Coronial law – a discussion of legal principles and provisions which help protect the doctors we represent

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Cameron Jackson

Second Floor

Selborne Chambers

Ph 9223 0925

cjackson@selbornechambers.com.au

Introduction

It's a pleasure to speak to you all today about coronial law. We will begin with procedural fairness. We will discuss how procedural fairness extended beyond the parties to civil claims and criminal prosecutions. We will see how the courts came to recognise that procedural fairness should extend beyond those at risk of criminal sanction or civil judgment against them to those at risk of less tangible harm, such as damage to reputation.

As we do so, we will see what sits behind the protections built into the procedures and practices of the Coroner's court that we take for granted today.

We will then consider various ways in which the law may be used to limit or control a doctor's risk of damage to their reputation or career when they are asked to give evidence at an inquest.

We will discuss three things. First, the role that further statements can play. Second, the restrictions on admission of evidence with respect to hospital investigations of hospital deaths. Third, the power of the privilege against self-incrimination.

I - Procedural fairness

A plane flies into a mountain

Let's turn to procedural fairness. Our discussion begins with a compellingly written decision delivered by Lord Diplock, sitting on the Privy Council, on appeal from the Court of Appeal of New Zealand.

The judgment of *Mahon and Air New Zealand*[1] begins as follows;

"This appeal to Her Majesty in Council is part of the unhappy aftermath of what in terms of loss of human life and family bereavement was the worst disaster to strike New Zealand since the end of World War II. It happened on 28 November 1979 when, in the hours of broad daylight, a DC-10 aircraft, operated by Air New Zealand Ltd and engaged on a sight-seeing trip to the Antarctic, flew at a height of 1,500 feet straight into the lower snowclad slopes of a 12,500 feet high volcano, Mount Erebus, causing the instantaneous death of all the 237 passengers and 20 members of the crew who were aboard."

Shortly later, Lord Diplock records *"three salient facts*";

"….first that the pilot of the ill-fated aircraft, Captain Collins, and the Flight Officer, First Officer Cassin, had been briefed for the flight, some 18 days previously, upon a flight plan which incorporated coordinates of latitude and longitude of its southernmost waypoint that would have taken the aircraft on a route passing over an area of ice-covered sea to the west of Mt. Erebus and well clear of it. The second was that shortly before the departure of the flight on 28 November 1979 the co-ordinates of the southernmost waypoint of the flight plan had been altered into one that flew directly at and over Mt. Erebus and it was this latter flight plan that, at the pre-despatch briefing on 28 November, was supplied to the aircrew to be fed into the aircraft's computer for use as the principal navigational aid. The third was that neither Captain Collins nor First Officer Cassin nor any other member of the aircrew was told of the change."

[1] [1984] AC 808

It would be hard to write a more concise account of the accident and its fundamental cause. However, the judgment, which is rich in generosity, compassion, and an understanding of what it is to be human and fallible, is important for another reason.

It is a foundational case in establishing that the interests which the principles of natural justice protect extend beyond the parties to litigation, and beyond the threat of criminal sanctions, financial penalties or rewards, to less direct interests, such as personal or professional reputation.

In *Air New Zealand and Mahon*, the parties denied procedural fairness were Air New Zealand, its Chief Executive, and its Flight Manager, and the way it arose was as follows.

Immediately following the accident, the Chief Inspector of Air Accidents conducted an investigation in private. While he was critical of Air New Zealand, he found that the primary cause of the accident was *“the decision of the captain to continue the flight at low level toward an area of poor surface and horizon definition when the crew was not certain of their position and the subsequent inability to detect the rising terrain which intercepted the aircraft’s flight path.”*

The government called a Royal Commission. The Royal Commission blamed Air New Zealand for the accident;

"The dominant cause of the disaster was the act of the airline in changing the computer track of the aircraft without telling the aircrew …. the single dominant and effective cause of the disaster was the mistake made by those airline officials who programmed the aircraft to fly directly at Mt. Erebus and omitted to tell the aircrew. That mistake is directly attributable, not so much to the persons who made it, but to the incompetent administrative airline procedures which made the mistake possible.

… neither Captain Collins nor First Officer Cassin nor the flight engineers made any error which contributed to the disaster, and were not responsible for its occurrence."

