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Medical Negligence Review

April 2015



**£55,000 recovered
after baby Lindsey
suffers catastrophic
brain haemorrhage**

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**£24 million recovered
for Maisha, after her
brain was injected
with glue**

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**£14 million life
changing settlement
for Rebecca, who was
left quadriplegic**

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+Plus

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- Obstetric Negligence
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- Nursing Negligence
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Welcome to our Medical Negligence Review - January 2015



Paul McNeil

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It is evident from the case reports which follow that Fieldfisher's Medical Negligence team continues to achieve high success on behalf of Claimants we represent. Readers only have to consider the record damages obtained by Edwina Rawson against Great Ormond Street Hospital to understand how easily things can go wrong. A simple marking of the relevant syringes would have avoided serious injury and heartache for all involved.

To be fair to the Clinicians at Great Ormond Street Hospital, they recognised the mistake immediately and informed the parents of the disaster. Inquiry and investigation were urgently undertaken to ensure as far as possible that such a mistake never happens again.

Following the Francis report, the Government has now introduced as a Statutory requirement of the Duty of Candour. This is a concept which we have long supported at Fieldfisher.

To the credit of the NHS LA, the guidance that it provides to its Clinicians is outstanding. The underlying philosophy is to compel Clinicians to help patients receive accurate and truthful information about their treatment, particularly when a mistake has been made. It advises that:-

"In reality Candour is all about sharing accurate information with patients and should be encouraged. The facts are the facts and staff should be encouraged and supported to help patients understand what has happened to them".

We consider that when treating Clinicians give effect to this guidance, then the culture of the NHS will immediately change for the better. The NHS will move from being closed and suspicious to an open, trusting culture. Such openness could result in an earlier resolution of claims, more creative settlement claims, a reduction in the cost of litigation and the maintenance of the relationship between the patient and the treating Clinicians.

The current edition of Medical Negligence Review shows a wide breadth of cases where our lawyers have fought hard to vindicate their clients' rights. The review highlights our continuing philosophy of "Caring for our clients, Commitment to our cases and Cutting edge expertise".

Paul McNeil

April 2015

'Fieldfisher's clinical negligence team has a "formidable reputation" and a great range of expertise in the fields of obstetrics, general practice and cosmetic surgery.'

Chambers, 2013



Great Ormond Street Hospital settles £24 million claim for girl whose brain was injected with glue



Maisha Najeeb, now aged 13, brought a claim for compensation for treatment received at Great Ormond Street Hospital for the accidental

injection of glue into her brain, which left her profoundly brain damaged.

At the time, Maisha was a healthy 10-year old girl. She has a rare medical condition, arterio-venous malformation ('AVM'), which involves arteries and veins becoming entangled and occurs in about 1% of the population. AVMs can be serious when they result in a bleed. However, Maisha was able to lead a very normal life. She had had 5 bleeds that had required treatment by embolisation, which were completed without complication.

The embolisation procedure involves an injection of glue (an embolic agent) to block off the bleeding blood vessels, and an injection of a harmless dye (contrast) to check the flow of blood around the brain and head.

On 2 June 2010, Maisha had a bleed which required embolisation. Tragically, there was no system in place of distinguishing the syringes containing the glue from those containing the contrast, and they were mixed-up during the procedure. This resulted in glue, instead of dye, being wrongly injected into the artery to Maisha's brain. The glue caused catastrophic and permanent brain damage.

Maisha's father instructed **Edwina Rawson**, medical negligence partner at Fieldfisher, to pursue a claim for compensation against Great Ormond Street Hospital.

The Defendant did not admit liability as quickly as anticipated. Judgment was entered on 1 March 2012.

Maisha needs care and assistance with all daily tasks, day and night. She is in a wheelchair and has lost the vast majority of her bodily and cognitive abilities. She suffers from painful leg spasms.

The claim was due to go to trial in January 2014 to decide how much compensation Maisha should receive. But at a meeting between the parties, an agreement was reached with Great Ormond Street Hospital.



Maisha

Edwina Rawson said:

“What is so heart-breaking about this case is that the injury was so avoidable. If the syringes had been marked-up so the hospital could see which contained glue and which contained dye, then Maisha would not have suffered what is an utterly devastating brain injury. Such easily avoidable mistakes should not happen.”

The agreed settlement was for an upfront lump sum payment of £2.8 million, and in addition £383,000.00 annually until Maisha is aged 19. This will then increase to £423,000.00 per year for as long as she lives. This agreement was approved by the Royal Courts of Justice in London on 27 January 2014. The compensation are based upon experts' assessments of Maisha's needs, and will be spent on her care and accommodation.

A central issue in the case was the impact that the brain injury and the pre-existing AVM would have on her life expectancy, the parties were not able to reach agreement about this and were very far apart. The annual lifetime payment means that for however long Maisha lives, payments will be made yearly.

“We are sad and devastated by what happened to our daughter. Her life is ruined. All her dreams have been broken. I hope that by bringing this case, lessons will have been learned to avoid this happening to other families. We are grateful that agreement has been reached with Great Ormond Street to ensure that Maisha's care needs are met.”

Sadir Hussain, Maisha's father said

£1.5 million award for patient who suffered brain damage because of a delay in diagnosis at Ealing Hospital A&E



Jonathan Zimmern was instructed by Mrs Wilshaw after she suffered a serious brain injury on 21 November

2008 following a delay in diagnosis and treatment of a stroke caused by an aneurysm in her brain.

At the time of her stroke, Mrs Wilshaw was aged 62 and in good health. She was working full time and living an independent life. The stroke left her with a serious brain injury and she spent several months in hospital for treatment and rehabilitation.

She is no longer able to live independently and was obliged to move in to supervised accommodation. She requires supervision around the home and when she is out of the house and she has been unable to return to work.

On 23 October 2008, Mrs Wilshaw suffered a sudden and violent headache with vomiting whilst on holiday in India.

On her return to the UK, she attended Ealing Hospital Accident & Emergency department on 31 October 2008. She was seen by a casualty doctor who examined but discharged her with no treatment.

Notwithstanding this, Mrs Wilshaw and her family remained concerned. She attended her GP the following day, who referred her to a neurologist. The neurologist arranged an MRI, suspecting a haemorrhage or an aneurysm.

The scan demonstrated the aneurysm but, unfortunately, the scan was misreported and Mrs Wilshaw was again discharged home. She suffered a catastrophic stroke the following evening.

Mrs Wilshaw's family instructed **Jonathan Zimmern**, a medical negligence claims expert, who obtained reports from a Neurosurgeon, Consultant in Emergency Medicine, a Neuroradiologist and a Neurologist. He was able to demonstrate that the

Trust failed to recognise Mrs Wilshaw's aneurysm and haemorrhage and treat it accordingly so as to prevent the stroke.

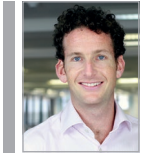
In their Defence, the Hospital Trust admitted that they were negligent in the management, care and treatment of Mrs Wilshaw when she was in A&E. Following this admission, Jonathan was able to negotiate in advance payments for Mrs Wilshaw whilst he finalised his investigations in to the value of the claim.

These interim payments allowed Jonathan to instruct a Case Manager to assist Mrs Wilshaw with her care and accommodation needs. At a meeting with the Defendant's Solicitor in December 2014, Jonathan negotiated a lump sum settlement of £370,000 and annual payments of £58,694 for the rest of her life, which, based on her current life expectancy, may result in a total award of over £1.5million.

The award for annual payments in particular will ensure that Mrs Wilshaw will have the funds available to pay for the care and help she needs for the rest of her life.



£50,000 recovered following delay in diagnosing appendicitis at University College London Hospital



Mark Bowman was instructed by Claire, following a delay in diagnosing her with appendicitis by University College London Hospital (UCLH), in June 2011.

