

Medical negligence can lead to a criminal prosecution

An NHS Trust was fined £75,000 and ordered to pay costs after it admitted breaching Section 3 (1) of the Health and Safety at Work etc Act 1974 by putting the safety of patients at risk. Leigh Carter, Solicitor at Weightmans LLP, considers the increasing willingness of the Health and Safety Executive to prosecute hospital Trusts.

Employment

Double trouble – combined discrimination claims

Mark Landon, Partner at Weightmans LLP, discusses the progression of The Equality Act 2010 and the consequences of its employment provisions that are due to be implemented in October 2010.

Edwards v Chesterfield Royal Hospital NHS Foundation Trust

Mike Berriman, Partner at Weightmans LLP, discusses the case of **Edwards v Chesterfield Royal Hospital NHS Foundation Trust** and the implications that it will have for other NHS employers.

Clinical negligence

Litigation round-up and useful lessons

Mid Staffordshire NHS Foundation Trust

Robert Francis QC published the report of his Independent Inquiry into the care provided by the Trust on 24 February 2010. Following investigation of the care at Stafford between 2005 and 2009, he highlighted a number of common themes including repeated accounts of poor continence and bladder care, particularly to frail and elderly patients; cases of falls leading to serious injury; that there often appeared to be too few staff to cope with the high dependency needs of elderly patients leaving those patients at risk from harm; call bells were out of reach; many patients experienced little or no help in washing or attending to other personal care needs; meals were placed out of reach or were taken away before they could be touched; there were accounts of poor pressure area care; many witnesses commented on the lack of appropriate cleaning. The standard of record keeping was a frequent concern. There were areas of misdiagnosis and inadequate communication.

He has made a number of recommendations including that:

- The Secretary of State monitor and review the arrangements of the training appointment, support and accountability of Executive, non-Executive Directors of NHS Trusts and NHS Foundation Trusts
- The Department of Health establish an independent group to examine mortality statistics
- The Secretary of State should consider whether the Trust should have its Foundation Trust status removed and if not, he should keep that option under review
- Fifteen recommendations to the Trust to improve safety and quality of care to patients

At the time of publication of the report, the NHSLA issued a press statement confirming that it has instructed solicitors to deal fairly and speedily with claims and would settle those properly to be met. It was hoped that the litigation process could be avoided.

DH Communications set up a helpline to handle enquires from individuals, referring those who wished to make a claim directly to us. No calls have been received.

'Cure the NHS' referred a number of cases to Leigh Day & Co Solicitors. They in turn have instructed Philip Havers QC, who represented the families at the inquiry.

The intimated claims include both Human Rights Act claims and clinical negligence claims. Secondary victim claims are now being intimated on behalf of family members. There is no general admission of liability and each case is being reviewed on its merits. Apologies have been provided by the Trust in a number of claims.

It is hoped that a collaborative approach can secure resolution on suitable claims promptly.

Weightmans LLP represented the Trust in connection with the claims arising from the alleged poor care at Stafford Hospital 2005-2009.

Patient information upon Hospital Acquired Infections

In acting for several NHS Trusts in connection with claims concerning hospital acquired infections, it has come to our attention that patient leaflets may be giving misleading information. Recently we reviewed guidelines on *Control and Management of Clostridium difficile infection* the appendix included: Clostridium difficile is a cause of diarrhoea which is *usually acquired in hospital* (our emphasis). We know from a number of experts in the field that community associated C. difficile infection is significantly under-reported and that some patients – even if a small minority – already have C. difficile within their gut prior to admission to hospital. We recommend careful consideration is given to the wording of such leaflets and old guidance is re-visited. (We understand the leaflet mentioned above was prepared by the Association of Medical Microbiologists in 1998.)

Innovative methods of resolving compensation claims

Avoiding overpayment by providing for reversion of unused compensation to the NHSLA

XY v Birmingham Children's Hospital NHS FT

The claim was pursued by a minor. Breach of duty and causation were admitted and the Official Solicitor was appointed as Litigation Friend. The Claimant suffered numerous physical injuries and a subtle brain injury superimposed on pre-existing learning/behavioural problems, he did not have capacity and expressed no interest in pursuing the claim. The Official Solicitor proposed the claim was quantified on the evidence available and Leading Counsel recommended settlement on condition that any unused funds reverted to the Defendant (NHSLA) on the Claimant's death. This mechanism was agreed. The Court approved, in principle, a settlement (in excess of £1m) paid into a Trust Fund with the Claimant and NHSLA as sole beneficiaries. On the claimant's death the Trustees will pay any remaining sum to the NHSLA.