It was not this finding of the Royal Commission, however, that was challenged on appeal. What was challenged is summed up in this devastating finding;

"No judicial officer ever wishes to be compelled to say that he has listened to evidence which is false. He always prefers to say, as I hope the hundreds of judgments which I have written will illustrate, that he cannot accept the relevant explanation, or that he prefers a contrary version set out in the evidence. But in this case, the palpably false sections of evidence which I heard could not have been the result of mistake, or faulty recollection. They originated, I am compelled to say, in a pre-determined plan of deception. They were very clearly part of an attempt to conceal a series of disastrous administrative blunders and so, in regard to the particular items of evidence to which I have referred, I am forced reluctantly to say that I had to listen to an orchestrated litany of lies."

In other words, the Royal Commission found both that Air New Zealand had deliberately destroyed incriminating evidence, and that their witnesses had conspired to, and given, false evidence.

None of the witnesses were warned that they were at risk of such findings, nor were the particulars of their evidence which were in question put to them. They were given no opportunity to meet the case against them.

In fact, there was ample evidence to contradict these conclusions, and it is highly unlikely that the Royal Commission would have reached the conclusions that it did had Air New Zealand or its witnesses had the opportunity to respond.

The Privy Council stated that two rules applied:

"The first rule is that the person making a finding in the exercise of such a jurisdiction must base his decision upon evidence that has some probative value in the sense described below. The second rule is that he must listen fairly to any relevant evidence conflicting with the finding and any rational argument against the finding that a person represented at the inquiry, whose interests (including in that term career or reputation) may be adversely affected by it, may

wish to place before him or would have so wished if he had been aware of the risk of the finding being made."

The Privy Council documented in some detail the findings that were not open on the evidence, and the extent of the failure to warn the witnesses that those findings might be made, or provide them with an opportunity to respond.

The Privy Council found both that the evidence could not logically support a number of the findings, and that both Air New Zealand and the witnesses who worked for it should have been warned that the findings might be made, and given the opportunity to respond.

It was on that basis that the Privy Council found that Air New Zealand, and the witnesses who had given evidence on its behalf, had been denied procedural fairness.

This was a departure from earlier authority in the UK, Australia, and other common law jurisdictions, which had tended not to accept that the common law rules of natural justice applied to public inquiries whose findings of their own force could not affect a person's legal rights or obligations.

It is not hard to see how the manifest injustice of the findings made against the parties in *Mahon v Air New Zealand*, with the extensive damage to reputation which those findings caused, prompted the decision which it did.

***Annetts v McCann;* a recognition that procedural fairness applies to inquests in Australia, as two boys perish in the desert**

From the frozen slopes of Mt Erebus, we travel to a flat sandy desert in Australia. *Annetts v McCann*[2] concerned the inquest into the death of two boys, one sixteen, the other seventeen, who had perished while working as station-hands on a cattle station in desert country in the north of Western Australia.

[2] Annetts v McCann [1990] HCA 57; (1990) 170 CLR 596.

Annetts v McCann built on *Air New Zealand v Mahon*, and a series of Australian cases which had followed it in the eighties, a golden period in the development of Australian administrative law, and procedural fairness in particular.

Western Australia, as NSW still does, had a provision which allowed parties with a *"sufficient interest"* to appear *"personally or by counsel"*, (now *"legal practitioner"*) and question witnesses, on relevant matters.

The coroner had allowed the parents of one of the boys, the Annetts, to appear, and cross-examine witnesses.

However, the coroner did not allow counsel to make submissions. The Annetts sought review of that decision, which made its way to the High Court via the Western Australian Court of Appeal. The appeal raised a novel question in Australia; the common law duty to afford procedural fairness had not previously been found to apply with respect to inquiries, where legal rights were not determined, and therefore not affected.

Their Honours cited (at [2]) a passage from one of my favourite cases, *Kioa v West*[3], where Mason J said that the law with respect to administrative decisions:

"…has now developed to a point where it may be accepted that there is a common law duty to act fairly, in the sense of according procedural fairness, in the making of administrative decisions which affect rights, interests and legitimate expectations, subject only to the clear manifestation of a contrary statutory interpretation."