On 21 June 2011, Claire, aged 29 at the time, was at work when she started to suffer from severe pain in her stomach. She referred herself to UCLH and was admitted at 13:20. After being triaged by a nurse, Claire was seen by a Senior House Officer in emergency medicine at 14:30. He noted that Claire was suffering from severe abdominal pain and that she felt nauseous. He diagnosed Claire as suffering from constipation or a urinary tract infection and kept her in for observations and prescribed painkillers.

Claire was seen by the same doctor again at 16:30. He noted no improvement in Claire's pain levels. He felt that there was a gynaecological explanation for Claire's symptoms and requested a gynaecological opinion. Claire was subsequently looked after by the

gynaecology team for the next 24 hours during which time a gynaecological explanation for Claire's symptoms was ruled out. During this time Claire's pain levels significantly increased and her blood tests revealed markedly raised CRP and WCC counts (signs of infection).

Claire was transferred to the surgical team for further investigation and at 18:45 on 22 June 2011 the surgical SHO diagnosed Claire as suffering from likely appendicitis. Even though the diagnosis was made, it was not until approximately 20 hours later that Claire was transferred for surgery. At surgery it was noted that Claire's appendix had perforated and she was suffering from significant peritonitis.

Claire required 7 days further treatment at UCLH. On 01 July 2011 she returned to her family home to recuperate. Claire subsequently required two further admissions to hospital to deal with post operative complications. She continued to suffer from severe abdominal pain and in May 2012 she required further keyhole surgery as a result of the formation of adhesions.

As a result of the avoidable complications Claire was unable to return to work until 24 October 2011, at which time she returned on a part time basis for a further two months. Claire subsequently had to take on a non client facing role as she continued to suffer from ongoing symptoms, and she subsequently missed out on a promotion at work.

Mark Bowman obtained expert evidence in the fields of General Practice, Gynaecology and General Surgery. It was alleged that having made the diagnosis of appendicitis at 18:45 on 22 June 2011 it was negligent to then wait a further 20 hours before operating. Furthermore, at the time that the diagnosis had been made, Claire's appendix had probably not perforated and, had she received prompt treatment, her appendix would not have burst and she would have avoided a number of the complications that subsequently arose.

Proceedings were issued against UCLH following which an offer of £50,000 was made in settlement of Claire's claim, which she accepted.

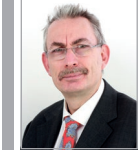


At the end of the case Claire commented:

“When I met Mark he was very clear on the process, the time frames and what needed to happen. He was very approachable and put my mind at ease.

On every meeting or interaction, he just continued to exceed my expectations, his efficiency, attention to detail, accuracy, professionalism and ability to synthesise information really impressed me.”

GP negligence leads to delay in diagnosis causing severe incomplete spastic quadriparesis



The Claimant was 38 year old mother of four young children living at home. She had been to the Ealing hospital complaining of pain in her cervical spine and had been prescribed strong analgesic drugs.

On Friday 28 May 2010 the Claimant's symptoms were much worse. She was suffering from pain in her arms, with difficulty in gripping, holding a pen and signing her name. She also had impairment of bowels, cramping weakness, pins and needles in her legs and experienced electric shock symptoms in her body.

She attended her GP on an emergency appointment at around 12.00 noon complaining of this constellation of symptoms. We alleged on her behalf that the GP did not listen to her or examine her properly. The GP dismissed the Claimant's symptoms, prescribed a topical cream and refused a request for an MRI scan of her neck.

The symptoms worsened during the day. Terrified, the Claimant called the ambulance service in the early hours of Saturday 29 May who transferred her onto NHS Direct. The transcript of the telephone call corroborated the earlier complaints to the GP. However, the operator was unsympathetic and advised that the Claimant contact the out of hours GP service or she attend Ealing A&E under her own steam.

By now she could hardly walk but her husband took her to the A&E department by taxi where she was admitted at around 04.00.

Even then it took some time for the doctors to admit her to a ward and begin investigations. Meanwhile, her condition was rapidly deteriorating. At around 9am the Claimant was referred to Charing Cross Hospital for the undertaking of an MRI scan of her neck. The MRI revealed an annular tear in her C6/7 disc. Urgent surgery was mandated.

At about 9pm an emergency anterior cervical discectomy and fusion at the level of the 6th and 7th cervical spinal vertebrae was carried out. Shortly afterwards the Claimant was



transferred to Stoke Mandeville Hospital for rehabilitation.

As a result of the tear (and the delay in diagnosis) she suffered a severe incomplete spastic quadriparesis. Given her poor state at the time of surgery she made a remarkable recovery. Nevertheless she remains in significant pain, is unable to mobilise outside the house without crutches and/or a wheelchair and is unable to climb stairs or look after her children in her former capacity.

Paul McNeil alleged on her behalf that with treatment 12 hours earlier she would have made a very good recovery so as to walk without a crutch, carry out normal activities of daily living and care for her children. She would have returned to work in some capacity.

Her bowel and bladder control were both likely to have been much better.

Proceedings were issued on her behalf in March 2013 with a trial date fixed for November 2014. The main allegations of negligence were that with the constellation of symptoms complained of, the GP should have referred her to the hospital urgently. The case was defended strenuously both on breach of duty of care and causation of injury. The GP's lawyers argued that even if we succeeded in showing that the Claimant should have been referred to hospital in the early afternoon, a reasonable response time by the hospital doctors would not have allowed earlier intervention which would have made a difference to the outcome.

In September after lengthy negotiations a substantial sum was paid to the Claimant.

GP admits failing to refer following lab finding of malignant melanoma



In May 2008 Larry's GP removed a mole from his right leg. The GP initially thought the mole was benign but after incision felt the lesion "looks more sinister". He excised the lesion.

The GP told Larry words to the effect

"if you don't hear from me in two or three weeks you can forget about it".

When Larry did not hear to the contrary he assumed that all was well. In fact it was not. The histology result (which was received by the GP practice, but not acted upon) concluded that the lesion was malignant melanoma. The report also stated that Larry should be discussed at a Skin Cancer Multi-Disciplinary Team (MDT) meeting. He was not referred to a specialist by his GP and the test result was not acted upon.

Subsequently in July 2009 Larry noticed a lump in his groin. He underwent a biopsy of his lymph node. The histology report identified metastatic malignant melanoma. The GP made an entry in the notes which confirmed that the earlier histology report was found in a box in storage indicating that report was received but not scanned electronically onto Larry's notes or acted upon.

Larry instructed **Sam Critchley** to investigate. He sadly passed away in January 2011, at the age of 72, from the disease and his son pursued the claim on his behalf. The GP made a personal apology to Larry during his lifetime and his lawyers made a formal admission of breach of duty of care in a letter in June 2013 for:

"failing to ensure that the adverse pathology result was properly acted upon in 2008"

We obtained expert evidence from a leading oncologist at the Royal Marsden Hospital which concluded that had Larry been referred to the Skin Cancer MDT in June 2008 as he should have been, he would have undergone wide local excision of the primary melanoma and his condition would have been appropriately managed. He would probably have had a sentinel lymph node

biopsy and would have been staged as N1.

Larry would then have undergone right groin lymph node clearance before his disease became advanced. Had his condition been managed as it should have been, Larry would have been cured of his cancer with a likelihood of surviving for at least five years and would have avoided undergoing radiotherapy.

As a consequence of the alleged negligence, Larry suffered the following:

- Unnecessary pain and suffering associated with the symptoms of metastatic melanoma. A PET scan in July 2010 revealed that the cancer had spread to his groin, pelvis, leg, ribcage and right lung. By November 2010 there was a significant visual deterioration and he developed very slow, slurred speech, a feeling of pressure in his head, fatigue and persistent nausea. The cancer spread to his brain and there was subsequently a progressive decline in functions. In addition he continued to suffer from painful, re-occurring

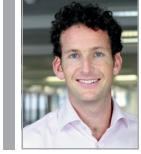
skin metastasis on his torso, back, arms, head and face.

