

Clinical negligence case

[Business](#), [Management](#)



To: NHS Litigation Authority, Re: Chandler Bing v FriendsHealthNHS Foundation Trust Dear Sir/ Madam, Thank you for your referral of the case concerning Mr. Chandler Bing's missed fracture scaphoid bone received on 31 August 2010. The following is the Letter of Advice to the NHSLA concerning the above-mentioned case. The Claimant: 1. The Claimant was born on 8 April 1969. As a result of the events referred to in their particulars of claim the claimant is now represented by Bloomingdale Solicitors to launch to launch a civil action against Friends Health NHS Foundation Trust on 31 August 2010.

The Defendant: 2. The Defendant was at all relevant times responsible for the management control, and administration of Friends Health NHS Foundation Trust, and for the employment of doctors, nurses, and other medical specialist s including emergency medicine, radiology and orthopaedic surgeons at and for the purpose of the said hospital. Duty of care: 3. Each of the doctors, nurses, and other staff employed at the hospital who treated the Claimant at the hospital owed the Claimant a duty of care. This duty included a duty in respect of: a. The advice given to the Claimant; . The diagnosis made in respect of the condition of the Claimant; c. The treatment prescribed for the Claimant and advice as to the effect of the treatment; d. The monitoring of the Claimant whilst treatment was given to the Claimant. 4. The Defendant is vicariously liable for any such breach of duty on behalf of any of its employees. Procedural Steps: 1. Protocol Steps: a. Obtaining health records: to provide sufficient information to alert the Healthcare provider where an adverse outcome has been serious; to request for specific medical records involving the case. . Request for copies of

patient's clinical records with approved standard forms. c. Make sure the copy records to be provided within 40 days of the request and for a cost not exceeding charges permissible under the Access to Health Records Act 1990. d. If the Healthcare provider fails to provide health records within 40 days, their advisers can then apply to Court for an order for pre-action disclosure. e. If Healthcare provider considers additional health records are required from a third party, these should be requested through the patient.

Third party Healthcare providers are expected to co-operate. 2. The response: Letter of response: a. Provide requested records and invoice for copying. b. Comments on events and/or chronology. c. If breach of duty and causation are accepted, suggestions for resolving the claims and request for further information offer to settle. d. If breach of duty and/or causation are denied, outline explanations for what happened by Healthcare provider suggests further steps like further investigations, obtaining expert evidence, meetings, negotiations or mediation, or an invitation to issue proceedings. e.

Healthcare provider should acknowledge receipt of letter of claim within 14 days of receipt. f. Healthcare provider should, within 3 months of letter of claim, provide a reasoned answer. g. If claim is admitted, then the Healthcare provider says so. h. If any part of claim is admitted, then Healthcare provider makes clear which issues of breach of duty and/or causation are admitted and which are denied and why. i. If claim is denied, include specific comments on allegation of negligence, and if synopsis or chronology of relevant events provided and is disputed, Healthcare provider's version of events provided. . Additional documents, for instance,

internal protocol, copies provided. k. If patient made an offer to settle at this stage as a counter-offer by supporting medical evidence, and/or other evidence in addition to claim in healthcare provider's possession. l. If parties reach agreement on liability, but time is needed to resolve claim, then aim to agree a reasonable period. Witness Evidence: The witnesses concerned in this case include: 1. Claimant's family members and colleagues concerning the accused loss of function in daily activities of living. . Healthcare providers beside the medical doctor in Accident and Emergency Department, including accident and emergency doctors and consultants, radiologists, orthopaedic specialists, nurses, family doctors, etc, who have treated the Claimant. 3. The Claimant himself. Where a witness statement or a witness summary is not served, the party will not be able to call that witness to give oral evidence unless the Court allows it. Matters to be covered in the witness's statement will include: 1.

Occupation and working ability of the Claimant, if this has changed, since the injury, previous occupation of the Claimant. 2. Brief description of marital and family circumstances including dates of birth of all the family members of the Claimant. 3. The Claimant's amount of the sequence of events relating to the treatment in question. Care should be taken to avoid importing text and phraseology from medical records or reports that the Claimant would not use in the normal course of discussing the case. 4.

If the witness's factual recollection of events differs in any important respect from the medical records, or from the version of facts set out in the Defendant, the statement should acknowledge this and comment upon these

differences. 5. The witness should describe the effects of the injury; this will include the effects on his physical condition, emotional condition, the practicalities of everyday life, the Claimant's financial affairs, family life, and future plans and projects. Additional witnesses should state their relationship to the Claimant. If a family member is providing a statement which is corroborative of the Claimant's account of events, the witness should confirm that he or she has read the Claimant's statement and state that he or she agrees with its contents, insofar as those within his or her knowledge. The statement should then deal with issues of which the witness can give primary evidence. Where a party is required to serve a witness statement and he is unable to obtain such a statement, for example because the witness refuses to communicate with the Defendant's solicitor, he may apply to the Court for the permission to serve only a witness summary instead.