Incidentally, the reason it is one of my favourite cases is because it adopts broad and flexible statements of principle from English law; that natural justice is *"nothing but fairness, writ large and juridically"*, and *"fair play in action"*[4].

[3] Kioa v West [1985] HCA 81; (1985) 159 CLR 550, per Mason J at p584.
[4] Per Brennan J, at p613.

This flexibility is the strength of common law procedural fairness, and gives it the nimbleness to respond to procedurally unfair situations in whatever context they arise, and in response to changing values and expectations.

The question in *Annetts* really boiled down to what the rights and interests which gave rise to the family's right to be heard were, and what fairness dictated.

The Court's answer was that reputation was the interest which needed protection. The extended to their reputation, and the reputation of their dead son.

It followed that they were entitled to be told what findings might be made which could be adverse to their reputation or interests as parents, or adverse to the reputation of their son, and that they were entitled to make submissions (either orally or in writing) on those issues alone.

They were not entitled to make submissions on the broader issues in the inquest, such as whether the boys had been adequately supported by the company who employed them, or the culpability of anybody who had failed in their duty to care for these boys, sent to work in the desert.

The coroner was ordered to consider the possibility he might make adverse findings against the boys or their parents, advise the parents in writing of any possibility, and hear submissions from them with respect to those findings.

Discussion

This seems an unduly restrictive characterisation of the interest which relatives might have with respect to the death of a loved one, which extends to understanding the circumstances in which their loved one died, what went wrong, and what could have prevented it.

It also seems inconsistent with the right to *"examine and cross-examine any witnesses on matters relevant to the proceedings"* (the same right granted in the NSW legislation), which

appears to allow questioning on *any* issue provided it has some relevance to the manner and circumstances of their relative's death, an interpretation the High Court appeared to accept in Annett.

If there is a right to explore those issues with witnesses, why not a right to make submissions on those same issues?

On a more basic level, what interest could be more poignant and pressing than the need for the family to be heard with respect to the adequacy of the care taken of their teenage sons, who they had allowed to work for an employer in a remote desert location, an employer they had trusted would take care of them.

It is certainly not consistent with the practice in the NSW Coroner's Court, where families regularly submit on these issues, and the manner and cause of death.

It is unlikely that the High Court would now take such a narrow view of a family's interests in the outcome of an inquest as they did in *Annett v McCann*.

<u>Musemici v AG of NSW; the right to respond to adverse information</u>

Of course the archetypal procedural fairness requirement is not to disclose the possibility of adverse findings, it is a requirement to disclose *"credible, relevant, and significant"* adverse material or information[5].

In *Musumeci v Attorney General of NSW and Anor*[6], the coroner had withheld certain evidence tending to suggest that Mr Musumeci was involved in the shooting death of Pauline Gillard for what he described as *"tactical reasons"*.

[5] *Applicant VEAL of 2002 v Minister for Immigration and Multicultural Affairs* (2005) 225 CLR 88, at [17]
[6] *Musumeci v Attorney General of NSW and Anor* [2003] NSWCA 77.

The coroner said that the material would only be provided when he had formed a preliminary view that the matter should be referred for prosecution, at which point Mr Musumeci's counsel could make submissions as to why that should not occur.

The Court of Appeal concluded that the coroner *"wished to obtain the forensic benefit that might result from witnesses testifying without the claimant being able to question them about the withheld material"*.

The Court of Appeal held that this was an insufficient reason to withhold the material. Such a course would be possible only if providing the information would have a tendency to interfere with the criminal investigation.

It was procedurally unfair to withhold the evidence from Mr Musumeci, because it deprived his counsel of the opportunity to provide evidence to meet it and to question other witnesses in response to it.

It is difficult to imagine a situation where it would be appropriate to withhold evidence from a medical practitioner.

Foote v Coroner's Court of the ACT; Dr Foote should have been warned about the particular findings that the coroner was thinking of making which were critical of him

In *Foote v Coroner's Court of the ACT*[7], the Supreme Court considered an appeal from the ACT Coroner's Court by a medical practitioner, Dr Foote, an obstetrician whose patient, Ms Medway, died under his care following the onset of hypertension after the birth of twins, which was not treated.