This was considered a pragmatic method of resolving a claim to ensure the claimant had the security of funds without incurring significant legal costs awaiting a Judicial Decision in the distant future when a complete portfolio of evidence/assessment may have become available.

A new method of resolving future loss of earnings compensation claims

Future loss of earnings claims are usually calculated by multiplying the annual loss (at today's average earnings rates) by a discounted actuarial figure (which provides for the number of years the loss will be incurred).

In a recent claim it was asserted that the claimant would (but for the negligently caused brain injury) have earned considerably more than average earnings and the compensation should be calculated by way of statistics providing for the top 90% of female earners.

Following significant input from statisticians and educational experts, it was asserted that the claimant was likely to have obtained a degree. Her solicitors argued that the annual loss of earnings figure should be paid each year (as periodical payment rather than a one-off lump sum) and should be reviewed annually in line with published data of graduate earnings, rather than the average earnings figures.

In negotiations, annual payments were agreed. However the claimant was persuaded to accept annual payments based on average earnings rather than graduate earnings (which would have provided a much higher level of compensation). It was agreed the payments would be annually reviewed and amended to reflect changes in the published data.

This settlement offered the benefit of periodical payments (which can change from year to year depending upon averages set out in published statistics) and preservation of the preferred method of

resolving such statistical issues thus avoiding potentially repercussive and costly litigation. It is hoped future claims can be managed similarly if the traditional method of calculating a lump sum is considered inappropriate.

Choosing the right case to defend

Consent for treatment

Saini v West Middlesex University Hospital NHS Trust

The claimant alleged that she did not give consent for surgery to correct bunions. Post operatively, she suffered pain which impacted on her ability to walk, stand and perform domestic tasks. She said she had never received pre-operative information sheets, had never discussed conservative options with the treating Consultant Podiatric Surgeon and did not read the consent form before signing it. She said if she had been made aware of the risks of on-going pain she would have opted for conservative management or obtained a second opinion rather than go ahead with surgery.

The hospital staff said she was given all of the necessary written and oral advice/information for the elective procedure, and she had exhausted conservative options without benefit and, as such, she had been referred to the hospital for a *surgical* solution.

The matter was essentially a dispute of fact. His Honour Judge Powles QC sitting at Brentford County Court preferred the Hospital's evidence. He had in mind that the claimant had no cause to question the consent process until three years after the operation and she had difficulty separating the risks from the eventual outcome. He concluded the claimant had been given information sheets and had genuinely forgotten that the Consultant had discussed the risks and benefits with her. He also concluded that the claimant would have agreed to the surgery in any event as her friends had undergone similar surgery with a favourable outcome.

This was an excellent outcome for the hospital and we are keen to identify and defend claims for trusts where there is clear evidence to support the trusts' actions especially when we have the benefit of supportive factual evidence from the hospital staff involved (of course this is always easier to secure if the staff have clear notes of discussions and/or department policies to rely upon).

Information about risks to staff from patients

Jordan Smith v Pennine Care NHS Foundation Trust

The claimant (a hospital employee) alleged that a patient had kicked his arm and that the Hospital had breached its duty to him for failing to advise him the patient had a history of violence. It was also alleged the patient should not have been allowed on the ward, and should have been more closely observed.

It was the Hospital's case that 22 patients on the ward presented such a risk and even with knowledge of this particular patient's history, the assault was so sudden that it could not have been prevented. The court accepted that the claimant would have wanted to know about the risks of all 22 patients but doing this on his first shift would not be reasonable. It also concluded the assault would have happened even if the Hospital had given all the information. The claim was dismissed and the Hospital awarded their costs.

If this claim had succeeded the demands on Trusts would have been unworkably onerous and this was clearly a sensible decision. However, it illustrates the possibility that when new employees join the Hospital information regarding wards and particular risks are important to pass on during health and safety training/induction.

Slip on ward

Elizabeth Terry v Blackpool Fylde and Wyre Hospitals NHS Foundation Trust

An auxiliary nurse slipped on a wet floor and injured her back. The Hospital relied on strong evidence from three members of staff on duty at the time that the “clean as you go” policy was working well and all staff knew what to do in the event of a spillage. The claimant was not convincing in her evidence and gave the location of the accident as near to a filing cabinet which did not exist.

