Case No: HQ13X0021

Neutral Citation Number: [2015] EWHC 3540 (QB)
IN THE HIGH COURT OF JUSTICE
QUEEN'S BENCH DIVISION
CENTRAL OFFICE

Royal Courts of Justice
Strand, London, WC2A 2LL

Date: 1 December 2015

Before :

HIS HONOUR JUDGE BRIAN C FORSTER QC
Sitting as a Deputy High Court Judge

- -

Between :

MR JOHN DAVID CRAMMOND	**Claimant**
- and -	
MEDWAY NHS FOUNDATION TRUST	**Defendant**

- -
- -

Mr E Woolf (instructed by **Irwin Mitchell LLP**) for the **Claimant**
Ms S Lambertsen (instructed by **Kennedys Law**) for the **Defendant**

Hearing dates: 16th-17th, 18th and 19th November 2015

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Judgment

His Honour Judge Brian C Forster QC :

The Claim

1. By a Claim dated the 18th of January 2013 the Claimant claims damages for personal injury and other losses arising out of his medical treatment at the Medway Maritime Hospital Gillingham Kent. This is an interesting case which involves some consideration of the relationship between Accident and Emergency Departments and Same Day Treatment Centres.

Common Ground

2. The Claimant was born on the 17th February 1952 and is now 63 years of age.

3. On the 22 January 2006 at 07.27 the Claimant attended the Accident and Emergency department at the hospital. He was not seen by a doctor but was seen by a triage nurse. The Claimant was complaining of chest pain. An ECG was performed which was essentially normal.

   The nurse recorded:

   > complaint chest pain
   >
   > *CCP radiating to both arms. Worse when moving. Had pain for 4/7.*
   >
   > *relieves when passing wind.*
   >
   > *BP 193/102 P 83 O2 Stats 97*
   >
   > *Triage Code 3 Yellow*

4. The triage nurse reported to a doctor in the Department. She has no recollection of the Claimant. It is her usual practice to show the doctor the ECG and outline the information she has obtained from the patient.

5. The doctor decided that the Claimant should be streamed to the Same Day Treatment Centre which was situated in immediate proximity to the Accident and Emergency Department.

6. The nurse made an appointment for the Claimant to be seen three hours later at 10.30. The Claimant left the Accident and Emergency Department at 0.745.

7. The Claimant went home and then returned to the Same Day Treatment Centre at 10.30 where he was seen by Dr Bhagiratham, a GP, who made a diagnosis of gastritis.

8. The Claimant thereafter attended his own GP from time to time with problems including chest pain. The symptoms were considered to be gastric in nature. In 2008 the Claimant was a hospital inpatient for two days.

9. On the 22 January 2010 the Claimant noticed that his lower legs and ankles were very swollen. He contacted a doctor and was told to go to the Accident and Emergency

Department. A diagnosis of cardiac failure was made. Whilst being assessed the Claimant suffered an ischaemic stroke affecting his right cerebral hemisphere.

10. On 26 January 2010 angiogram confirmed severe three vessel coronary disease and significant impairment of left ventricular function.

The Issue

11. On behalf of the Claimant it is submitted that the Claimant should not have been streamed to the SDTC without a history being obtained and relevant risk factors identified. The course taken did not accord with acceptable Accident and Emergency practice. If such an examination had been carried out the Claimant would have been admitted into hospital where relevant tests would have been undertaken and the existing coronary disease identified.

The Evidence

12. I have heard oral evidence from:

The Claimant

The triage nurse Ms Jade Sa`Adedin

Dr A Stewart Consultant Cardiologist

Mr P Richmond Consultant in Accident and Emergency

Medicine instructed on behalf of the Claimant

Mr J Paskins Consultant in Accident and Emergency Medicine instructed on behalf of the Defendant

Professor Roger Hall Consultant Cardiologist instructed on behalf of the Claimant

Dr S Stephen Brecker Consultant Cardiologist instructed on behalf of the Defendant.