With respect to Dr Foote's treatment of Ms Medway, the Coroner concluded;

[260] …I am satisfied…that Dr Foote failed to administer appropriate treatment for the

[7] Foote v Coroner's Court of the ACT [2020] ACTSC 141.

acute pregnancy induced hypertension suffered by Ms Medway between 18:00 to 18:30 hours on 19 May 2011.

[261] Dr Foote's failure to treat Ms Medway's acute pregnancy induced hypertension between 18:00 hours and 18:30 hours resulted in her blood pressure continuing to escalate to a critical level which ultimately caused her cerebral haemorrhage and death.

[262] Further, I am satisfied that treatment was available within a reasonable period of time sufficient to have ameliorated the significantly high blood pressure.

The coroner also found that Dr Foote either knew or was told about other elevated blood pressure readings taken by midwives between 6pm and 7.30pm, which was contrary to the evidence he gave, and that Dr Foote was at times untruthful in his evidence and blamed others.

The ACT Coroner's Act contains a specific provision requiring proposed adverse comments to be put to the person against whom the coroner proposes to make them, and to give them an opportunity to respond. There is no corresponding section in the NSW legislation.

The coroner did warn Dr Foote in some detail of the criticisms that the court was proposing to make, and pointed to particular paragraphs of the submissions of counsel assisting, but neither the coroner's note, or counsel assisting's submissions suggested that Dr Foote was aware of blood pressure readings that he denied being aware of, or that his failure to diagnose the blood pressure problem caused Ms Medway's death, or that Dr Foote was untruthful or blamed others.

The Court found that Dr Foote should have been warned that the coroner was considering each of these particular findings in order to be given an opportunity to respond. The Court found that there was a failure to accord procedural fairness amounting to error or law. However, the Coroner did not consider the interests of justice required the findings of the inquest to be quashed, and another inquest ordered.

Discussion

A few things stand out about this case.

The first is that the decision is affected by the specific requirements of the ACT legislation. Procedural fairness is always informed by the particular statutory regime being applied. In *Foote*, the ACT Supreme Court considered and applied the authorities we have considered through the lens of the specific provision which required a person to be warned of any potential adverse comment the coroner might make.

It may be that the common law would not require such a high degree of detail with respect to the adverse comments that the coroner was considering making.

The second is that in practice, it is unusual for the coroner to go beyond the findings that counsel assisting is urging them to make. Usually, the submissions of counsel assisting mark the boundaries of what the coroner might determine adversely to your client, and put you on notice of the criticisms you might expect.

It is now well understood that inquiries are subject to rules of procedural fairness, and that reputation, and particularly professional reputation, is an interest which attracts the protections which procedural fairness affords.

The practice of identifying and notifying people who have a “sufficient interest” in the outcome of an inquest, of circulating issues and witness lists, and of allowing submissions from interested parties is a reflection and acknowledgment of the case law with respect to procedural fairness which has developed over the last 40 years.

Limiting the potential harm for doctors asked to appear at inquests

Let’s move now to the various ways of limiting the potential harm for doctors asked to appear at inquests.

II - A further witness statement?

First, I want to discuss in what circumstances you should consider a further witness statement which responds to the issues identified by the coroner. Often a doctor will have prepared their initial statement without consulting their insurer. The statement may be made at the request of the police and be in the form of a police witness statement, or it may have been prepared with the assistance of the hospital’s lawyers.

The police do not have a focus on protecting a doctor’s interests, nor the expertise to advise a doctor. The hospital’s insurers have the expertise, but their client is the hospital. Their interests may not coincide with those of the doctor.

Even if it were prepared with the assistance and advice of the insurer, it may be clearer closer to the hearing what is actually in issue in the proceedings when the brief of evidence is available, and the issues list has been circulated.

The discretion whether to hold an inquest pursuant to sections 21 and 25 of the *Coroner’s Act* is very broad, but two critical reasons at the heart of the decision are that a public hearing will allow an issue of public health and safety to be reviewed, or that a cross-examination of witnesses might uncover, disclose, or clarify facts and evidence not apparent from the investigation materials.

If a witness is being called, it is often because there is something more that they can say, because their account conflicts with other evidence or witnesses, or because there is something unclear or unresolved about their account.