- A post-operative seroma in his groin which required daily dressing and draining and severe lymphedema.
- Painful post-operative radiotherapy. His mobility was severely restricted to the extent that he was unable to dress himself without assistance and he lost all confidence with walking, hardly leaving the house. By December 2010 he had become bedbound.
- Post-operative chemotherapy resulting in severe constipation, painful mouth ulcers and a constant feeling of nausea.
- Death on the 5 January 2011, aged 72.

Sam Critchley issued court proceedings in January 2014 and proceedings were served thereafter. We secured damages of £50,000 in June 2014.



Coroner heavily critical of the Priory Hospital following death of 15 year old boy



Mark Bowman was instructed by Justin and Joanne Werb to represent them at the inquest into the death of their son, George, who passed away

on 28 June 2013, whilst under the care of The Priory Hospital in Southampton. The inquest was heard on 6th and 7th October 2014 at Devon County Hall.

George, aged 15, was admitted to The Priory Hospital, Southampton, on 23 May 2014 suffering from depression. Before George's admission he had been treated at The Huntercombe Hospital in Maidenhead where he had, in particular, been concerned over the medication he was being prescribed. George held delusional beliefs that, the medication he was given, was giving him adverse

side effects.

On 24 May 2013, the day after being admitted to The Priory, George was placed on 1:1 observations. Over the course of the following weeks his observations were reduced and his medication regime increased and on 27 June 2013 George was prescribed the anti-depressant Fluoxetine for the first time at The Priory. George had previously had an adverse reaction to the drug whilst being treated at Huntercombe Hospital. Within a couple of hours of being given the drug, and without a risk assessment being conducted as to whether or not George might react to the drug, he was allowed out on home leave.

In the early hours of 28 June 2013 George left the family home, walked

to the local railway line, and stepped in front of a train. His father, Justin, discovered the body.

At the inquest into George's death, evidence was heard from George's parents and the staff responsible for George's care at the Priory. In particular, evidence was heard from the psychiatrist with overall responsibility for George's care.

Directly conflicting evidence was heard as to George's mental state and presentation in the key last few days leading up to his death. Specifically it was alleged that George's parents insisted on George being allowed on a weekend leave and that they did not trust the psychiatric services.

Assistant Coroner, Lydia Brown



George



summed up the position in providing her conclusion, in which she noted that it was clearly recorded that George was very suicidal during the afternoon of 24th June 2013, information that was set out in every handover sheet thereafter. In addition George's parents made it clear that they were concerned that George was suicidal at this time.

The coroner accepted the parents' evidence that such concerns were expressed to staff but not acted upon. In addition, due to inadequate internal communications and a failure to properly connect with George's parents, this meant no proper risk assessment was conducted prior to George departing on 27th June 2013.

The coroner refuted any suggestion that George's parents would have taken George home had they been in possession of the full facts and commented that she could not blame them for failing to trust the psychiatrists' services. She commented that the parents were doing their best for George and had the right to expect the same from those entrusted with looking after George.

Ms Brown also noted a lack of psychiatric support at the Priory, in the form of a junior doctor, as well as the lack of a clinical psychologist. The coroner also referred to the Consultant Psychiatrist's admission that he did not make any clinical notes during George's admission

and therefore had to rely on his recollection of events in giving evidence at the inquest; recollections which she found, in part, contradictory and upon which reliance could not be placed. As a result of the above, ultimately the information used to assess George's level of risk was incomplete and did not reflect the actual situation.

Following the inquest, **Mark Bowman** stated:

"This is a perfect example of a case where liability should be admitted at an early stage, yet despite the coroner's findings, no admission of liability has been received as yet and a claim on behalf of George's estate, and his father as a secondary victim, is ongoing."

Mr and Mrs Werb commented:

"Losing George is an unimaginable loss to our family, our pain is beyond expression. To lose our son who had so much more to accomplish and live for is totally heart-breaking"

Substantial damages awarded after Tesco pharmacy prescription error causes renal failure



Mrs J had been taking calcium supplements following a thyroid gland removal over a number of years. In February 2011 she presented a

prescription to the pharmacy at her local Tesco. The prescription was for 0.25mg tablets of Alfacalcidol. She received 39 boxes of the tablets and had been instructed to take seven tablets per day.

Mrs J started taking the tablets at the beginning of April 2011 after her previous supply of medication had been completed. Soon after she became confused, was unable to concentrate and needed to drink a lot of water. Three months later, Mrs J vomited, and continued to do so frequently for approximately one month. She remained in bed throughout this time. She was very confused and was hallucinating. She attended her GP and was prescribed an anti-emetic. On one occasion, an ambulance was called to assess her.

On 1 August 2011 Mrs J collapsed. An ambulance was called again and she was admitted to the Royal London Hospital. Intravenous fluids were commenced. Her calcium levels were noted to be 4.79mmol/l. She was transferred to Barts and the London NHS Trust two days later. She remained in hospital, receiving intravenous fluids, until 7 August 2011. When she was discharged from hospital she continued to feel dizzy and her head felt fuzzy.

On 22 August 2011 Mrs J was readmitted to the Barts and the London NHS Trust. Intravenous fluids were recommenced. On 25 August 2011 it was discovered that Mrs J had been given 1mg Alfacalcidol



tablets instead of 0.25mg tablets. Because of this prescription error she had taken around 420 tablets of the incorrect dosage. She required further treatment in hospital before being discharged on 31 August 2011.

Mrs J sustained hypercalcaemia leading to acute renal failure, causing dehydration, vomiting, confusion and hallucinations. She had to be admitted to hospital on two occasions for intravenous fluids.

After discharge from hospital, Mrs J continued to suffer from tiredness, fatigue and poor concentration. She had to take a month off work and thereafter struggled with the physical requirements

of her job necessitating a phased return. She continued to feel tired and lethargic until the end of 2013. During this period her prescription for Alfacalcidol was changed on several occasions to achieve the appropriate dosage again. She was extremely tired, struggled to manage housework and shopping and was restricted in her social life.

We wrote to Tesco shortly after receiving instructions from Mrs J, and the Defendant admitted liability in the matter. Proceedings were issued and we were able to enter into judgement, with damages to be assessed. After a short period of negotiation, we were able to successfully settle Mrs J's case.

Mrs J's daughter said after the case was settled:

"Mum and I just wanted to thank you once again for all the work and support in dealing with our case, we really appreciate everything you have done."

Mother recovers £114,780 after nursing failure at John Radcliffe Hospital



A Doctor instructed Jonathan Zimmern, on behalf of his mother, Mrs M, to investigate a claim for negligence in relation to the treatment that she received at the John Radcliffe Hospital in April 2010.

Mrs M fell at home on 2 April 2010. She fractured her right femur and attended the John Radcliffe Hospital for an operation to repair it. In the days after her operation the nursing staff allowed her to fall from her hospital bed on several occasions a result of which she developed a haematoma at the site of her operation. This became infected and she required two further operations to washout the infection and a prolonged three month stay in hospital. Even though she took antibiotics for nearly six months, the infection and the damage it caused to her hip led to her re-admission and a hip replacement in November 2010. In total, she spent six months in hospital.

It was accepted that, after her operation, Mrs M was confused and had already attempted to get out of bed on previous occasions. Indeed, the surgeon's operation note records that she kept trying to leave the operating table and the nursing notes make numerous references to her disorientation. Notwithstanding this she was left unsupervised and was placed in a bed where she could not be seen from the nursing station. As a result she was able to remove her wound dressing unobserved twice but was still not supervised.