This application should be made without notice. The witness summary is a summary of the evidence which would otherwise go into a witness statement, or if the evidence is not known, matters about which the party serving the witness summary will question the witness. Expert Evidence: 1. In clinical negligence disputes, expert opinions may be needed: a. On breach of duty and causation. b. On the patient's condition and prognosis. c. To assist in valuing aspects of the Claims. The main expert witnesses to be considered include: a.

Orthopaedic specialists. b. Accident and Emergency specialists. c. Radiology specialists. 2. The new Civil Procedure Rules will encourage economy in the use of experts and a less adversarial expert culture. It is recognized that in

clinical negligence disputes, the parties and their advisers will require flexibility in their approach to expert evidence. Decisions on whether experts should be instructed jointly; and on whether reports might be disclosed sequentially or by exchange, should rest with the parties and their advisers.

Sharing expert evidence may be appropriate on issues relating to the value of the Claim. However, this protocol does not attempt to be prescriptive on issues in relation to expert evidence.

3. Obtaining expert evidence will often be an expensive step and may take time, especially in specialized areas of medicine, where there are limited numbers of suitable experts. Patients and Healthcare providers, and their advisers, will therefore need to consider carefully how best to obtain any necessary expert help quickly and cost effectively. Assistance in locating a suitable expert is available from a number of sources. Here the NHSLA has already supplied a number of experts for this case.

5. This is a case of missed fracture of the waist of the scaphoid, for a patient initially seen in the Accident and Emergency Department, is often a clinical diagnosis rather than a radiological diagnosis, because this fracture may not become apparent on an X-Ray until often a period of 10 days, and sometimes longer, has elapsed. Tenderness in the anatomical snuffbox at the base of the dorsal aspect of the thumb, or pain produced by proximal pressuring on the wrist joint in radial deviation by comparison to the unaffected side, together with diminished power of grip, is an indication for the forearm to be put into a scaphoid plaster of Paris.

7. The patient must have the plaster checked the following day and will need to be X-Rayed again in 10 to 14 days if a fracture line was not initially visible.

8.

When a fracture of the scaphoid is suspected, “scaphoid views” should be asked for. 9. The doctor at Accident and Emergency Department must ensure that 4 views have been carried out: Anterior-Posterior, Lateral, Supination oblique, and Pronation oblique. 10. If there is doubt about the diagnosis or the fracture is displaced, then a more senior or orthopaedic opinion must be sought forthwith, otherwise a scaphoid plaster must be applied, and the patient referred to the next Accident and Emergency review clinic or fracture clinic. 11.

There is a component of contributory negligence by the Claimant who insists to remove the plaster in the follow up clinic despite he was strongly advised not to do so. The effect of this contributory negligence on the Claims should be further explored and evaluated. Quantum of damages: The means to calculate the quantum of damages made in this case of clinical negligence include various heads of the following damage: 1. Pain, suffering and loss of amenity; 2. Loss of earnings; 3. Care and assistance; 4. Travel and parking; 5. Miscellaneous expenses.

The Claims on items (1), (3), (4) and (5) are measured quite subjectively by the patient affected. The calculation of loss of earning could be done by using the Ogden tables, which are involving a set of statistical tables for use in Court case in the United Kingdom. Beside the age of this patient (Date of Birth= 08/04/1969) being 41 years old on the date of claim (that is 12-11-2010) is known, we still need to know about the patient’s earning per annum, what is his occupation, whether he had any disability resulted, his qualifications, and his planned age for retirement.

In case where the period of loss of earnings will continue for many years into the future, it is particularly important to ensure that account is taken of likely periodic changes to the Claimant's income. The Claimant will want to point to anticipated career progression. In such cases, the Court will either: 1. Determine the average multiplicand, based upon the likely earnings throughout the period of loss, which will be applied to the full period of the loss, or; 2. Use stepped multiplicands for each stage of the Claimant's career.

Generally, this will result in a lower multiplicand at the beginning and possibly at the very end of the period of loss, with one or more higher multiplicands to represent the likely career progression that would have been followed. There is a need to interview the Claimant in more detail to decide these uncertainties for a more comprehensive evaluation. Last but not least, the importance of expert evidence in such a case is vital. Medical evidence can provide an indication as to what work the Claimant will be capable of undertaking, both at present and in the future.

This, together with evidence of the Claimant's employment prospective, will assist the Court in determining what will happen to the Claimant in the future. Another means to calculate for the approximate quantum of the damage in this patient is to look into common law and journals for similar cases for comparison and a rough estimation of quantification of similar claims. In *Johns v Greater Glasgow Health Board*¹, a 44 years old lady broke her scaphoid bones in both wrists in a fall. The fractures were only diagnosed three months later. As a result the fractures would not unite, causing continuous incapacity and pain.

Bone grafting was contemplated, despite an earlier unsuccessful attempt. Held, that solatium was properly valued at 11, 000 pounds with wage loss to date and for a further 4 years. In *W v Ministry of Defence*², which is a case of failure to diagnose fractured scaphoid from *Clinical Risk 2010; Volume 16: p. 198* (by Collier et al). The case was settled concerning damages awarded to the Claimant pursuant to the delay in the diagnosis of the fracture of his hand, without which the Claimant could have avoided undergoing surgery and regained his complete and normal wrist function.

