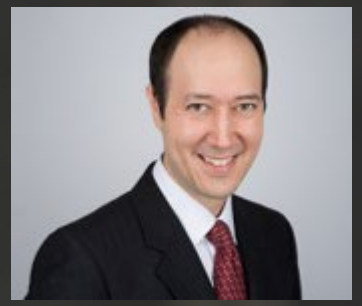
12
King's Bench Walk

Lower Limb Injuries and Cases

Speakers:



Daniel Sokol
sokol@12kbw.co.uk

Elizabeth Boulden
boulden@12kbw.co.uk

with
Professor Gerard Stansby, Honorary Consultant Vascular Surgeon

8th July 2021

CLINICAL NEGLIGENCE CLAIMS AGAINST VASCULAR SURGERY IN THE UK: AN OBSERVATIONAL STUDY (2021)

- Hansrani, V. et al. Published in Annals of Vascular Surgery, vol 70, Jan 2021, 549-554.

'Vascular surgery is a specialty with a disproportionately higher number of claims for clinical negligence.'

METHODS

- Retrospective observational study: April 2005 to April 2018
- Freedom of Information Act request from NHS Resolution

CLINICAL NEGLIGENCE CLAIMS AGAINST VASCULAR SURGERY IN THE UK: AN OBSERVATIONAL STUDY (2021)

SUMMARY OF RESULTS

- 1,189 claims in vascular surgery, over 13-year period. Steady increase over the years.
- Lower limb amputation most common primary injury (140 closed cases)
- 46% of cases closed with financial payment made to claimants
- Most common reason for claims when payment made: failure/delay in treatment (27%)
- Mean annual total payment: £10,015,373.

Hansrani, V. et al. Published in Annals of Vascular Surgery, vol 70, Jan 2021, 549-554.

CLINICAL NEGLIGENCE CLAIMS AGAINST VASCULAR SURGERY IN THE UK: AN OBSERVATIONAL STUDY (2021)

PRIMARY CAUSES FOR CLAIMS CLOSED/SETTLED WITH DAMAGES PAID (2006-2017)

- Failure to treat/delay treatment: 145 cases (27%)
- Failure/delay in diagnosis: 61 cases (11%)
- Intraoperative problems: 31 cases (6%)
- Inappropriate treatment: 21 cases (4%)
- Failure to recognise complications: 14 cases (3%)
- Delay in performing the operation: 12 cases (2%)
- Failure to warn/obtain informed consent: 10 cases (2%)
- Operator error: 5 cases (1%)

Hansrani, V. et al. Published in Annals of Vascular Surgery, vol 70, Jan 2021, 549-554.

CLINICAL NEGLIGENCE CLAIMS AGAINST VASCULAR SURGERY IN THE UK: AN OBSERVATIONAL STUDY (2021)

PRIMARY INJURIES (FOR SETTLED PAID CLAIMS)

- Amputation of lower limb: 140 claims (26%)
- Death: 63 claims (12%)
- Avoidable pain: 37 claims (7%)
- Additional/unnecessary operation: 32 claims (6%)
- Nerve damage/injury: 21 claims (4%)
- Thrombosis/Embolism: 12 claims (2%)
- Retained instruments/foreign body
- Wrong-site surgery

Hansrani, V. et al. Published in Annals of Vascular Surgery, vol 70, Jan 2021, 549-554.

CLINICAL NEGLIGENCE CLAIMS AGAINST VASCULAR SURGERY IN THE UK: AN OBSERVATIONAL STUDY (2021)

DISCUSSION

“The Vascular Society of Great Britain and Ireland published that the number of vascular consultants in the UK is lower than other comparator countries. The centralization of the network of vascular services may lead to complex referral system between primary and tertiary health care providers. This together can potentially lead to a delay in diagnosis and treatment, which is one of the most common causes of litigation.’

“The authors encourage the use of preprepared consent forms. There is a growing popularity for the use of audio-taped consultations.”