Whether to provide a further statement is a tactical decision. Police statements often fall well short of meeting the issues which arise out of the evidence, and which are identified in the issues list. You have control over how a statement is structured and what it covers, whereas if the evidence is given orally, the first account will be in response to questioning by counsel assisting.

Particularly if there is one obvious issue which is unclear or not dealt with in a statement from a doctor who has been served with a letter informing them they have a *"sufficient interest"* in the inquest, it is usually worth providing a statement which addresses the issue.

This can lead to a further communication from the coroner that the doctor is no longer to be called, and, not at risk of adverse comment.

Case study number 1;

An example was an inquest I appeared in several years ago where the issues list disclosed concerns with respect to the indications for certain decisions with respect to anti-convulsant medication during the patient's hospital admission, a suggestion that her seizures were *"poorly controlled"* and issues with respect to her care and treatment over a particular weekend.

One of the two doctors I was representing was able to clarify in a further statement that he was not on call that particular weekend, and to explain his prescribing decisions, which included reductions and changes to her anti-convulsant medication.

We then provided the statement to the expert we had retained, and asked him to comment on whether the patient's seizures were *"poorly controlled"* during her admission, and whether the lower levels of anti-convulsant medication contributed to her death.

The expert confirmed that her seizures were as well controlled as they could be during her admission, and that the changes or reductions in anti-convulsant medication were not implicated in her death.

As a result of the clarification about when our doctor was on call, his rationale for medication changes, and the further expert opinion, the coroner no longer wished to hear from the doctor, and he was not the subject of criticism in the coroner's findings.

One other point to be aware of when preparing statements is well understood by lawyers, particularly those involved in civil litigation, but not always appreciated by medical practitioners; an apology, whether or not it implies an admission of fault, does not constitute an express or implied admission of fault, is not relevant to the determination of fault, and cannot be used in any civil proceedings as evidence of fault or liability of the person.

If a medical practitioner still does not believe you, then direct them to section 69 of the Civil Liability Act.

II - Hospital investigations; keeping them out of inquests

Let's move on to our next topic, the protection from disclosure of hospital investigations. An issue which arises regularly at inquests is the use, either directly or indirectly, of Root Cause Analyses, prepared under the *Health Care Administration Act* 1982 (NSW). Root Cause Analyses are mandated for "reportable incidents". Invariably, a death which involved hospital care that is reportable and has resulted in an inquest will be a reportable incident, and will be the subject of a Root Cause Analysis.

It is important that they are protected from disclosure. Their focus is upon getting to the bottom of what went wrong in order to address systemic failures. In order to be effective, they require unguarded and frank admissions from practitioners. If practitioners worry that what they disclose will be used against them in a public forum such as an inquest, they will be less likely to make full and frank disclosures to the investigators.

The *Health Care Administration Act* was amended significantly in 2018. The amendments create a layered approach to investigation and reporting of hospital incidents which is more

complex and detailed than the regime it replaces, but critically, the amended Act includes the following protective sections;

21O Information not to be given in evidence

(1) A person is neither competent nor compellable to produce any document or disclose any communication (or to disclose any information that the person obtained from any such document or communication) to a court, tribunal, board, person or body if the document was prepared, or the communication was made, for the dominant purpose of the exercise of a function under this Part by an incident reviewer……

21P Advice and reports not to be admitted in evidence

(1) Evidence as to the contents of an advice or report of an incident reviewer cannot be adduced or admitted in any proceedings……

Section 21O thus provides some protection with respect to material produced during any investigations, while section 21P more straightforwardly prevents admission of an advice or report in proceedings, which, in my view, would include coronial proceedings.

This was also the view of Deputy State Coroner Freund with respect to the predecessor to section 21P, in the *Inquest into the death of XY* (2012/392095), which comprehensively analysed the statutory history and purpose of these provisions, and rejected the family's application to admit the Root Cause Analysis in those proceedings.

There are also provisions prohibiting the provision of such reports, or the contents of such reports, to others, subject to limited exceptions.

It is not unusual for experts retained by the coroner to be provided with the RCA. Given the object and purpose of such reports, I don't think this is appropriate.

Consideration should be given, in a case where such a report has been provided to an expert and appears to have unfavourably influenced that expert's view about the treatment your doctor provided, whether to object to that expert's report being relied upon, and to object to that expert giving evidence.