W made an offer to settle in the sum of 15, 000 pounds. The amount awarded to the Claimant was reduced to 9, 000 pounds after further negotiation. 1. *Johns v Greater Glasgow Health Board* (1990) SLT 459. 2. *W v Ministry of Defence* (2009) MLC 1652 In *B v Norfolk & Norwich University Hospital*³, the Claimant, a male nurse aged 29 years, had attended the Norfolk & Norwich University Hospital NHS Trust after falling off his bike in July 2004. His left fractured scaphoid bone was missed and a non-united scaphoid fracture with humpback deformity and associated ligament damage had occurred.

The Claimant thus made a Part 36 Offer for the sum of 14, 000 pounds that was agreed with the Defendants in March 2006. In *N v Pontypridd & Rhona NHS Trust*⁴, the Claimant injured his right wrist in a fall whilst ice-skating on March 14, 1998. He attended the Hospital's Accident and Emergency Department and was noted as having a tender scaphoid. An X-Ray of the wrist was taken which was interpreted as disclosing no fracture. Nonetheless the wrist was set in plaster of Paris and the Claimant released. On March 19,

1998, the Claimant re-attended the Hospital's Accident and Emergency Department still in pain.

The cast was removed; no X-Ray was repeated. The Claimant was given tubi-grip dressing and told to exercise the wrist. On April 29, 1998, the Claimant attended a different Hospital complaining pain and swelling over scaphoid region. X-Ray showed a fracture of scaphoid bone in his right dominant hand. On May 29, 1998, the fracture showed sign of delayed union. As a result, a settlement of total damage of 12, 500 pounds; general damage of 8, 000 pounds, and special damage for income loss and care of 4, 500 pounds were awarded.

In *P v United Bristol Healthcare NHS Trust*⁵, the Claimant was involved in a fracas at nightclub in Bristol and arrested for punching security camera. The Claimant attended Accident and Emergency Department at the Bristol Royal Infirmary on 27 May 2000 and he experienced problems relating to his right wrist. The SHO treated the injury as being a sprain and no X-Ray was taken. The Claimant's GP then identified tenderness in anatomical snuffbox. An X-Ray confirmed fracture through scaphoid being missed by Accident and Emergency Department. The Claim was finally settled for 40, 000 pounds with causation proved. 3.

B v Norfolk & Norwich University Hospital (2006) MLC 1350 4. *N v Pontypridd & Rhona NHS Trust* (2003) MLC 1031 5. *P v United Bristol Healthcare NHS Trust* (2004) MLC 1159 QBD Settlement Where a Claimant has received State Benefits as a result of a disease and is subsequently awarded compensation, the Department for Work and Pension (DWP) will seek to recover these

benefits from the Defendant via a system operated by the Compensation Recover Unit (CRU). The CRU is also responsible for collecting from a Defendant the cost of any NHS treatment that a Claimant has received following a clinical negligence.

Notifying the DWP: Section 4 of the 1997 Act requires the compensator to inform the DWP not later than 14 days after receiving the Claim. The Notification should be made on Form CR1 which is sent to the DWP. On receipt of Form CRU1, the CRU will send Form CRU4 to the Defendant. The Claim then progresses to the settlement stage. When ready to make an offer of compensator, the compensator submits form CRU4 to obtain a Certificate. The CRU acknowledges receipt of form CRU4 within 14 days. The CRU sends the Certificate to the compensator- a copy will also be sent to the Claimant's solicitor.

The compensator will then settle the compensation claim and pay the relevant amount to the DWP within 14 days of the settlement. The compensator will also complete and send to the DWP Form CRU102 detailing the outcome of the Claim. The rules relating to recovery of benefit apply to clinical negligence claims. Due to their complexity, especially relating to causation, the CRU has set up a specialist group to deal with the claims, and makes a special request their compensators inform the CRU about clinical negligence claims as soon as the pre-action correspondence is received.

Part 36 Offer: A party who wishes to make a Part 36 Offer must first apply for a Certificate of Recoverable Benefit from the CRU. Although Part 36 does not spell it out , guidance from case law suggests that the offer should therefore

particularize the various heads of damage, and indicate the amount of benefits to be deducted against each head. Mediation: The parties should consider whether some form of Alternative Dispute Resolution Procedure would be more suitable than litigation, and if so, endeavour to agree which form to adopt.

Both the Claimant and Defendant may be required by the Court to provide evidence that alternative means of resolving their dispute were considered. The Courts take the view that litigation should be a last resort, and that claims should not be issued prematurely when a settlement is still actively being explored. Parties are warned that if the protocol is not followed, then the Court must have regard to such conduct when determining costs.

Mediation is one option for resolving disputes without litigation: it is a form of facilitated negotiation assisted by an independent neutral party.

The Clinical Disputes Forum has published a guide to mediation which will assist, available at www.clinicaldisputesforum.org.uk The Legal Services Commission has published a booklet on " Alternatives to Courts", CLS Direct Information Leaflets 23, which lists a number of organizations that provide ADR services. It is expressly recognized that no party can or should be forced to mediate or enter into any form of ADR. (Total: 3000 words) Bibliography:

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