Following a complaint, the hospital accepted that Mrs M was collected from the recovery area at 23:20 and was attended by a nurse at 00:15, 01:15 and 01:35. However, no bed rails were attached to her bed and she was found having fallen out of bed at 02:10.

In the following four week period, and despite the injuries caused during the first fall and recognition that Mrs M remained at risk of falling, she fell on three further occasions. The cumulative effect of these further injuries caused additional pain and suffering.



Prior to her fall, Mrs M had been a lively, self-caring 81 year old who lived alone and was still driving. Although she had mild memory impairment and osteoporosis she was otherwise well. After she was finally discharged from hospital following her hip replacement on 24 December 2010, she had very limited mobility, significant muscle wastage, was unable to live entirely independently and was unable to manage her own affairs.

Jonathan Zimmern, instructed a Geriatrician, an Orthopaedic Surgeon and a Nursing Expert to comment on Mrs M's case. Jonathan wrote to the Trust in January 2013 outlining the criticisms of the care that Mrs M had received. In particular he argued that as a result of her injuries Mrs M would require formal residential

care three years earlier than she would otherwise have required.

The Trust responded saying that there were no additional precautions that were not already in place on the night of Mrs M's fall that would have prevented her from falling.

As a result of the Trust's refusal to accept responsibility for Mrs M's injuries, Jonathan issued proceedings in July 2013. Following further discussions, the Trust eventually admitted liability and made an offer to Mrs M of £80,000 in November 2013.

Further negotiations followed and Jonathan was able to secure a settlement of £114,780 in August 2014.

Substantial damages awarded in a claim against Portsmouth Hospitals NHS Trust following negligent knee surgery



Mr Hall instructed Jonathan Zimmermann in December 2012, to investigate a claim against Portsmouth Hospitals NHS Trust following the

injuries that were caused to him during knee replacement surgery performed on 5 November 2008.

In 2008, Mr Hall was close to completing his training to become a professional sailor. He began to suffer problems with his right knee and he was referred to the Queen Alexandra Hospital in Portsmouth for a right Oxford medial unicompartmental knee replacement.

The operation initially appeared to be successful but Mr Hall began to suffer problems, particularly after his grandson jumped on his right knee in Christmas that year. This caused an abnormal protrusion on the anterolateral aspect of the right knee. Mr Hall made numerous complaints about loss of function and pain over the following months, but he was ignored by his surgeon. He suffered from significant mobility problems and pain and as a result was unable to start his new career as a professional sailor.

His complaints went unanswered and eventually Mr Hall contacted the NHSLA (National Health Service Insurers) personally. The NHSLA obtained their own report from a Consultant Orthopaedic Surgeon in October 2012. The report concluded that the original surgery had not been performed to an acceptable standard, the tibial component had been undersized and there was a femoral mal-alignment in relation to the tibial component. Furthermore, the report indicated that Mr Hall's surgeon should have investigated Mr Hall's concerns. Had an examination taken place he would have found that Mr Hall had ruptured his anterior cruciate ligament and required further urgent treatment.

Mr Hall instructed **Jonathan Zimmermann** to investigate the damage that the delay caused. Jonathan obtained a report from an orthopaedic surgeon who reported that Mr Hall's right leg remains fundamentally unstable and painful. He suffers problems in his left knee which cannot be addressed until his right knee is fixed. If the ACL deficiency had been detected in April 2009, Mr Hall would have received an MRI followed by an urgent revision of the unicompartmental knee arthroplasty. This would have saved



Mr Hall 19 months of pain, instability and suffering. This delay has resulted in recurrent subluxation/dislocation of the meniscal polyethylene which has probably caused soft damage.

The NHSLA initially offered to settle the claim for a few thousand pounds. However, following his investigations and negotiations, Jonathan was able to reach an out of court settlement for a substantial sum for Mr Hall on 12 May 2014.

Mr Hall had this to say about Jonathan:

Jonathan was different from the start, wanting to meet and talk face to face rather than my having to answer a list of barely relevant, prepared and generic questions asked of me over the 'phone by a "Trained Legal Adviser" who was unable to answer my own questions. He was never too busy to answer his 'phone, nor was he invariably "in a meeting" if I had questions, not that I ever had many questions as I was continually updated on the rapid progress that was now being made, progress which saw the NHSLA almost scurrying to settle my claim and settle it very much to my satisfaction."

£1million recovery for 82 year old grandmother who lost her leg due to negligence by Queen’s Hospital Romford and Basildon Hospital



On 27 March 2013, Paul McNeil issued proceedings on behalf of Irene who, at that time, was aged 82 years.

Sadly, Irene suffered an above knee amputation to her right leg, in January 2013, which we alleged was due to the negligence on the part of both hospitals. At the time proceedings were issued, the Defendants had offered to settle the claim in the sum of £3,500. In November 2014, the case settled for almost £1m three days before the trial.

Irene was admitted to the Basildon Hospital on 26 October 2011. She had been complaining of pain in her right knee. In September 1996 she had undergone a right knee replacement. On admission, she was noted to have a high temperature, be clammy and have elevated markers for infection. She was given intravenous antibiotics to fight the infection.

From 31 October her treatment began to go badly wrong. A mistaken entry in her notes suggested that she had “lung cancer” (in fact, she had suffered from a dermoid tumour many years previously). The error was corrected by Irene’s son (a GP). Nevertheless, a CT scan of the chest was performed on 2 November but the Request Form incorrectly stated that she had lung cancer. The radiologist reported the CT scan as showing metastatic lesions notwithstanding that there was a clear differential of bacterial pulmonary emboli - consistent with sepsis caused by the knee infection.

A consultant microbiologist was asked to consider the history and he concluded that, given the evidence of bacterial infection in the blood cultures, the lung lesions were likely to be “septic emboli”. Incredibly and very sadly, this advice was ignored and later, overruled in a review of the CT scan by 2 consultant radiologists.

Irene was then referred to the palliative team and she was discharged home to die on 8 November. She was expected to succumb before Christmas 2011. She and her family were obviously extremely distraught, but had trusted the advice of the treating doctors at Basildon Hospital.

Between November 2011 and March 2012, Irene was treated as if she had terminal lung cancer. The underlying septic condition remained largely untreated.

The family were surprised that Irene’s condition did not deteriorate as they had been told to expect. She was confined to bed, but there was little evidence of the “cancer” progressing. Eventually, they sought a second opinion from a private consultant physician. The lung CT scan was repeated and this excluded the diagnosis of lung cancer because it revealed her lungs were completely normal.

She was then referred to the Queen’s Hospital in Romford (the second Defendants) for treatment of her infected knee prosthesis on the right side. Even then, the investigations and treatment were very slow. Irene required the infected prosthesis to be removed quickly so as to avoid significant flare up of the infection. The revision surgery was not listed until 11

January 2013 (by which time, the knee had become badly infected and very painful). Removal of the prosthesis did not improve the, by now, rampant infection and on 2 February 2013, a trans femoral amputation of the right leg took place.

The evidence of medical negligence was strong but the defendants’ legal team took every point possible and failed to recognise just how significantly the injuries caused by the negligence had affected Irene and her family. Three days before the trial, the Defendants finally made a realistic offer to settle the claim. The compensation (some of it paid by way of an earlier interim payment) allowed Irene to extend the ground floor accommodation at home and to pay for professional care and therapies.

