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CELEBRATING 40 ★ YEARS ★ 1982-2022

Editorial

Lisa O'Dwyer
Director, Medico-Legal Services

A lot has happened in the three months since our last LS Newsletter. AvMA was delighted to host its annual conference in Leeds, the first since 2019! The final Ockenden review into Shrewsbury and Telford Hospital was published. April was the closing date for the consultation on FRC in low value clinical negligence claims, the Health & Social Care Committee also published its report on NHS litigation reform. In May, it was announced that the thematic review of maternity concerns at Nottingham has been taken over by Donna Ockenden, not forgetting that AvMA's CEO, Peter Walsh publicly announced his intention to retire at the end of this year.

With all that in mind, it is appropriate that I start with **Peter Freeman**'s article ***"A change gonna come"***. Peter is a barrister at Temple Garden Chambers, an experienced clinical negligence practitioner and mediator with Independent Evaluation: https://www.independentevaluation.org.uk/evaluations. In this article he considers both the Ockenden report and the FRC proposals, he throws down the gauntlet for NHS Resolution to engage in a meaningful pilot on independent evaluation.

Prompted by numerous previous maternity scandals, maternity care has been an on-going priority for successive governments. So, what does the Ockenden Review tell us that we did not already know? To help answer that question we are pleased to refer to **Janine Wolstenholme**, barrister at Park Square Barristers (Leeds & Middlesbrough) article, ***"Maternity care in England: Some observations on the key findings of the Ockenden Report"***.

We wait for the Court of Appeal to resume their consideration of ***CAM Legal Services Ltd (appellant) v Belsner*** at the end of July, in the meantime, Checkmylegalfees has been focusing its attention on firms' obligations to disclose details of any commission received from ATE insurers. **Ged Courtney** at Kane Knight explores the issues with reference to the recent decisions in ***Edwards & Others v Slater & Gordon UK Ltd*** **and** ***Raubenheimer v Slater & Gordon UK Ltd*** **[2022] EWHC 1091 (QB)**.

Clinical negligence lawyer know too well that the success or failure of their caseload largely rests on the strength of the verbal and written evidence given by the medical experts in the case. The importance of the expert acting independently, impartially and in full recognition that their duty is to

Inquest touching the Death of Connor Wellsted

Outer Temple

ELIZABETH GRACE, COUNSEL
OUTER TEMPLE CHAMBERS

I first met Connor's foster parents, Barbara and Shazia, in 2018, having read a thick bundle of papers that Charlotte, my AvMA caseworker had put together ahead of the inquest.

Those papers, beautifully prepared though they were, could never have expressed to me the joy with which Connor had lived and the tragedy of how he had died. I was only able to understand that once I met Barbara and Shazia, who had fought for transparency and honesty as to how their little boy had come to pass away while staying at The Children's Trust. Their dignity and their strength over the past four years while waiting for the Inquest to conclude has been an extraordinary testament to them as a family.

Connor was a joyful, exuberant child. His five years were not without their obstacles, but Connor lived every moment of those five years fully. As a newborn, Connor suffered a cardiac arrest which resulted in a brain injury: this left him with complex needs. It was shortly after that incident, at the age of just five months, that Connor came into his foster parents' care with an extremely guarded prognosis. This did not deter them. With their love and dedication, Connor made remarkable progress, despite the limitations of his brain injury.

This is how Connor came to stay at The Children's Trust for a second period of rehabilitation. Connor was a well child, and his stay at the Trust was simply to help him develop his mobility and communication skills. His death was sudden and unexpected.

On the morning of 17 May 2017, Connor was found deceased in his cot at around 7.45am. Nursing staff discovered Connor sitting upright in the corner of his cot, with a rigid cot bumper on his neck. By the time Barbara was called from her on-site accommodation, the bumper had been moved. She was told he had died in his sleep. She knew that something was wrong, and that what she was being told could not be right.

The purpose of an inquest is to answer four statutory questions: who the deceased was, when they died, where they died, and how they died. Where Article 2 of the European Convention on Human Rights, the right to life, is engaged, the fourth question is read to mean *"by what means and in what circumstances"*, which allows a Coroner to undertake an enhanced investigation into the death. An Article 2 inquest is only available where the death occurs while the deceased was in the care of the state.

The Coroner, Dr. Karen Henderson, found in relation to Connor's death that Article 2 was engaged. She was satisfied that Connor had been trapped by the rigid padded board that had lined his cot, and that the board had been found on his neck, and not on his chest as had been stated by some of the Trust's witnesses. The Coroner was concerned at the use of the cot and the bumpers, and found that the steps and system in place for its safety were wholly inadequate. The Coroner further found that from the point of Connor's death, a narrative that the bumper had been on his chest had resulted in a negative impact on her investigation, the investigations of the Police, the Coroner's Officer, and the Coroner's Pathologist, as well as the Trust's own Serious Incident Report and its addendum. The Coroner was concerned by the lack of enquiry by those on duty and those in senior management positions at the Trust.

Ultimately, the Coroner found that Connor had died as a result of airway obstruction, and was satisfied that the Trust had failed to keep Connor safe in his cot. The Coroner also indicated that she would make a Prevention of Future Deaths Report, sometimes called a "*PFD*" for short. A Coroner must issue a PFD where the Coroner is of the view that action should be taken to prevent future deaths. Here, the Coroner was deeply concerned by the lack of transparency and insight, and found that remedial action to date had been inadequate. The Coroner took the view that this was sufficiently serious for her to make a PFD.

I was privileged to be instructed by Charlotte at AvMA to ensure that Barbara and Shazia's voices were eventually heard. Though nothing can ever fill the huge void left by Connor's death, I hope that the Inquest process gave Barbara and Shazia the answers they needed as to how Connor died.