III - Objecting to evidence if a doctor is at risk of civil penalty

Section 61 of the *Coroner's Act* allows a witness to object to giving *"particular evidence*" or "*evidence on a particular matter"* on the grounds, relevantly, that the evidence *"may tend to prove that the witness"* is liable to a civil penalty.

The requirement that the objection taken must be with respect to *"particular evidence"*, or *"evidence about a particular matter"* means, in practice, that the topics of questioning where the practitioner is exposed must be identified, and objection taken.

In practice, the coroner will allow the objection to be taken by the doctor's advocate, usually accompanied by oral submissions with respect to the risk to which the practitioner is exposed.

In other cases, a discussion with counsel assisting will have resolved this issue already.

The coroner must then consider that objection, and if there are reasonable grounds for the objection, determine whether it is in the public interest to issue a certificate and compel the witness to give evidence.

If the certificate is given, then subsection (7) provides that:

(7) In any proceeding in a NSW court within the meaning of the Evidence Act 1995 ***or before any person or body authorised by a law of the State, or by consent of parties, to hear, receive and examine evidence*** *—*

(a) evidence given by a person in respect of which a certificate under this section has been given, and

(b) evidence of any information, document or thing obtained as a direct or indirect consequence of the person having given evidence, cannot be used against the person. However, this does not apply to a criminal proceeding in respect of the falsity of the evidence.

Two points are important; first, the protection extends to quasi-judicial decision-making processes, which would include both NCAT, and the Medical Council, and second, the immunity conferred is both on the evidence given by the witness, *and* any evidence obtained *as a result of* that evidence. This form of immunity is quite powerful.

Case study #2; the power of derivative immunity

I had the power of derivative immunity demonstrated to me early in my career at the Bar, when I advised a solicitor migration agent who had been lodging protection visa applications for women on the instructions from some very shady business people who were trafficking women from Thailand. The fees they were paying him reflected the risk.

A number of the business people were criminally prosecuted, and he was summonsed to give evidence against them. He was provided with a certificate of immunity under the Evidence Act.

The Law Society subsequently notified him that they were investigating a complaint over his involvement in this scheme. We wrote to the Law Society informing them of the certificate. The Law Society wrote back informing us that the complaint would not be pursued and, remarkably, wish him all the best with his practice.

I have been involved in cases where, having taken the objection, the doctor has been excused from giving evidence for this reason.

Taking the objection will be an obvious course where the brief of evidence reveals conduct which clearly puts the doctor at risk of disciplinary action and an assessment of the doctor in conference confirms that their responses on particular topics are unlikely to assist them.

The coroner has the power to provide relevant parts of the evidence to the Medical Council under section 151A of the *Health Practitioner National Law* (NSW), in which case, it is taken to be a complaint.

In a case which is sufficiently problematic to warrant taking the objection, it is almost inevitable that a referral will occur whether or not the objection is taken. The doctor may as well have the benefit that taking the objection will provide.

Section 74(1)(b) of the *Coroners Act* provides that unless the coroner otherwise orders, the fact that the objection has been taken cannot be reported. It is necessary to ask the coroner to remind the media of this provision.

To summarise, when it is clear that oral evidence from a doctor will harm their position, it is worth considering taking advantage of section 61. While it is unlikely to prevent a referral to the Medical Council, it will prevent the unnecessary public exposure of the doctor to questioning, and the embarrassment and loss of face which may come with it. The default operation of section 74(1)(b) means that the fact that the doctor has objected to giving evidence will not be reported.

