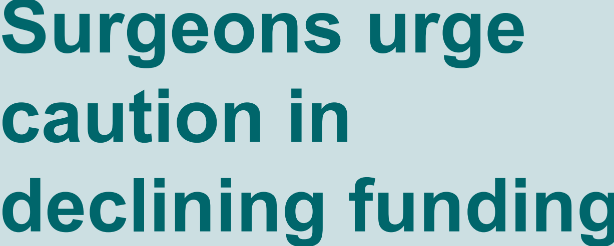
The sharp rise came against the backdrop of a rise of only 0.1% across all procedures and a fall in the numbers of male cosmetic surgical procedures of 4.7%.

At the same time as the audit was released, the current BAAPS president and consultant plastic surgeon Paul Harris called for further regulation of non-healthcare professionals conducting cosmetic treatments.

Mr Harris said: “The rise in high-street and DIY non-surgical cosmetic procedures is hugely concerning for a number of reasons, not least the potential for profit to be placed before patient care. Other issues are that it makes it easier for underage individuals to access, unrealistic expectations may not be addressed, and any emergency complications would need to be dealt with outside of a medical environment. Further regulation of products, practitioners, procedures and premises is urgently required to ensure patients’ physical and psychological well-being.”

He added: “Undergoing a cosmetic procedure is never a decision to take lightly – that’s why the BAAPS always advocates that any procedure should be preceded by a robust assessment of the patient’s physical and psychological well-being: something all BAAPS surgeons do as standard.”

His comments came at the end of Mental Health Awareness Week, which this year took as its theme body image. ❑



Surgeons urge caution in declining funding

THE ISSUE OF a distinction between plastic surgery that is ‘cosmetic’ and that which is medically required, particularly when it comes to funding a procedure, is one that has attracted attention.

Some procedures around the eyes fit into that blurred space.

According to the Royal College of Ophthalmologists: “Brow lifts, blepharoplasty, ptosis correction, removal of benign eyelid or skin lesions, and procedures to treat watering eyes are often included on lists of procedures for which Clinical Commissioning Groups do not routinely provide funding.

“Although this is an understandable response to difficult economic times, it is important that it does not hinder prompt assessment and treatment where there is a likelihood of malignancy, or where eyelid malposition threatens the ocular surface – for example where eyelashes are abrading the cornea or where the ocular surface is exposed.

“There should also be provision for treatment where brow droop or ptosis reduce the field of vision to the point where the ability to drive is compromised.” ❑

Mr Richard Matthews
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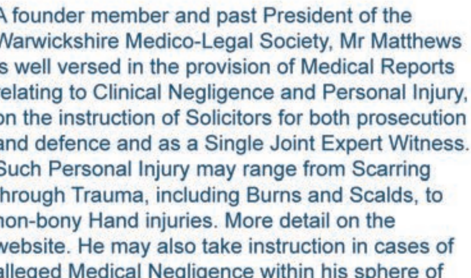
PLASTIC & HAND SURGEON

Mr Richard Matthews is a highly experienced Consultant Cosmetic, Burns, Reconstructive Plastic & Hand Surgeon with over 25 years experience as an Expert Witness.


A founder member and past President of the Warwickshire Medico-Legal Society, Mr Matthews is well versed in the provision of Medical Reports relating to Clinical Negligence and Personal Injury, on the instruction of Solicitors for both prosecution and defence and as a Single Joint Expert Witness. Such Personal Injury may range from Scarring through Trauma, including Burns and Scalds, to non-bony Hand injuries. More detail on the website. He may also take instruction in cases of alleged Medical Negligence within his sphere of expertise.

Mr Matthews is a Member of The Academy of Experts

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Special measures follow maternity report

MATERNITY SERVICES AT Cwm Taf Morgannwg University Health Board in South Wales have been placed into special measures, following publication of an independent invited review by the Royal College of Obstetricians and Gynaecologists (RCOG) in January.

The review assessed the safety, accountability and governance arrangements of maternity services at the Royal Glamorgan Hospital and Prince Charles Hospital sites. It followed a request from the Welsh Government after the discovery of under-reporting of a number of serious clinical incidents.

A multi-disciplinary team of six independent healthcare experts produced the report, which is based on information provided by the health board, as well as interviews with healthcare staff and women and their families.

The team of assessors found maternity services working under extreme pressure and under sub-optimal clinical and managerial leadership. Other key concerns centred around availability of consultant obstetricians on the labour ward, midwifery staffing levels, inadequate support for trainee and middle-grade doctors, lack of adherence to national guidelines and poor governance to support safe practice.

The serious concerns, which the reporting team says require immediate action to ensure the safety of the maternity services, were communicated immediately to the Welsh Government and the health board when the assessors visited the maternity units. The report includes a further list of recommendations required to ensure the safety of the maternity services.

