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Clinical Negligence newsletter

This newsletter is one in a series of publications produced by the clinical negligence and personal injury group within the Private Individuals Division of Penningtons Solicitors LLP. If you would like further details on any of the subjects covered, please contact us at the addresses at the end of the newsletter.

In this issue...

- 01 | Understanding retractor injuries
- 02 | Hospital acquired infections and the COSHH Regulations
- 03 | Casewatch
- 04 | Leading the field

Understanding retractor injuries

Femoral nerve injuries are an avoidable feature of abdominal surgery using a surgical retractor. This article examines what happens when things do go wrong and the damages that can be claimed by patients in compensation.

In any surgical operation which involves opening the abdomen, the surgeon will want to make the smallest possible opening because the wound will heal better and look better. At the same time, he or she will also require the largest possible opening to carry out whatever activities are needed on the internal organs most efficiently.

The abdominal wall is quite elastic. To produce that wider opening, it can be stretched and held apart by using a device known as a surgical retractor. This is usually a metal lever with a blunt, blade-like end that can be either directly held by the surgeon and therefore remain mobile, or fixed to a framework (the self-retaining retractor) which keeps the surgical opening stable while a procedure is completed.

Inevitably, the self-retaining type puts pressure on the underlying tissue which is constant while it is in place. This very unnatural pressure can cause an interruption in the blood supply or direct trauma to the tissue which may include permanent damage by effectively killing, rupturing or bruising it.

If the retractor is inserted very deeply, it will press against the back wall of the abdomen. It may press against the psoas muscle, an important muscle in the lower back, which

passes over the edge of the pelvic girdle. Lying within that muscle is the femoral nerve. This is a very critical nerve, or rather bundle of nerves, which serves a number of important muscles in the leg and provides skin sensation. Damage to it causes numbness and pain, which can be very difficult to treat, and movement difficulties that can be seriously disabling, in some cases confining the patient to a wheelchair.

Pressure on the femoral nerve can cause it to be severed or, where the nerve sheath remains intact, the underlying nerve fibres may be damaged. Pressure on a vessel providing a blood supply to the nerve can lead to part of the nerve dying. In other instances, the nerve can be stretched or simply traumatised or bruised.

All of these injuries can repair themselves but may not do so. A repair will usually have happened within two years of the operation. Some nerve injuries are more likely to repair quickly than others, but the more profound the injury, the less likely that repair will occur as part of the healing process. The precise nature of the nerve injury is often impossible to determine.

This sort of injury is a recognised complication of major abdominal surgery including hysterectomy, appendicectomy,



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After an admission of liability,
the claim settled for £300,000.

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kidney surgery and aortic artery repair, but that does not mean that it occurs without fault. There are many research papers dealing with the issue. One states 'It is more common than is generally appreciated and most importantly, is almost completely avoidable'. In another 'simple preventative measures should eliminate this completely' and another '[this]...can be prevented by careful attention to the use of a self-retaining retractor at the beginning and during operation'.

Those 'simple measures' are the choice of the length of the retractor blades used, the positioning of the blades but, above all, the use of appropriate padding between the blades and the underlying tissues. Put simply, surgical opinion is clear that

femoral nerve damage caused in this way is usually avoidable with the proper care. For it to occur will often be an indication of negligent use of the self-retaining retractor.

We have been involved in a number of cases involving this type of injury. Two are described below:

- Client A was diagnosed as suffering from a cancer of her left kidney. This was treated by removal of the kidney during an abdominal operation. A self-retaining retractor was used. When the patient awoke, she was found to have bilateral femoral nerve palsies. The left leg never recovered and the client remained disabled. Liability was quickly admitted and the case was settled for £80,000.

- Client B required a hysterectomy and it was decided that it would be carried out abdominally. Our client awoke from the procedure with a left-sided femoral nerve injury which was initially misdiagnosed. For a short time she was confined to a wheelchair but, with much effort on her part, she managed to regain some use of her leg. She continued to suffer from movement difficulties and altered sensation, pain and discomfort in her leg, which has remained disabling. Again, after an early admission of liability, the claim was settled for about £300,000.

Both these injuries were avoidable and compensation should be available in most similar cases.

Hospital acquired infections and the COSHH Regulations

In 2006 when Mrs Cope brought a claim against the Princess of Wales Hospital in Bridgend for having contracted MRSA after hip replacement surgery, there was a school of thought that a new legal approach using the COSHH Regulations would open the floodgates in hospital acquired infection cases. Here we examine whether this has actually proved to be the case.

Hospital acquired infection cases have traditionally been brought under common law principles of negligence with the burden of proof resting on the claimant. However, in *Cope v Bro Morgannwg NHS Trust*, Mrs Cope successfully argued that as a patient she was owed a strict statutory duty by the NHS trust under the COSHH (Control of Substances Hazardous to Health) Regulations. Her case was that the NHS trust was under a duty to protect its employees and patients against exposure to biological agents (ie MRSA) through disinfection and the contamination procedures. If she was correct that the COSHH Regulations applied, then the strict test of liability would have the effect of shifting the burden of proof onto the defendant. This would mean that the NHS trust would have to prove that it put in place

and administered satisfactory procedures to prevent the spread of MRSA.