“Over the last decade, the swift advancement in vascular and endovascular practices is still accompanied by a significant rise in clinical negligence claims and with a changing claims culture is expected to continue.”

Hansrani, V. et al. Published in Annals of Vascular Surgery, vol 70, Jan 2021, 549-554.

Delay and the hypothetical exercise of what would have happened

- Delayed treatment cases = multiple causes (at least 2 causes: 1. pre-existing condition, 2. delay)
- In working out causation ("what would have happened 'but for' the negligence?"), we engage in speculation.
- Often, series of 'but for' questions:
  - 'But for' [breach A], when would C have been seen by specialist?
  - If seen by specialist, what investigations and examinations would have been done?
  - If they had been done, when would they have been done and when would results have been obtained?
  - What would results have shown?
  - In light of the results, what action would have been taken and when?
  - Would this have prevented or reduced the severity of injury?

JAH v Burne and Ors [2018] EWHC 3461 (QB)

- Blood supply to C's left arm became compromised by a thrombo-embolus
- Caused a below-elbow amputation, then an above-elbow amputation
- Also tissue damage to left leg due to ischaemia, caused by thrombo-emboli
- Caused below-knee amputation, then an above-knee amputation

- C argued in the alternative that the amputations of one, or both, limbs should have been avoided
- Issues were breach and causation
- In particular, causation issues included:
  - If there should have been an earlier vascular referral, by when would the Claimant have been seen by a vascular surgeon?
  - Upon vascular referral, whether a thrombo-embolic source would have been suspected or recognised and anti-coagulant treatment commenced, or whether atherosclerotic peripheral arterial disease would have been diagnosed and antiplatelet therapy instigated?
  - If anticoagulation would have been given initially, would this have continued or would the treatment have been switched to antiplatelet therapy?
  - In the event that the Claimant would have received full anticoagulation pursuant to any of the above alternatives, would that have been in time to avoid amputation of: a) Her leg; and/or b) Her arm.?

- Judge did not find breach or causation in respect of the leg injury
- However, the claim succeeded in respect of the arm injury

JAH v Burne and Ors [2018] EWHC 3461 (QB)

Regarding the arm injury alone:

- 64. […] In my judgment, in resolving issues of detail such as how long it would have taken for the Claimant to be seen, how long it would have taken for investigations to be carried out and when a competent vascular surgeon would have appreciated that anticoagulation was the appropriate treatment, the court should err in favour of the Claimant where it is the Defendant's negligence which deprives the court of the best evidence and causes the need to delve into this hypothetical world.

- 65. This approach has support from the decision of the Court of Appeal in *Keefe v Isle of Man Steam Packet Co* [2010] EWCA Civ 683 and *Raggett v King's College Hospital* [2016] EWHC 1604 (QB) per Sir Alastair MacDuff. *Keefe* concerned a claim for noise-induced hearing loss. The Court of Appeal held that the Claimant had been prejudiced by the fact that a Defendant had failed to take noise surveys, in breach of duty, thereby causing an evidential lacuna in relation to the nature and extent of the noise to which the Claimant had been exposed."

Keefe v Isle of Man Steam Packet Co [2010] EWCA Civ 683

- “19. If it is a defendant's duty to measure noise levels in places where his employees work and he does not do so, it hardly lies in his mouth to assert that the noise levels were not, in fact, excessive. In such circumstances the court should judge a claimant's evidence benevolently and the defendant's evidence critically. If a defendant fails to call witnesses at his disposal who could have evidence relevant to an issue in the case, that defendant runs the risk of relevant adverse findings see *British Railways Board v Herrington* [1972] AC 877, 930G. Similarly a defendant who has, in breach of duty, made it difficult or impossible for a claimant to adduce relevant evidence must run the risk of adverse factual findings. To my mind this is just such a case.