The Judge concluded that, despite the inconsistencies in the claimant’s evidence, she seemed very pleasant and was unlikely to be dishonest; the inconsistencies arose due to her shock at having fallen. On the balance of probabilities the accident occurred as alleged but the cleaning policy was effective and proportionate. There was no evidence that the hospital’s witnesses had negligently failed to implement the system and he could not make a finding as to who had caused the spillage or how long it had been there. The claim was dismissed and the Hospital secured an order for payment of their costs.

This result continued a trend of successful defences in slipping cases where we and the Trust believed the policy in place was appropriate, proportionate and efficiently implemented.

Jasmine Armstrong, Associate
Weightmans LLP

Healthcare Advisory

Self-harm minimisation and the law

There’s a limit to how often you can counsel caution – whether you’re a nurse or a lawyer

Kate is approaching middle age and for much of the last 25 years, she has cut herself. There are proud weals, and also fresh, livid scars, on her arms and thighs. What she does might be about control or exhilaration; it might have its roots in abuse or even mental disorder. It certainly makes other people uneasy.

Kate is a cipher, of course; someone to stand for the 170,000 people who are said to attend A & E every year after deliberately harming themselves. Sometimes, she finds sympathy there and a comforting word. More often, her wounds are stitched up disinterestedly and maybe, as some kind of lesson, without anaesthetic. Occasionally, Kate even finds herself being detained under the Mental Health Act.

Lately, though, something has begun to change. It seems to Kate that the nurses and doctors are less quick to condemn, and some have even begun to say that to prevent her cutting herself might actually compound the problem. None has gone so far as to hand Kate a razor, but she has been told which part of her body is safest to cut, and she has been given both privacy and sterile dressings. There is a name for that approach: self-harm minimisation.

Until recently, anyone practising such an approach did so in a vacuum, with little to guide them. Little, that is, but the still, small voice that counsels caution, but that might equally ask whether there isn’t a better way of doing things.

Now, the position is a little surer. In 2004, the National Institute for Clinical Excellence published guidance that put minimisation alongside other techniques practitioners might choose to discuss with their self-harming patients. This was a modest start, but two years later, at its annual congress in Bournemouth, the RCN gave

self-harm minimisation qualified support. Meanwhile, pilot projects supported by the Department of Health have been underway in Stafford and Newcastle.

There is, undoubtedly, something unsettling about self-harm, and, for the lawyer, about any intervention that seeks to do something other than prevent it entirely. But should such an intervention be viewed any differently from surgery, physiotherapy or the giving of medicine? How does it differ from handing our syringes and needles to drug-addicts?

It seems likely, in fact, that self-harm minimisation falls within accepted notions of 'medical treatment', which Lord Denning once defined, rather broadly, as "the homely art of making people comfortable and providing for their well-being". What matters, surely, is that any intervention satisfies the '*Bolam* test'.

That, of course, is the standard test for health care negligence (and for many other forms of negligence besides). To be lawful, an intervention, or a failure to intervene, must be consistent with a practice accepted as proper by a responsible body of relevant opinion. Doctors and nurses, in short, are to be judged by the standards of their peers.

When deciding whether self-harm minimisation was lawful, a court might consider how well the patient's background – and in particular, any history of self-harm – was researched, and how well understood; how carefully her needs were considered; and how closely those needs corresponded to the intervention that was made.

An intervention might be least difficult to defend where a patient had tried to harm herself before and had done so in a fairly consistent way and to a fairly consistent degree. The NICE guidance said much the same thing. There is no guarantee, of course, that an intervention – or the decision to use self-harm minimisation in the first place – would comply with *Bolam*. Now, however, we need no longer assume that it would not.

Even where they favour self-harm minimisation, those who encounter Kate will tread cautiously. That would be sensible, for the law is particularly suspicious about anything new. It has long recognised, however, that the requirements of the *Bolam* test cannot be allowed to impede clinical progress.

There is, of course, a danger for advocates of self harm minimisation: if they get what they want, they will raise the expectations of Kate and many thousands like her, and those raised expectations will be difficult to manage. As all clinical innovators have found, every attempt to devise or even discuss an appropriate level of care runs the risk of elevating that level even higher.