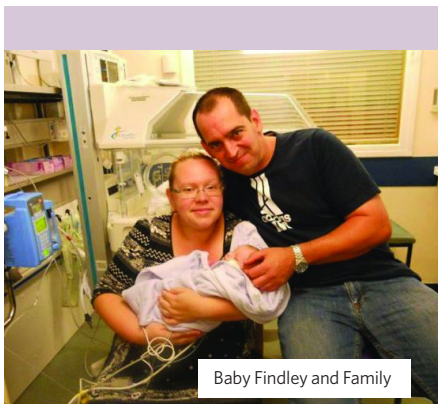


After the case her GP son said:

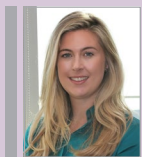
“Paul performed brilliantly on behalf of our family, always listening and keeping us up to date with the case and making a sensible case for damages. It does not give Mum back her life, but the settlement means we as a family know that her future care is guaranteed financially.”

£850,000 recovered for patient of North Devon District Hospital, following delayed treatment of compartment syndrome

Estimated recovery in excess of £5 million after catastrophic birth injury leaves baby Findley with cerebral palsy



Baby Findley and Family



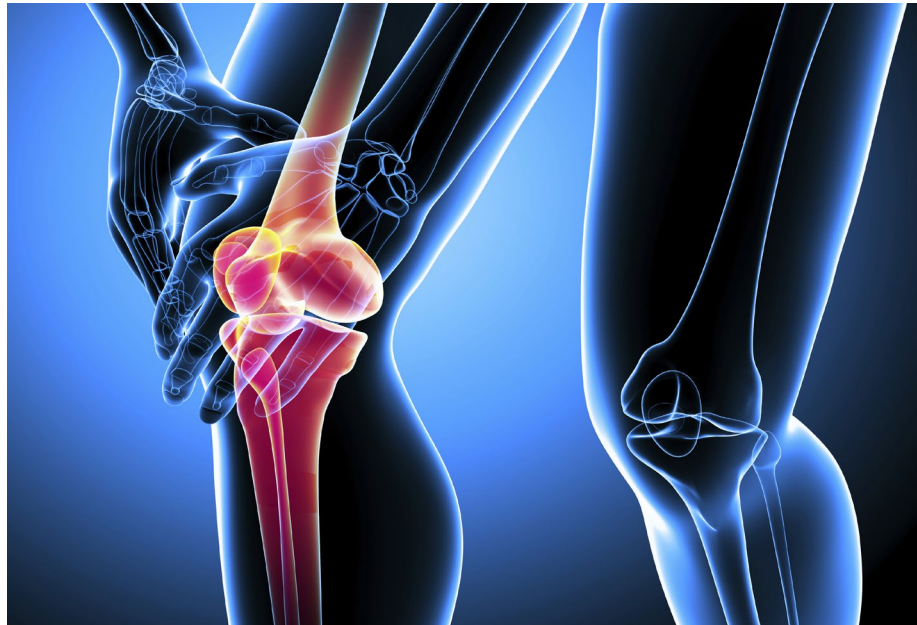
In August 2010, the midwives at the Stoke Mandeville Hospital repeatedly and negligently misclassified the CTG trace resulting in a 10 and a half hour delay in delivery.

Findley suffered catastrophic brain injury caused by deprivation of oxygen. He also sustained severe damage to his kidneys causing renal hypertension for which he may require dialysis and transplantation later in life.

Iona Meeres-Young obtained Judgment for Findley in June 2014 and Findley's mother and father's psychiatric claims were settled shortly thereafter.

After obtaining judgment for Findley, Lisa commented:

"Iona works tirelessly on our case and is always available even when I call her at weekends. Nothing ever seems like too much trouble and she has been a pillar of strength during a difficult few years. We couldn't ask for anyone better to fight Findley's corner"



Jonathan Zimmern recovered £850,000 for, Mr Darren Stuart, from North Devon Healthcare NHS Trust following the treatment Mr Stuart

received at North Devon District Hospital after an RTA in June 2005. Whilst in hospital, there was a significant delay before Compartment Syndrome was diagnosed. This delay caused irreparable damage and led to an amputation of Mr Stuart's right leg four years later.

The case was particularly difficult as Mr Stuart had previously been awarded compensation for injuries sustained in the original road traffic accident. The case therefore involved first of all demonstrating that Mr Stuart had received negligent treatment, and then showing that the delayed treatment caused injuries over and above those caused by the original accident.

Before the road accident, Mr Stuart was a very fit and healthy young man who ran his own business as an osteopath and was in the Territorial Army. On 2 June 2005, he was involved in a road traffic accident on Exmoor and suffered substantial injuries to his right leg. He underwent an operation in the early hours of 3 June 2005. Throughout the following day, doctors at the North Devon District Hospital failed to diagnose his developing Compartment Syndrome.

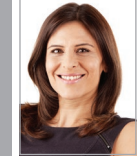
The diagnosis was not made until that evening, after which he underwent an emergency operation to release the pressure in his right leg caused by the Compartment Syndrome.

Unfortunately, due to the delay in diagnosing and consequently treating Mr Stuart's condition, he required numerous avoidable operations and suffered severe pain and disability. This ultimately led to the amputation of his right leg in August 2009.

Jonathan Zimmern was instructed by Mr Stuart in summer 2012. The Hospital Trust argued that Mr Stuart's claim should be struck out because it constituted a double claim for compensation as a result of Mr Stuart's initial claim for the road traffic accident. Jonathan instructed Leading Counsel for the hearing in the High Court in July 2012, at which the Defendant's application was denied.

Jonathan then instructed an orthopaedic expert to consider the case and argued that but for North Devon District Hospital's delay in diagnosing and subsequently treating his Compartment Syndrome, he would only have had to undergo three operations and would not have had his right leg amputated due to the pain. He was able to negotiate an out of court settlement of £850,000 on 7 April 2014, just one week before the trial was due to begin.

£200,000 recovered after negligent knee replacement causes further fractures at Kettering General Hospital



In July 2008, the Claimant, then aged 53, underwent a right total knee replacement at Kettering General Hospital. During the operation Mrs Patel suffered a fracture of her right femur.

It was noted on a pre-operative x-ray that Mrs Patel had a deformity (bowing) of the bottom part of her thigh bone which would make the operation technically more difficult. The operation note referred to the bowing of Mrs Patel's femur and that "notching of femur was inevitable owing to deformity of bone."

Mrs Patel was in a lot of pain after the operation. She was unable to weight bear. A post-operative x-ray of her right knee was taken and reported a fracture in the femur above the knee replacement prosthesis. She underwent a second operation during which the fracture was fixed with a pin and plate.

Unluckily Mrs Patel fell two years later, in November 2011, and suffered a further peri-prosthetic fracture of her right femur, just above the metal plate in her thigh bone. She was admitted to the same hospital and underwent surgery to reduce and fix the fracture with a metal plate.

Sam Critchley took up the fight for Mrs Patel, after being personally approached by her niece. We obtained Legal Aid to fund the claim. We secured expert evidence from a leading orthopaedic expert who said the surgeon performed the knee replacement surgery negligently in July 2008 by:

- failing properly to take into account the deformity of the Claimant's thigh bone;
- failing properly to angle the surgical cuts so as to avoid notching of the bone (making it more likely to fracture); and
- having caused notching to the femur, failing to take appropriate steps to achieve secondary stability of the femur and prevent subsequent fracture by using a different component to bypass the defect and achieve stability or by applying a supplementary plate to protect the femur.



The hospital strongly defended the claim, arguing that the surgeon did take account of the bone deformity and performed the operation correctly. The Defendant argued that the operation was technically very difficult because of the femur deformity and some notching of the bone was necessary and unavoidable. The Defendant also argued that the complication of peri-prosthetic fracture - which was communicated to the Claimant during the consenting procedure - was inherent in the nature of the Claimant's condition and complexity of the knee operation and there was no failure to take appropriate steps to prevent subsequent fracture.

The Defendant specifically denied that the fracture two years later was in any way related to the initial surgery and argued that after a successful total knee replacement there is normally a high risk of fracture.

