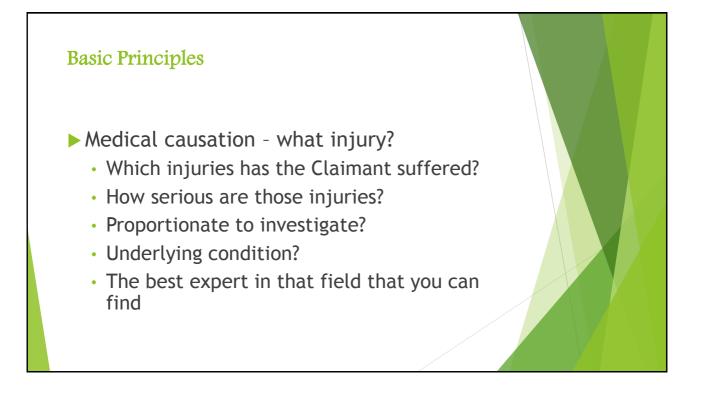


# **Basic Principles**

Factual Causation - Bolitho

- Negligent omission
- What would and should have happened?
- Failure to refer e.g. lump
- Breach of duty: GP expert
- Causation: Oncologist



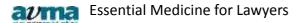


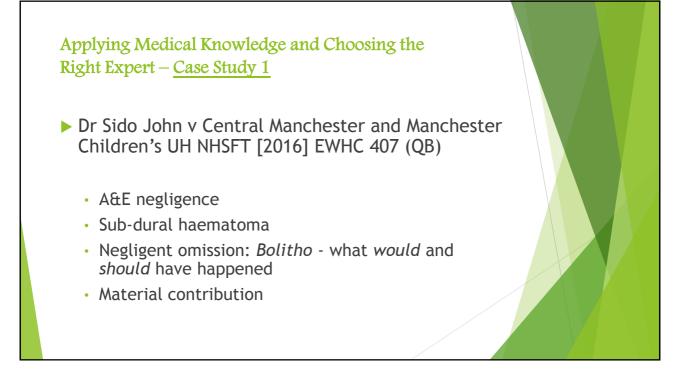
## **Basic Principles**

## LOA and LOI

- Review the medical records thoroughly
- Complex condition? Ask the expert to explain it in the report - for the client and the court (shipping/gas/oil)
- Ask specific questions
- Phrase the questions properly eg material contribution







#### BACKGROUND FACTS:

- Successful GP locum, prison doctor
- Age 16 intra-cranial infection left-sided craniotomy
- mild right-sided hemiparesis right hand, right foot drop
- > 23.12.07 Christmas night out with friends
- Returns to communal flats
- 18 factual and expert witnesses



- Falls backwards on stairs
- Found by a neighbour, another doctor, 2 hours after fall
- Vomited, dysphasia, GCS 9/15
- 06:52 admitted by ambulance to MRI
- CT scan ordered
- A&E Consultant, Dr Stewart, "chatted"; says GCS 15 and cancelled CT scan
- Review on CLDU; GCS 12-13; CT scan re-ordered went ahead at 13:12
- SDH diagnosed and plan to transfer to Hope for surgery
- Seizure and delays in calling an ambulance

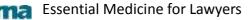
## Dr Sido John v Central Manchester and Manchester Children's UH NHSFT [2016]

## Hope Hospital

- Transferred to Hope Hospital ventilated
- 19.30 surgery at Hope Hospital
- Craniotomy to evacuate acute SDH and relieve raised ICP
- Severe post operative brain infection

## Injuries

- Prolonged rehabilitation
- Developed hemianopia, cognitive impairments and depression
- Unable to return to work as a GP



#### Gathering evidence - facts

- Claimant's witness statements
  - claimant
  - doctor who found him
  - nurse in A&E
  - neurosurgeon from Hope Hospital
  - mother
- Medical records/disclosure
  - condition on and during admission
  - computerised records re scan ordering/cancellation
  - operation note from Hope Hospital

## Dr Sido John v Central Manchester and Manchester Children's UH NHSFT [2016]

## Gathering evidence

- Factual evidence: what would have happened if scan done earlier?
  - Witness statement from surgeon at Hope Hospital
    - Was damaging raised ICP present earlier?
    - Would Hope have accepted him as a patient?
    - Would Hope have operated if transferred earlier?
    - Was a damaging level of raised ICP present when Hope operated?
- Expert evidence: what should have happened: expert evidence
  - Accident & Emergency
  - Neurosurgery



Claimant's allegations:

- ▶ The CT scan should have been performed soon after admission
- C would have been transferred to Hope Hospital sooner
- Negligent delay in calling the ambulance
- Monitoring = raised ICP
- The neurosurgeon would have operated
- Would still have had a post-operative infection
- Would have avoided a damaging period of raised ICP
- The negligent period of raised ICP materially contributed to his cognitive and neuropsychological deficits which have meant that he will likely never work as a doctor again.

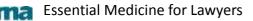
## Dr Sido John v Central Manchester and Manchester Children's UH NHSFT [2016]

## Defence

- Breach of duty denied
- Dr Stewart examined at 9.30
- GCS was 15/15
- Reasonable to cancel the scan
- Causation: necessary to apportion damages between the damaging raised ICP (caused by the negligence) on the one hand and the initial head injury, raised ICP and post-operative infection not caused by any negligence on the other.



- Evidence to prove when Dr John had raised ICP
  - GCS score, dysphasia, finding at operation
- Experts were agreed that:
  - if the judge decided that there was a period of damaging raised ICP prior to the surgery at 19:30, this would have made an unquantifiable yet more than de minimis contribution to Dr John's injuries; and
  - it was not possible to separate out the relative contributions of the three factors of: (a) the initial trauma; (b) an extended period of RICP; and (c) the post-operative infection.



#### Judgment by Mr Justice Picken

- ▶ The CT brain scan should have been performed not later than about 10:00.
- A negligent delay in arranging a transfer to Hope Hospital.
- Dr John had been suffering from damaging raised ICP from at least 12:15 or so, which lasted for a period of in excess of 7 up to surgery at19:30.
- Factual causation: Dr John would have avoided about 6 hours of raised ICP, assuming 15 minutes for initial decompression during the surgery at 19:30.
- Ambulance delay: Dr John probably would have avoided an hour of damaging raised ICP.
- The test of material contribution had been satisfied and Dr John could recover for all of his injuries.
- Damages £454,858.65, inclusive of interest. £100,000 of this was for PSLA

# Applying Medical Knowledge and Choosing the Right Expert – Case Study 2

- Cerebral Palsy
- Delay in second stage of labour
- Left occipito -posterior position
- Spinal block
- Registrar attempts to manual rotate
- Bradycardia
- Further attempts to manual rotate
- Forceps
- Consultant attempts to manual rotate and forceps
- LSCS
- Acute profound hypoxic ischaemic brain injury