And the still, small voice persists: how can it be lawful to help someone cut – or burn or bruise – themselves? It would be understandable if lawyers faced with that question gave the advice they would have doctors and nurses give to their patients: don't do it. Yet, that is an unimaginative response, and it is also becoming an irrelevant one. In far too many cases, it neglects the realities of the situation as surely as a nurse who does no more than scour a patient's bedroom for sharps.

David Hewitt, Partner
Weightmans LLP

At what cost “just satisfaction”?

Much has been written about the decision of the House of Lords on the preliminary issue of whether the NHS Trust owed an operational obligation to a detained patient in **Savage v South Essex Partnership NHS Foundation Trust** in December 2008. In March 2010 this matter was heard by Mr Justice Mackay in the High Court it having been referred to trial following the decision in 2008.

The facts

A patient detained under Section 3 of the Mental Health Act 1983 made several attempts at absconding from the hospital. She had also made suicide threats, including advising those caring for her that she was suffering from hallucinations telling her to jump out of the window.

On 5 July 2004, Mrs Savage absconded from the hospital, jumped in front of a train and was killed. At Court, whilst recognising that the Claimant was not bringing the claim for a financial gain, Mr Justice Mackay awarded damages of £10,000 – an amount considered appropriate for “just satisfaction”.

Criticisms

The issue to be determined by the court, the CA having held that the NHS Trust owed an operational obligation, was whether there was a “real and immediate” risk Mrs Savage might self-harm or commit suicide.

Mr Justice Mackay was highly critical of the quality of the risk assessments performed on Mrs Savage together with actions (if any) taken in light of the assessed risk. The Judge considered that Mrs Savage was not at risk of self-harm/suicide attempts when she was on the ward but that this became a “real and immediate” risk upon absconsion and one that the Defendant Trust should have been aware of. The Judge decided that the Trust failed to do all that could reasonably be expected of it to avoid or prevent that “real and immediate” risk.

Future impact

The Judge emphasised the importance of the quality of risk assessments, of members of staff acting upon them and of regular reviews of the risks attached to individual patients. It is important that staff are aware both by the actions of patients and also during handover between shifts of any risks posed by individual patients and of the frequency required to review those risks. It may be that Trusts consider reviewing their risk assessment policies to reflect this case.

Whilst the threshold of “real and immediate risk” is relatively high (in this case, it was held there was a 20% chance Mrs Savage might self-harm), the test for causation creates a much lower threshold – lower than the standard clinical negligence threshold of the “but for” test rather that, in an Article 2 claim, the Claimant merely has to prove that they “lost a substantial chance” that the deceased would not have committed suicide.

Emma Galland, Solicitor
Weightmans LLP

Further concern about NHS Data Protection

The Information Commissioner’s Office (ICO) has warned that access to sensitive medical records is not being strictly controlled, and hence many NHS Trusts are breaching the law.

In 2008, the European Court of Human Rights ruled in **I v Finland**, that Governments have a legal duty to restrict access to medical records to those who are directly involved in the personal care of the patient. The UK Campaign Group, Big Brother Watch, surveyed 151 NHS Trusts. They found that large numbers of non-medical staff can access confidential patient records. On average 723 staff in an NHS Trust can have access to such records, without any need to do so.

The concern about the failure of NHS Trusts to take data security seriously, ties in with the report from the ICO that between 1988 and 2010 (so far), there have been 1007 security breaches reported to the ICO. Of that, 305 involved the NHS. Upon analysis of these figures, it is apparent that the major areas of concern are lost and stolen data and hardware. This reflects a rather lax attitude towards protecting IT hardware that may well have vast amounts of personal data stored upon it.

The ICO has shown a growing impatience with the NHS, due to its perceived continuing failure to take data protection security seriously. For a recent example, please see the link below to a ICO Press Release dated 15 June 2010, detailing data security lapses by NHS Stoke-on-Trent and Basingstoke and North Hampshire NHS FT. Note the undertakings given by the CEOs.

In addition to obtaining undertakings, the ICO has powers to impose fines of up to £500,000 for the most serious breaches. This would have to be a very serious contravention causing substantial damage and/or distress. It would be either caused deliberately, or the data controller knew or ought to have known there was a risk of contravention, and failed to take reasonable steps to prevent this occurring.

http://www.ico.gov.uk/upload/documents/pressreleases/2010/nhs_stoke_on_trent_and_basingstoke_north_hampshire_150610.pdf

Simon Charlton, Associate
Weightmans LLP

Commercial

The NHS IT Programme – Coalition to continue roll-out of Summary Care Records

The Coalition Government has recently announced that, contrary to indications by both the Conservative and Liberal Democrat parties prior to the General Election; it plans to proceed with the implementation of the Summary Care Records database which recently began in England.