Mrs Patel continues to suffer from marked pain and discomfort in her right knee, including when sitting and at night. Her knee gives way when she walks and her walking distance is now restricted. She

mobilises with a stick. These problems are compounded by the fact that Mrs Patel suffers from widespread osteoarthritis, affecting her hands, shoulders and her left knee. What was most upsetting for Mrs Patel is that she was unable to return to work. She had worked all her adult life and this gave her independence. As a result of the negligent surgery Mrs Patel developed moderately severe depression.

The Defendant argued that her inability to work and daily restrictions were due to her underlying osteoarthritis and nothing to do with the alleged negligence. They suggested she had not been working before the operation in July 2008 and would never have returned to work in any event.

We served court proceedings in May 2012. A full Defence was received in September 2012. A trial date was fixed for March 2014 and we settled what was a hard fought case, two months before trial, in January 2014. Samantha secured £200,000 damages for Mrs Patel which went some way in removing the anxiety that she faced of an uncertain future and retirement.

Mrs Patel said, after the case:

"I was so very happy with the job that Samantha did on my case. She got more for me than I could have hoped for. Thank you"

Quadriplegic teenager secures life changing settlement worth £14 million from The Royal National Orthopaedic Hospital



Jonathan Zimmern has been able to secure a settlement potentially worth over £14 million for Rebecca Ling, who was left quadriplegic and unable to breathe without a ventilator following a routine operation to correct the curvature of her spine at the age of 13.

Rebecca Ling, from Wickford in Essex, was admitted to The Royal National Orthopaedic Hospital in 2006 to undergo an operation which would correct the curvature of her spine (scoliosis), a condition which was caused by a genetic condition - Prader-Willi Syndrome.

During the operation Rebecca was connected to a monitor to detect nerve signals in the spinal cord. The purpose of these signals was to alert the surgeon to the possibility that damage was being done to the spinal cord and to allow him to take remedial action to ensure that any such damage was not permanent. During the surgery, the signals dropped significantly on two separate occasions. On the first occasion, the surgeon stopped the procedure, gave appropriate drugs and took steps to check whether the drop represented a technical fault with the equipment. As a result, the signals returned to an acceptable level and he continued the operation. When the signals dropped on the second occasion - this time by 80-90% - he chose to continue with the procedure without further consideration.

When Rebecca woke up, she was initially unable to move her arms. Over the following hours, the paralysis spread to her legs and then her chest until she was no longer able to breathe without a ventilator. She had previously enjoyed a very active life but now requires, round-the-clock care from two carers.

Rebecca's parents, Julia and Andy Ling, instructed **Jonathan Zimmern** in a claim against The Royal National Orthopaedic Hospital. The claim was funded by Legal Aid and the case went to trial in January 2012, when the High Court ruled that the surgeon had been negligent in continuing to operate once the signals dropped so dramatically for the second time. The hospital tried to appeal this decision but the permission was finally refused in January 2013.

Since the High Court's decision, Jonathan has worked to quantify Rebecca's claim so as to ensure that she will have enough money to pay for all of the care and support she so desperately needs. He instructed eight experts to assist including experts in neurology, care, occupational therapy, accommodation, technology, physiotherapy and speech & language therapy. Rebecca's neurologist argued that she was likely to live for 33 years, not least because of the extraordinary care that her

parents had given to her.

The Trust's legal representatives argued that Rebecca would have needed some form of care in any event due to her Prada-Willi Syndrome and also argued that Rebecca's likely life expectancy was only in the region of 17 years. Jonathan settled a lump sum payment of £2,777,261 and annual payments of £352,494 for the rest of Rebecca's life.

These sums will ensure that Rebecca receives the care and support she needs as well as allowing her to move into an appropriate house and live as independent life as possible. The money will also mean that her parents can stop being nursing carers, and go back to being what they should have been - Rebecca's mum and dad.

Andy and Julie Rebecca's parents commented on the case

"This has been absolutely devastating for our family. Before the operation our daughter was a happy, active child who lived a full life, enjoying dancing and horse riding. Now she is unable to move, or feel anything from the neck down. She cannot breathe without a ventilator and needs constant care. We were relieved that the Judge ruled that the hospital was at fault but we were devastated that despite his decision the hospital sought an appeal. Our daughter had to endure an entire, awful year in hospital after she was paralysed, followed by seven more years whilst we tried our best to cope with her at home - financially and emotionally - and fight for compensation. We only hope that the hospital have learnt lessons from what happened to our daughter and that future spinal operations will be undertaken with more caution."

£55,000 recovered after baby Lindsey suffers catastrophic brain haemorrhage and death at the hands of University College London Hospitals' obstetric team



K fell pregnant with twins in early 2010. The pregnancy was relatively straightforward with an estimated due date of 14 January 2011.

At 36 weeks K's waters unexpectedly broke at home and as a result she went into hospital early on 14 December 2010. The mother and the twins were monitored initially by ultrasound and later by a fetal heart monitor. It was thought that one of the twins might be in breech position and the possibility of a caesarean section was raised.

K was eventually taken to theatre at around 7pm with no vaginal examination being performed on the ward or in theatre before the caesarean operation was begun. The previous vaginal examination had been performed 3 hours earlier.

Lindsey was born in very poor condition – she was not breathing and was immediately taken for resuscitation. In the meantime Jonathan was delivered well and healthy.

The birth of Lindsey had been very traumatic. She had suffered a serious head injury and it became evident that there were 5 distinctive finger marks on Lindsey's head where the midwife had been pushing from below to move her up the birth canal. Unfortunately Lindsey's skull had been broken as a result of the excessive pushing by the midwife. This resulted in a massive and catastrophic brain haemorrhage.

The injuries to Lindsey were so extensive that the parents were informed that she was unlikely to survive. Sadly, on 19 December 2010 treatment was withdrawn and after a few hours Lindsay died peacefully.

Paul McNeil wrote a Letter of Claim on behalf of the family on 15 July 2013 and by a response 6 months later the Trust admitted liability and accepted that there had been failings. In particular:

"It is accepted that there was a negligent omission of "on table" vaginal examination. It is admitted that had an "on table" vaginal examination been carried out this may have offered the opportunity of proceeding with a vaginal delivery and/or enabled the doctors to anticipate and plan for a difficult delivery of twin 1 at LSCS. Failure to perform an "on table" vaginal examination resulted in a very complicated delivery during which twin 1 suffered significant trauma to the head which caused her subsequent death"



After the case the mother said:

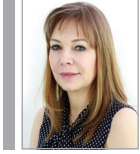
"Our family is so grateful to Paul and his team for pursuing this claim against the hospital on our behalf. We were hesitant to do so at first because we were worried that it would bring up many difficult emotions and memories. Of course it did, but Paul handled everything very professionally and sensitively. I am so glad we pursued the case because the hospital's acceptance of liability drew a line in the sand for us.

Even though I could not keep Lindsey from harm during the delivery, I was able to make sure that the hospital took full responsibility for the mistakes they made and that provided me with a sense of closure. I feel that I have done as much as I could for her and her twin brother who will undoubtedly ask many questions some day. Paul's sensitive, kind and straightforward approach helped us get the best outcome in a difficult situation."

Also, as a result of the Letter of Claim, University College Hospital apologised to the parents for the first time for the mistakes made during the delivery. This apology made a substantial difference to the family and was an important step in the recovery process.

Negotiations between the parties took place and even though the defendant did not accept the full extent of the psychiatric and physical injuries to the mother, in May 2014, the matter was settled in the sum of £55,000 plus legal costs.

£12 Million recovered in cerebral palsy claim against Newham University Hospital



Edwina Rawson successfully settled a claim on behalf of a baby boy who suffered quadriplegic cerebral palsy as a result of hypoxia during birth, for about £12 million if he lives to his life expectancy of age 49 (subsequently increased to 53.6 years in light of the Strauss updated figures).