- 20. This has been accepted law since *Armory v Delamirie* (1721) 1 Strange 505, the famous case in which a chimney sweep found a jewel in a chimney and left it with a pawnbroker for valuation. The pawnbroker, in breach of duty, failed to return it and could not be heard, when sued, to assert that the chimney sweep could not prove its value. The court awarded the highest sum realistically possible. A bailee's duty towards his bailor is, of course, different from an employer's duty to his employee but breach of the latter duty is not necessarily less serious than breach of the former.”

YOUNAS v OKEAHIALAM [2019] EWHC 2502 (QB)

- Judgment of Deputy High Court Judge, Rowena Collins Rice. Under appeal
- In Jan 2014, C (43 years old) fainted in a car park and sustained a serious spinal injury.
- Faint caused by heart condition called 'intermittent atrioventricular block'.
- D (GP) admitted he should have referred C to hospital cardiology dept after ECG showed electrical abnormalities.
- C's case: if done, would have had pacemaker and would not have fainted in car park and injured himself.
- Causation only

- Questions for judge included: when would C have been seen in out-patients? What would have been found? What investigation would have been done and when? What would they have revealed? If pacemaker fitted, when? Etc.

YOUNAS v OKEAHIALAM [2019] EWHC 2502 (QB)

- 34. Mr Bradley [Counsel for C] raised another legal issue. This goes to the correct approach I should take to the necessary reconstruction of the diagnostic process in this case, particularly as to timescales. He drew my attention to the decision of the Court of Appeal in Keefe v Isle of Man Steam Packet Co [2010] EWCA Civ 683, and the principle that "a defendant who has, in breach of duty, made it difficult or impossible for a claimant to adduce relevant evidence must run the risk of adverse factual findings." (paragraph 19). In these circumstances, "the court should judge a claimant's evidence benevolently and the defendant's evidence critically." (ibid).

  [...]

- 37. Ms Toogood [Counsel for D] acknowledged the relevance of 'benevolence' in the present case to the extent, for example, of finding that, if something probably happened within a particular range of days or weeks, then if it would favour Mr Younas to find it happened at the beginning rather than at the end of that range, I should do so. But she put it to me that the burden remained on him to establish the probability of that range (and the event) in the first place.

YOUNAS v OKEAHIALAM [2019] EWHC 2502 (QB)

- 46. I must also bear in mind that it is the fault of the defendant that we are having to undertake this exercise at all, and it would be unfair for the defence to seek to capitalise on the absence of the very evidential audit trail of which the claimant has been wrongly deprived. The claimant starts at a disadvantage inflicted by the defendant; it is right both that that disadvantage should not be unfairly exacerbated, and also that a degree of minimisation of the disadvantage should be looked for, to level things up as fairly as possible. That is what 'claimant benevolence' tries to achieve.

- 47. I cannot, however, simply assume that the diagnostic process, or any part of it, would have happened as quickly as the claimant needs it to in order to win his case. Nor can I disregard relevant evidence that is not in his favour, even in this hypothetical space. I have to build up the picture as best I can on the materials before me. Where I am satisfied that the evidence points to a decision within a range, but cannot otherwise discriminate within that range, then I should incline to the point in the range favouring the claimant. But it is the claimant's obligation to satisfy me as to that range. I must give him the benefit of the doubt, but he must persuade me to doubt in the first place. These are fine distinctions, but real ones, in conducting a difficult exercise fairly.

Summary

- Significant proportion of cases seem to be in relation to failure to treat/delay treatment or failure/delay in diagnosis
- In respect of causation, these are based upon a hypothetical of what would have the diagnosis/treatment pathway have been, “but for” the alleged negligence
- Claimant needs to prove this with expert evidence
- However, where the evidence points to a decision within a range, the judge should incline to the point in the range favouring the claimant (*Younas* para 47)
- Due to *Keefe*: “it would be unfair for the defence to seek to capitalise on the absence of the very evidential audit trail of which the claimant has been wrongly deprived” (*Younas* para 46)