The Summary Care Records system is part of the national broadband network linking NHS sites which will provide the structure for access to electronic health records of all NHS patients. Certain patient information is uploaded to a central database where it will be accessible by hospital staff, GPs and other health professionals involved in patient care. Patients are entitled to opt out of the scheme. The Summary Care Records database is intended to help healthcare professionals make faster and more appropriate clinical decisions by providing them with access to a central record of patients' medical information, e.g. details regarding patients' drug history, allergies and adverse reactions to drugs. Such information is particularly valuable in emergencies.

The system has many potential benefits, however the scheme has led to fears that patients' personal data will be accessible too widely and could be misused or lost, infringing patients' privacy and rights under data protection legislation. There are also fears that the Summary Care Records database includes omissions and inaccuracies, making it difficult for health professionals to have confidence in it as a comprehensive and reliable source of information.

In a move that has dismayed privacy campaigners, the Government will continue to roll-out the database despite promising that centralisation of NHS medical records would be stopped. Simon Burns, Minister for Health, suggested in a parliamentary answer published on 3 June that Summary Care Records are here to stay, albeit subject to a number of caveats. In answer to the question of whether it would become Government policy to end uploading of medical data to the database, Mr Burns replied as follows:

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“Uploading of information to the summary care record will continue to take place, where the relevant general practitioner (GP) practices and primary care trusts (PCTs) agree that patients have been adequately informed about the process, and properly enabled to opt out should they wish, and where GP practices and PCTs are satisfied that data are of an appropriate quality for sharing.”

The British Medical Association (“BMA”) feels that the Summary Care Record system is imperfect and its implementation has been rushed. On 9 June, the Chairman of the British Medical Association GPs Committee advocated the review of two NPFIT (National Programme for IT) schemes – Choose and Book and the Summary Care Record.

In a speech to the Local Medical Committees Conference, Dr Lawrence Buckman highlighted the dangers of compromising patient care in a bid to save money in the delivery of healthcare and called for a review of what he referred to as the “the current wrongly consented version of the Summary Care Record.”

Although it seems likely that the Summary Care Record system will survive, the exact form that it will take is currently unclear. In any event, Summary Care Records are likely to continue to prove controversial in the short term.

Clare Sellars, Partner
Weightmans LLP

Health & Safety – Regulatory

Negligent care could lead to a charge of Corporate Manslaughter

An NHS Foundation Trust was fined £50,000 this month and ordered to pay £40,000 in costs following the tragic death through asphyxiation of a severely disabled young man (KF) in 2006 after his head became trapped between the bottom rail surrounding his bed and the edge of the bed itself.

Twenty year old KF had the body of a twelve year old boy. He was blind, deaf, quadriplegic and had cerebral palsy. The Court heard that during the night before KF died, he was found on several occasions to have been lying diagonally in his bed and with his head wedged between the rails. He was repositioned twice by nurses but later, despite concerns raised by a passing cleaner he became trapped, but no action was taken. It transpired that there had been a similar incident during an earlier stay at the hospital when KF had suffered bruising, swelling and a bleeding mouth after he forced his head part way through the rails.

Department for Health guidelines published in 2001 highlighted the fact that people with cerebral palsy are known to be particularly at risk of entrapment. The hospital staff had no knowledge of the previous incidents and KF was placed in a single room without one-to-one care and monitored at irregular intervals. Disregarding KF's size, he was placed in a bed with adult spacing bed rails and no bumpers. Had the correct bed been used it would not have been physically possible for KF to place his head through any gap.

The Trust was investigated by the Health and Safety Executive (HSE) and a prosecution was brought under s.3(1) of the Health and Safety at Work etc Act 1974.

The HSE investigation found that the Trust had no systems in place on each ward for assessing the risk to patients from bed rails and that the Trust's practice for obtaining, recording and disseminating information about KF's needs was poor. Staff did not formally share knowledge of individual patients and concerns raised by staff were not recorded and acted upon. There was no system in place to alert staff to a patient's particular

needs or habits. Instead staff were relied upon to remember the patient from previous visits or to retrieve records to read through past medical notes.