Conclusion

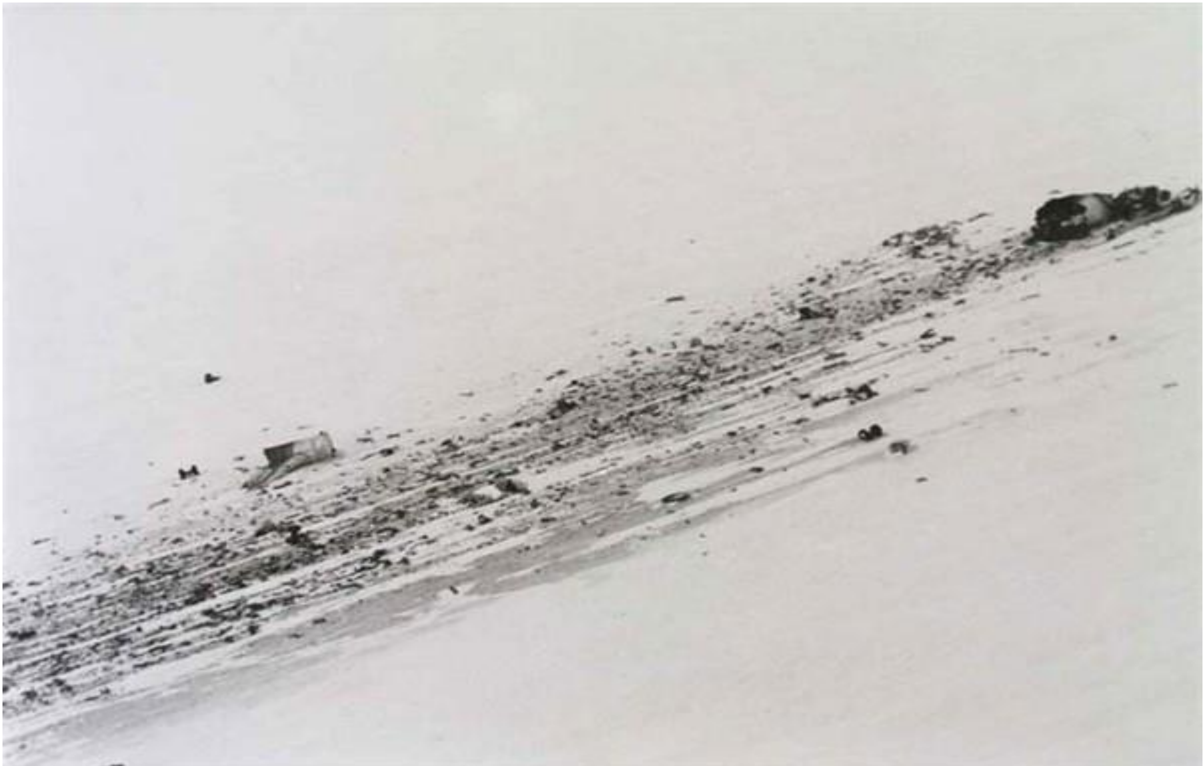
Those are the topics I wanted to discuss today. Given what we have all experienced over the last eighteen months, perhaps we could also have discussed the legislation, regulations, and case law which the pandemic has generated with respect to online hearings, the different ways in which hearings can be "online" (from simply a few witnesses, to all participants), and how they would function in the coronial setting where there are so many parties, or we could have explored concurrent evidence.

That is for another day. It has been great to see those of you present, and to know that there are others listening online, and I wish everybody the very best as we reach the end of another year that has been not quite like any other.

The Air New Zealand disaster

A view of the crash site of Air NZ flight 901, with the peak of Mt Erebus to the far left

A closer view



Larger pieces of debris from the crash site

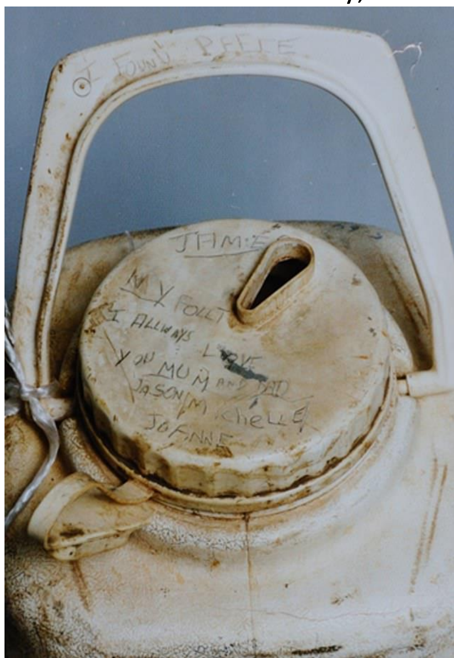
The tail of the plane

<u>Annetts v McCann; two boys perish in the Great Sandy Desert</u>

The boys travelled this poorly marked road, turning right

James Annett

James’s words to his family, scratched on an empty water bottle



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