The Claimant was severely disabled, with severe HIE (grade 3) and a dystonic form of cerebral palsy. He had developmental delay. He had no swallow and had excessive salivation that was not under control. He was nil by mouth and gastrostomy fed. His lack of swallow resulted in him requiring intrusive suctioning at very regular intervals day and night. He dribbled constantly, which interfered with his ability to enjoy life as he could not look down for more than a very short period of time before dribbling on to whatever he was doing. He required 24-hour care. He was, however, aware of his surroundings.

The claim was put on hold for a number of years, especially as the Claimant was developing cognitively better than expected. During this time, the Defendant adopted an extremely helpful approach and made a number of interim payments voluntarily, totalling £1.6 million. The Claimant benefitted enormously from the care and various therapies that were available to him in light of the interim payments and was able to attend a school that was excellent for him. He far exceeded the experts expectations. Against the odds, he even learnt to take a few steps, with a walking frame.

This young boy was an inspiration to us all. His delightful personality and zest for life won everyone over, including the Defendant's experts! He was loving and bubbly and thrived when he was the centre of attention. He was a golden-boy at school.

It had always been recognised that the Claimant would need to move schools at about age 10. The family waited to receive the opinion of the education expert in the case before deciding where they would finally live, so no claim was made during the case to purchase a property. Subsequently, the family have relocated and the Claimant started at Infield Manor School last year, and is doing brilliantly.



A round table meeting was held in the autumn of 2014. The parties were far apart at the outset, largely because the Defendant gave a life expectancy of 38 years.

The parties were able to reach settlement in this case by agreeing that not only future care and case management costs should be met by annual periodical payments, but also other heads of loss including Court of Protection costs and loss of earnings. Settlement was based upon payment of a lump sum of £3,276,000, with £125,000 for care and case management to age 14, £175,000 to age 19, and £228,000

thereafter. Further, he would be paid £18,644 per annum from age 19 onwards for loss of earnings to spend on outgoings other than care and case management and £11,000 per annum for Court of Protection and deputy costs.

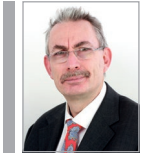
The settlement was approved at a Hearing in October 2014.

Edwina considers this case to be an example of the benefits of access to therapies from a very young age. The Claimant was encouraged to maximise his potential from a very young age, which he did and which we are sure he will continue to do.

The Claimant's father said:

“Edwina has been fantastic. Not only is she a brilliant lawyer, but she is a powerful combination of professionalism and compassion. She fought for our son every step of the way, and explained everything to us carefully and clearly. We regard her as part of the family. We will be eternally grateful to her for ensuring that our son has the happiest life possible.”

£125,000 recovered after failure to interpret fetal monitor leads to death of baby Sally at The Ashford and St Peter's Hospital



Paul McNeil was instructed by this family in connection with a claim for medical negligence arising out of the care during the pregnancy and delivery of their daughter, Sally, at St Peter's Hospital on 18 June 2008.

At the time of the pregnancy J was 38 and Sally was a very much wanted baby. Both parents are professionals working in the City of London.

In the early afternoon of Tuesday 17 June J reported to the antenatal unit at the Hospital complaining of absence of fetal movements. A fetal heart monitor was put in place and J was asked to indicate fetal movement by clicking a button on the machine. There were no movements and J was extremely concerned.

She was seen by a Registrar who examined the trace and pronounced it to be normal. She performed a manoeuvre to "wake the baby up" and left soon after with J in serious distress. The Registrar had erroneously noted three movements on the CTG and one acceleration with no decelerations.

In fact this CTG had been very abnormal and had shown sinusoidal features which are very distinctive and easily recognisable to all responsible midwives and obstetricians. Nevertheless J was sent home most definitely not reassured (as the notes had indicated). She was very worried and knew that things were "not right". She felt no further fetal movements during the afternoon and evening even though she was checking regularly. Anxious and distressed she returned to hospital at around 10.30pm.

A midwife checked the previous CTG and clearly was worried that it was abnormal. A further CTG was arranged and a doctor came to urgently review. The trace showed a similar sinusoidal pattern and steps were taken to initiate an emergency caesarean section. Sally was delivered at around 01:15 hrs in extremely poor condition. The evidence on the trace had been of a massive feto-maternal haemorrhage and notwithstanding extensive support and treatment in the special care baby unit, sadly Sally died about 12 hours later.

The loss of Sally was devastating for this family.



After the case Richard Sally's father, a partner in an international law firm, said:

"Paul helped us with a sensitive case for my wife and I. What marked Paul's ability out for us and we particularly valued was just how effective he was at building up what was needed to develop a successful claim and providing experienced guidance on driving the matter to a conclusion without taking unnecessary diversions.

I think when as a client you are dealing with thinking about an event which may be extremely distressing to go over again and again with lawyers and other professionals, to have Paul's perfect blend of efficient action, and fierce representation his client's interests, tempered by wisdom of advice born from years of experience is invaluable."

An internal investigation by a consultant at the hospital soon recognised that the initial trace had strong features of a sinusoidal pattern which was likely to be evidence of an ongoing massive feto maternal haemorrhage. Ironically the midwife who saw J in the afternoon had spotted this but she was overruled by the Registrar.

We were instructed in place of previous solicitors who had failed to progress the

matter substantially. Since breach of duty of care was likely to be admitted and the main issue was likely to be causation of injury i.e. what would have happened had steps been taken to deliver Sally in the early afternoon we instructed a neonatologist.

The Defendant's legal team took a pragmatic approach and the matter was settled in the sum of £125,000 in early 2014 including claims for Sally herself and the parents.

£12,000 recovered for unnecessary surgery at St George's Hospital



Mrs H instructed Jonathan Zimmern to bring a claim against St George's Hospital in respect of the gynaecological surgery which she underwent

on 15 July 2010.

Mrs H was treated for a cystocele from approximately October 2008 at St George's Hospital, Tooting. She required a laser excision of a urethral prolapse on 10 February 2009, an operation to repair the cystocele on 7 July 2010, a third operation following the failure of the graft on 15 June 2011 and, finally, a fourth operation at King's College Hospital.

Following the third operation on 15 June 2011, Mrs H suffered intense pain, discomfort and urinary problems. She was informed that the surgeon had inserted a transobturator tape ("TOT"), a procedure which she knew nothing about and had not consented to. She required significant time off work, was unable to sit or stand for any length of time, suffered pain and constant pressure inside her vagina and in her right buttock and had difficulty urinating.

Mrs H received inadequate responses to her complaints to the original surgeon

and she sought a second opinion from surgeons at King's College Hospital. She underwent a fourth operation on 3 January 2012 during which a 2 cm piece of the tape was removed and the graft was repaired. She felt immediate relief from the symptoms. However, she continues to suffer from residual pain and a feeling of pressure. She is also very distressed by the aesthetic results of the numerous procedures she has undergone and she has suffered psychiatrically as a result.

Mrs H instructed **Jonathan Zimmern** to investigate her claim. Jonathan instructed a consultant gynaecologist to comment

on the care that had been provided to Mrs H. The expert confirmed that that a TOT had been unnecessary given Mrs H's symptoms and the clinical findings at the time. Further Mrs H had not been given appropriate information in relation to the procedure.

Jonathan wrote a Letter of Claim to the Trust in November 2013 whilst also including an offer to settle the claim. Following tough negotiations with the Trust, Jonathan was able to secure £12,000 for Mrs H in June 2014.

Mrs H had this to say after her case concluded:

"It was such a traumatic event but Jonathan was so discrete and encouraging and I never once felt uncomfortable sharing intimate information with him. I felt supported through the whole process and appreciated his professional but sympathetic approach. I can't thank him enough for the positive outcome."