This systematic failure led directly to this tragic death and whilst the prosecution was brought under the Health and Safety at Work etc Act 1974, if brought now given the systemic failings there would have been a distinct possibility that the prosecution could have been brought under the Corporate Manslaughter and Corporate Homicide Act 2007.

This comes as a timely and salutary warning to managers to review, update and implement appropriate procedures to ensure that such tragic incidents do not recur and that Trusts comply with health and safety legislation.

Leigh Carter, Solicitor
Weightmans LLP

Medical negligence can lead to a criminal prosecution

In May 2010 an NHS Trust was fined £75,000 and also ordered to pay costs of £25,000 after it admitted breaching Section 3 (1) of the Health and Safety at Work etc Act 1974 by putting the safety of patients at risk due to their methods employed concerning the storage and administration of drugs.

Section 3(1) of the Health and Safety at Work etc Act 1974 states: "It shall be the duty of every employer to conduct his undertaking in such a way as to ensure, so far as is reasonably practicable, that persons not in his employment who may be affected thereby are not thereby exposed to risks to their health or safety."

In this case a patient, MC, was given an epidural drug, bupivacaine, in her arm instead of a saline solution which had been prescribed to help raise her blood pressure having just given birth. MC died an hour later following medical complications caused by the bupivacaine being administered in error.

The consequent Police and Health and Safety Executive investigations showed that there was no proper management system for the storage of the drugs, and warnings from earlier incidents had not been properly actioned. The two fluids had been kept in the same dispenser, despite having almost identical packaging.

This, and similar unfortunate cases, show an increasing willingness on the part of the HSE to prosecute hospital Trusts. The potential costs to a Trust over an error of this nature are immense, not just in fines and compensation but in terms of public confidence and prestige. Here, simple measures could have been put in place to remove the threat of mistakes being made.

In some instances it would be beneficial for a Trust to review its systems to ensure compliance with health and safety legislation and to ensure that no instances such as the above occur. To assist our clients, Weightmans Regulatory Services Unit offers a range of health and safety consultancy services which include assistance with risk assessments, audit services, staff training and the design of safety management systems which can be tailored to your needs.

Leigh Carter, Solicitor
Weightmans LLP

Employment

Double trouble – combined discrimination claims

The Equality Act 2010 ('the Act') received Royal Assent on 8 April 2010 and the majority of its employment provisions are due to be implemented in October 2010 (albeit that some of its provisions may well be subject to review by the new coalition Government).

The Act has two main purposes, namely to harmonise and strengthen existing discrimination law. As regards the latter, the Act introduces a number of new provisions which include the ability for employees to bring combined discrimination claims: it's been reported that some of the worst discrimination is suffered by people falling into more than one disadvantaged group. However, a Tribunal currently hearing a direct discrimination case must consider the grounds of, for example, race and sex separately, and may not make a global finding (e.g.) that the claimant was treated less favourably because she is a "Pakistani woman" (as compared, for example, to the treatment of a Pakistani man or a British (white) woman).

To address this issue, section 14 of the Act ("Combined discrimination: dual characteristics") was introduced. This provision will enable direct discrimination claims to be brought in relation to a combination of any two (and only two) of the following protected characteristics:

- age
- disability
- gender reassignment
- race
- religion or belief
- sex
- sexual orientation

This new right will only allow claims of combined *direct* discrimination to be brought: it won't be possible to bring combined claims based upon indirect discrimination, harassment or victimisation. However, the Act will permit claimants to bring, in addition to a combined claim, separate claims in the same proceedings for each of the protected characteristics. For example, a black woman who is subjected to less favourable treatment might bring a section 14 claim based upon race and sex, as well as separate race and sex discrimination claims in the alternative.

The underlying aim of this new protection against combined discrimination is easy to understand and one can envisage at least two combinations which may prove significant:

- 1) the incidence of disability increases markedly with age, and yet many employers are more reluctant to make reasonable adjustments for elderly employees who may have a comparatively short period of service remaining before retirement: maintaining such an attitude could well fall foul of a combined claim of age and disability discrimination;
- 2) some employees from ethnic minorities suffer teasing and bullying as a consequence of their attitudes or practices: a combined claim based upon race and religion is likely to prove a potent challenge in such circumstances.