Mrs Cope's case was settled out of court and therefore without a legal ruling. However, the judgment given in *Ndri v Moorfields Eye Hospital NHS Foundation Trust* in 2006 sheds further light on the issues. Mrs Ndri lost sight in one eye after contracting pseudomonas infection following a corneal graft. Her claim was brought under common law and the COSHH Regulations. While the judge accepted the argument that the infection she contracted was a 'biological agent' under the COSHH Regulations, he was reluctant to find that the Regulations applied to patients in hospital ie to a clinical negligence claim. He was not persuaded that the intention was that hospital patients should fall within



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The judge was reluctant to find that the Regulations applied to patients in hospital.

those protected by the Regulations; a not altogether surprising sentiment. In any event, Mrs Ndri failed to prove causation and was therefore also unsuccessful under common law.

Claimants are still able to pursue infection claims and the door to using the COSHH Regulations may not be completely closed. However, it seems unlikely following the Ndri decision that claimants will rely solely on the Regulations despite the advantageous position created by the reversal of the burden of proof. We do not therefore conclude that the Cope case has been a 'landmark decision' as was initially thought.

Casewatch

Examples of the work undertaken by our team:

Settlement after post surgical negligence leads to amputation

Our client underwent breast surgery at S District Hospital and then contracted a virulent infection (Group A Beta-Haemolytic Streptococcus) leading to septicaemia, toxic shock, multi-organ failure and severe ischaemia to her thigh and both feet. A partial foot amputation was carried out. She continued to face restricted mobility and was unable to return to her previous job. Below knee amputation was a realistic prospect.

She claimed that those treating her negligently failed to adequately note, investigate or respond to her persistently abnormal post-surgical observations, including hypotension, elevated heart and respiratory rates and abnormally high degree of pain, and did not follow the hospital's own 'early warning scoring system'. Her case was that if these failures had not occurred, her condition would have been diagnosed and treated more quickly, preventing the worst effects of the infection and the ischaemic process to her feet.

The claim was vigorously defended and a trial to decide the issue of primary liability was listed. After witness and medical evidence was exchanged, the NHS trust conceded breach of duty but maintained a denial of causation.

The claim was quantified on the most likely scenario ie that R would undergo further surgery, face considerable future prosthesis costs and have a reduced earnings capacity. The parties entered settlement negotiations, culminating in a substantial settlement and with an admission of causation.

Damages for delay in diagnosing skin carcinoma

Mrs W had been diagnosed with a melanoma and advised that she would need to be seen regularly by a dermatologist as there was a high risk that others would develop.

Two years later Mrs W's care changed to a new dermatologist, Dr F. At that time she was concerned about a mark on her nose which Dr F examined. He commented that the mark was worth watching and gave her a follow up appointment for six months time.

During the follow up appointment, Dr F diagnosed actinic keratosis and advised Mrs W that she could pursue scaling on her nose if she wished. He added that medically speaking there was nothing further that needed to be done and discharged her from further follow up. Her GP was not informed.

A friend of Mrs W, who happened to be a doctor, raised concerns about the mark. She immediately saw her GP and further investigations confirmed the diagnosis of basal cell carcinoma. Mrs W was referred for oral and maxillofacial surgery.

Excision surgery was undertaken and, following a delayed healing due to infection, the graft ultimately healed well. The grafted area was subsequently treated with dermabrasion to improve Mrs W's cosmetic appearance.

Mrs W alleged that discharging her from further skin surveillance with an incorrect diagnosis of actinic keratosis constituted an unacceptable standard of care. Had a diagnosis been confirmed earlier, on the balance of probabilities her carcinoma would have been excised and the defect repaired with a local flap advance in skin from the side of the nose. This would have resulted in a better cosmetic result.

Mrs W sought damages to reflect pain, suffering and loss of amenity and a subrogated claim was brought on behalf of her healthcare provider for the cost of private medical treatment. After an initial denial of liability, further expert evidence was obtained and in the meantime a Part 36 offer of £17,500 was made by Mrs W. While liability was not conceded, the Part 36 offer was accepted by the NHS Litigation Authority on behalf of the defendant trust.

The breakdown of the damages was estimated as follows:

- general damages for Mrs W's pain, suffering and loss of amenity - £14,000
- miscellaneous special damages - £250
- recovery of insurer outlay - £3,250.



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Discharging her constituted an unacceptable standard of care.



Leading the field

Penningtons' clinical negligence and personal injury groups are recognised as among the leading practices in their field in the South of England by the latest issues of The Legal 500 and Chambers Guide to the Legal Profession.

Both directories awarded our teams top rankings and highlighted the contributions of the partners who head up the groups, Tim Palmer, Philippa Luscombe and Alison Appelboam-Meadows.

Our teams are praised for their 'highly personalised service' and for having 'the respect of many of the best experts in the field'. Tim Palmer is described as having 'a great mind for tactical considerations' as well as 'considerable experience' while Philippa Luscombe is acknowledged as 'a good team leader with a highly pragmatic approach' and Alison Appelboam-Meadows as a 'very switched-on lawyer who achieves excellent results'.



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