£200,000 recovered after negligent podiatric surgeon causes catastrophic consequences



Manori Wellington was instructed by Dr K who had developed a painful bunion in his left big toe and a deformity in the second toe on the same foot. He was aged 62, by which time the deformity had started to affect his ability to walk and work as a doctor in private practice. Initially he went to the Royal Gloucester Hospital where he was informed that any surgery would mean that he would have a long period of recovery.

He was then referred by his Podiatrist to a Podiatric Surgeon Mr X, to advise on any alternative surgical treatment. K and his wife, were led to believe that Mr X was able to perform a new surgical technique and that the post-operative recovery would be much shorter. K left the meeting believing that by paying privately he would be receiving better care.

The surgery took place in June 2006. The bunion in the big toe was corrected by metatarsal osteotomy with internal fixation and the second toe was amputated. There was a dispute about why the toe had been amputated and whether it was infected as at the initial appointment a different procedure had been planned.

K was discharged from hospital on the same day after the operation. At home he followed the post-operative instructions. He was expecting to return to work within two or three weeks. In fact, he did not get better but

got worse. He developed ongoing problems in the left foot because of the surgery and it was later discovered that the internal fixation had fallen apart. This resulted in the foot healing in a deformed position.

It was alleged his business failed because of the surgical negligence and there were catastrophic consequences to him and his family. He became very depressed and developed other medical problems. K had not yet earned a profit on his business prior to the negligence. K also had pre-existing co morbidities and subsequent to the negligence he developed a number of medical issues, some of which we were able to attribute to a pain disorder. A significant proportion of the value of the claim related to care and loss of earnings.

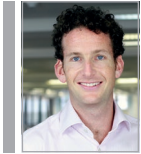
K instructed **Manori Wellington** to investigate his claim. After obtaining expert evidence from orthopaedic and podiatric surgeons. Mr X defended the claim and made a very low offer of £22,500 to settle early on. This offer was subsequently repeated several times.

Sadly K died in April 2012, due to an unrelated event, shortly before the date fixed for trial. The claim was continued by his wife after his death and a successful settlement of £200,000 was obtained which included loss of earnings, care and other expenses incurred whilst K was alive.

At the end of the case, J commented:

“Manori genuinely cared. There were many complexities to navigate and Manori left no stone unturned. It was a very difficult time for the family and we could speak with her openly at all stages of the case. My husband and I were heartened by Manori’s tenacity and her personal touch.”

£200,000 compensation recovered against Harley St specialist following misdiagnosis of recurrent cancer



Mark Bowman was instructed by David in connection with a claim against a leading Harley St oncologist following a misdiagnosis of recurrent rectal cancer in February 2010.

In 2008 David was treated for rectal cancer at The London Clinic. He made a good recovery, but in early 2010 repeat scans were suggestive of a tumour recurrence. David was seen by the oncologist that had previously treated him in 2008, who diagnosed David as suffering from a recurrence of his rectal cancer. Repeat chemotherapy, including use of the drug Bevacizumab, was commenced in February 2010, and continued until the end of April 2010.

At the beginning of May 2010, David was admitted to The London Clinic acutely unwell, where he required extensive surgery to his pelvis and bottom. As a result he was diagnosed as suffering from a significant rectal infection. He was categorically not suffering from, and had not been suffering from, a recurrence of his rectal cancer.

Due to the severity of the infection, which had been made worse by the delay in treating it, by administering chemotherapy, which weakened his immune system, and by prescribing Bevacizumab, which has a known side effect of gastrointestinal perforation and exacerbating any fistula, David required multiple surgeries, and remained in hospital until September 2010.

David required major resection to his right buttock and has been left with permanent bilateral foot drop due to the nerve damage sustained during the life saving surgery which was required due to the delay in diagnosing the infection. David has also been left with a permanent stoma and extensive unsightly scarring. David requires specialist aids and equipment to help him in his daily life, adapted rental accommodation which is suitable for him due to his disabilities, and care to assist him with many daily tasks.

David instructed **Mark Bowman** to investigate a claim on his behalf. It was alleged that the diagnosis of recurrent cancer was negligent. In particular, during the period February to April 2010, it was alleged that the oncologist failed to discuss David's case in the context of a multidisciplinary team meeting, failed to acknowledge that



Mark commented:

“This was an unusual case, as frequently we see cases where there has been a delay in diagnosing cancer, as opposed to incorrectly misdiagnosing someone with cancer. The Defendant raised some unusual arguments, including that there was no need for a multidisciplinary team meeting in David's case, as he was in the private sector and therefore that NHS standards did not apply. Ultimately the award of compensation represents a good outcome and I wish David all the best for the future.”

David's blood test results, which included abnormal neutrophil counts and C-reactive protein (CRP) (both of which are indicative of infection), and failed to organise further tests to confirm the diagnosis prior to commencing chemotherapy, involving the use of the drug Bevacizumab.

The Defendant admitted that David did not have recurrent cancer and that it was negligent to prescribe Bevacizumab, given David's previous medical history. All other allegations were denied, and it was specifically denied that David was left with a permanent stoma as a result of the alleged or admitted negligent treatment.

The trial in David's case was listed for April 2015, but in December 2014, following negotiations with the solicitors for the Defendant, the claim settled for the sum of £200,000. This sum compensates David for his pain and suffering, for his past expenses, and the expenses he will be likely to incur in the future. It represented a discount on the full value of the claim as unfortunately, unrelated to his claim, David suffered deterioration to his health in 2014, reducing his life expectancy.

At the end of the case, David said:

“Thank you Mark for all the time and effort you put into my case on my behalf. I really do not think I could have asked for more.”

**Paul McNeil**

Head of Personal Injury and Medical Negligence

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Paul heads the personal injury and medical negligence department and has specialised in claiming on behalf of victims for over 20 years. He is a member of both the Law Society and AvMA clinical negligence panels. He is responsible for High Court Users group and frequently writes and lectures on the subject.

**Samantha Critchley**

Partner

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Samantha has over a decade of experience acting for Claimants in medical negligence claims. She has expertise in acquired brain injury cases involving adults and children. Samantha is on the AvMA clinical negligence panel and is a member of the Association of Personal Injury Lawyers (APIL).

**Edwina Rawson**

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Edwina is a partner in our medical negligence team. She is on the Law Society's clinical negligence panel and is a member of the Association of Personal Injury Lawyers (APIL). Edwina gives regular presentations to AvMA and APIL.

**Mark Bowman**

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Mark pursues cases on behalf of victims of medical negligence. A member of the Law Society clinical negligence panel, Mark is also a senior litigator at the Association of Personal Injury Lawyers (APIL).

**Iona Meeres-Young**

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Iona is a partner in the medical negligence team at Fieldfisher. She is on the specialist Law Society Clinical Negligence Panel, a member of AvMA and is an accredited expert in acting for the victims of medical accidents.

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Manori Wellington has specialised in Claimant medical negligence claims for over 15 years. She is a member of both the AvMA and Law Society clinical negligence panels. She has recently joined the Fieldfisher medical negligence claims team.

**Jonathan Zimmern**

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A barrister, Jonathan acts for those injured through negligence or accidents. Jonathan is a member of the Association of Personal Injury Lawyers (APIL) and a volunteer on the AvMA helpline.

**Caron Heyes**

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Caron has pursued medical negligence claims on behalf of patients across a broad spectrum of claim types, including obstetrics gynaecology and neonatology. Caron has a particular expertise in complex neonatal, obstetric, surgical mismanagement and accident claims.

**Arti Shah**

Associate

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Arti graduated with a first class degree in law and joined the team at Fieldfisher in 2013 having qualified in 2009. Working exclusively on behalf of Claimants, Arti has experience of dealing with a wide range of medical negligence claims and maximum severity claims, including cerebral palsy and brain injury cases.

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