Mr Edward Morris, vice-president of clinical quality at the RCOG, said: "We welcome the publication of the full report and the actions taken today by the Welsh Government. To drive much needed improvements in its maternity care services, we urge the government and health board to act on our extensive list of recommendations.

"It is crucial that healthcare staff are fully supported and adequately resourced and that women, their babies and families receive the very highest standards of maternity care."

Helen Rogers, the Royal College of Midwives (RCM) director for Wales, said: "The RCM has voiced serious concerns over the safety of maternity services at Cwm Taf for some time, so we are pleased to see this report. It shows a service that has too many times failed the women, babies and their families that it cared for.

"There are very real problems in terms of having the right amount of staff, with access to the right training, to support the delivery of safe and high-quality care. This in turn puts significant pressure on staff in the maternity service and does not support them to deliver the level of care that they want to. Too often the system and the leadership at the health board did not support staff to do their job to the best of their ability.

"There were also behaviours outlined in the report that fall short of the standards we would expect to see. All health professionals must at all times treat the people they care for with kindness, respect and compassion. We must be very clear that to not do this is unacceptable. This should also of course extend to their colleagues.

"The health board must now act on the recommendations of this report. It is imperative that this is done to firstly reassure the women and their families who are using the service that they will receive the safest possible, high-quality care. It is also important that the health board supports and nurtures its staff so that they can do their jobs effectively, safely and with compassion.

"When health professionals work in a system that often places them under significant pressure, which does not value its staff and which adopts a punitive approach when they raise serious concerns, this does not lend itself to support the types of behaviour we want to see." ❑

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Dr Emma Ferriman MBChB MRCOG FRCOG

Consultant Obstetrician and Fetal Medicine Specialist

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Prof Kevin Dalton

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Professor Dalton has over 25 years' experience of medico-legal work, for both Defendants and Claimants, and is jointly instructed in some cases. He advises on clinical negligence and personal injury and has given evidence in both civil and criminal courts, in coroners' courts and in the family court.

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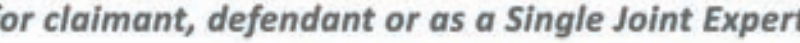

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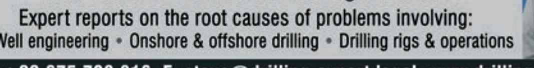

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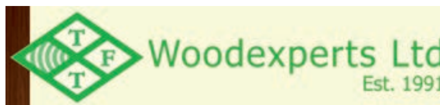

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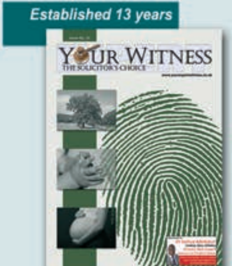

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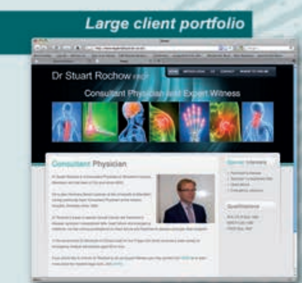

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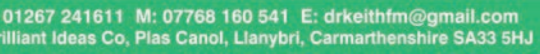

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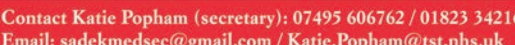

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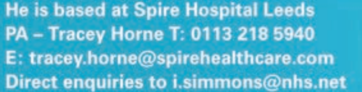

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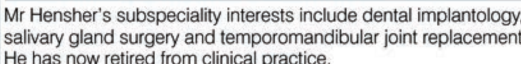

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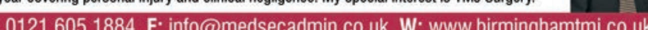

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Special areas of expertise include Road Traffic Accidents involving the cervical and lumbar spine, industrial and occupational back disorders.

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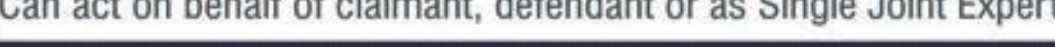

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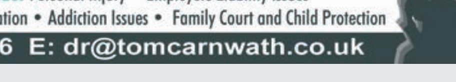

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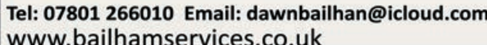

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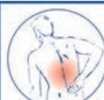

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Sarah specialises in carrying out and reporting on Legal Assessments including:

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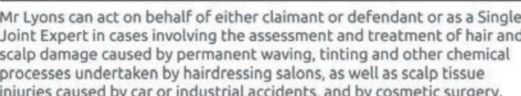
Mr Glenn Lyons FIT FRSPH MAE

Consultant Trichologist



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