From a practical perspective, perhaps the most vexed question is that of evidence: how does a claimant prove that it was the *combination* of two protected characteristics which resulted in his/her discrimination? Seemingly recognising this difficulty, section 14(3) of the Act states that the claimant need not show that the treatment complained about amounts to direct discrimination because of *each* of the characteristics in the combination (taken separately).

Does this mean, therefore, that although I might not be able to succeed in establishing enough evidence for a claim of racial discrimination or religious discrimination on their own, I might nevertheless manage to prove a claim of combined racial and religious discrimination because there's a lower evidential threshold in such circumstances? Exactly how this will work out in practice remains to be seen, and no doubt this issue will be the subject of some early test cases under the new Act.

One source has estimated that the new combined discrimination provision is likely to result in a significant increase in Employment Tribunal discrimination claims of up to 10%; no doubt we'll all have an opportunity to experience the practical issues of dealing with such claims in the relatively near future.

Mark Landon, Partner
Weightmans LLP

Edwards v Chesterfield Royal Hospital NHS Foundation Trust

It has been well established for a number of years that in a claim by an employee alleging a breach of contract in the operation of a contractual disciplinary procedure, there is an effective limit to the scale of damages awardable; they could not exceed the sum of the salary and benefits etc that would have been payable for the duration of the disciplinary process, but for the breach of contract, and the duration of the employee's contractual notice period. As an employer may lawfully terminate a contract of employment that is in a way which is compliant with the contract (including the right to notice), this approach was regarded as consistent with the purpose of damages for breach of contract – to put the injured party in the position he or she would have been if the breach of contract had not occurred.

Mr Edwards, a consultant surgeon with the hospital, was dismissed for gross professional and personal misconduct. Since his dismissal he had been unable to obtain permanent employment in the NHS.

Mr Edwards claimed damages for breach of contract, arguing that:

- 1) The conduct of the disciplinary hearing was defective and in breach of the terms of the disciplinary procedure because it failed to meet a number of requirements contained in the Local Negotiating Committee procedure;
- 2) The application of the disciplinary procedure was a term of his contract of employment;
- 3) The defects led to the finding of misconduct;
- 4) The misconduct finding caused his inability to find permanent NHS employment; and
- 5) The NHS Trust's breach of contract had caused him career-long losses in excess of £4 million.

In the first instance Mr Edward's extended claim was struck out and he appealed to the High Court and then to the Court of Appeal which decided that he was entitled to pursue his claim for lost income suffered as a result of disciplinary proceedings which were conducted in breach of the terms of his contract of employment.

It is still for Mr Edwards to prove his case and it is understood that the hospital intends to appeal the decision. The case is therefore of obvious importance for NHS employers (as well as other employers who operate contractual disciplinary procedures) who would be well advised to ensure that their disciplinary cases are defect-free – just in case.

Mike Berriman, Partner
Weightmans LLP



Lead contact details

Clinical Negligence

Vicky Morris

Tel: 0151 242 7924

Email: vicky.morris@weightmans.com**Tony Yeaman**

Tel: 0121 200 8108

Email: tony.yeaman@weightmans.com**Rena Field**

Tel: 020 7822 1916

Email: rena.field@weightmans.com

Employment

Stuart Jones

Tel: 0151 242 6523

Email: stuart.jones@weightmans.com**Michael Berriman**

Tel: 020 7822 1942

Email: michael.berriman@weightmans.com

Property

Anne Dobie

Tel: 0161 233 7354

Email: anne.dobie@weightmans.com**Stephen Whittaker**

Tel: 020 7822 7354

Email: stephen.whittaker@weightmans.com

Healthcare Advisory

Kiran Bhogal

Tel: 020 7822 1939

Email: kiran.bhogal@weightmans.com**Tony Yeaman**

Tel: 0121 200 8108

Email: tony.yeaman@weightmans.com**Richard Jolly**

Tel: 0151 242 7954

Email: richard.jolly@weightmans.com

Commercial

Sean Crotty

Tel: 0151 242 6517

Email: sean.crotty@weightmans.com**Claire Sellars**

Tel: 020 7822 1969

Email: claire.sellars@weightmans.com

Regulatory

David Lewis

Tel: 0151 242 7923

Email: david.lewis@weightmans.com**Euros Jones**

Tel: 020 7822 1928

Email: euros.jones@weightmans.com

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