The Submissions

13. The full submissions are set out in the written skeletons provided by each side.

In summary on behalf of the Claimant it is submitted:

- the Claimant presented with symptoms consistent with an Acute Coronary Syndrome
- the Accident and Emergency doctor should have examined the patient and obtained a clear history so as to be able to begin to make a diagnosis and to enable him to identify the Claimant's risk factors for cardiac disease before deciding to send the claimant to the SDTC
- the Accident and Emergency doctor failed to admit the Claimant in order to carry out further investigations to exclude cardiac disease

- the Accident and Emergency doctor did not follow the guidance and approach set out in the hospital protocol and the medical literature

On behalf of the Defendant it is submitted that:

- in a busy hospital it is necessary to triage patients so that priority is given in the Accident and Emergency Department to those with life threatening illness

- the Claimant was not suffering from an Acute Coronary Syndrome

- a reasonable decision was made to stream the patient to the SDTC. The Claimant was not discharged. He was streamed to be seen by a doctor within three hours

- A GP at the SDTC was competent to examine the Claimant, make a diagnosis, and decide what treatment or referral was required. No proceedings have been brought against that Doctor

Discussion of the evidence and findings

SDTC

14. The SDTC became operational in 2004. It is not operated by the Defendant. It is operated by a Medway Community Healthcare. Medical treatment and examination is provided by general practitioners. The centre is intended to deal with non-acute cases. Exclusion criteria were agreed with the Accident and Emergency department and the criteria identified patients that would not be accepted by the SDTC. The criteria for chest pain excluded patients with cardiac type of chest pain highly suggestive of myocardial infarction or other acute coronary syndrome. It is noted that the SDTC is happy to accept chest pain when the most likely diagnosis is non-acute cardiac. It is clear that following triage in the Accident and Emergency Department some patients were streamed to the SDTC

15. Ms Jade Sa`Adedin, the triage nurse was an experienced nurse. She gave her evidence in a careful manner. She cannot recall the Claimant because she sees many patients. She told me that you learn by experience the type of questions to ask. It was not her purpose to obtain a full history from the Claimant and it was not her responsibility to decide upon a treatment plan. She confirmed that she did make the record already outlined. When cross-examined she conceded that she was unable to say what questions she asked about past history. She accepted that she did not ask if or how the pain had differed before attendance at hospital. She asked about the level of pain at the time of her assessment. She was unable to recall whether the Claimant had been sweating at the time but such a presentation was not recorded.

16. The Claimant is a very pleasant man who is clearly trying to recall events from some time ago at a time when he was unwell. I find him to be hard working and not someone who would ordinarily attend hospital. He said that he could remember the circumstances at the time of his visit to the Accident and Emergency Department. He told me that he had pain in his chest like someone sitting on him and his wife had to help him to take his top off. In cross examination he said that he thought was going to die and referred to feeling "like a belt around your chest getting tight." He described how his arms felt heavy. In his witness statement the Claimant described telling the

triage nurse that "he could not breathe". When cross-examined he said that he could not recall saying that he could not breathe. His recollection was that he was sweating at the time of the assessment.

17. It is useful to consider the history recorded at the SDTC. The history includes a reference to *tightening not in the centre of the chest.*

18. The triage nurse followed the recognised procedure and an ECG was performed. She then reported to a doctor. The doctor on duty has not been identified but was probably a senior house officer

19. The Accident and Emergency doctor considered the information supplied by the triage nurse and the ECG and made the decision not to examine or see the patient and advised that the Claimant be streamed to be seen at the SDTC.

20. Although the Claimant was not seen for three hours Mr Richmond stated that this is not of causal significance.

21. In my judgment the Claimant did attend hospital in circumstances where he thought he was experiencing a heart attack. I accept the circumstances were so out of the ordinary that the Claimant has a good recollection of them. Furthermore I was impressed by the willingness of the Claimant to make concession when he could not remember. The weight to be attached to the medical record is reduced having regard to it being so brief.

22. Having carefully assessed the evidence I make the following findings of fact;

    1) the Claimant did describe to the triage nurse that he was suffering from central chest pain and that the pain was like someone sitting on him pressing down on his chest.

    2) The Claimant told the nurse that he had experienced the pain for some four days but that it had become unbearable that morning.

    3) The Claimant explained to the nurse that his pain went into both arms which felt heavy and that his pain was better when he belched.

23. Both Mr Richmond and Mr Paskins agree that if the Claimant had been examined by a doctor in the Department and a full history taken important information would have been obtained. Risk factors would have been identified including the fact that the Claimant himself had been a smoker, had longstanding problems with cholesterol control and there was a family history of cardiac illness including the fact that his brother suffered significant problems in his 40s requiring a coronary artery bypass graft.

24. In the joint meeting Mr Richmond and Mr Paskins agreed in answer to question 10:

> "had a doctor in the emergency department reviewed the Claimant on 22 January 2006, an appropriate assessment of the Claimant would have been made and arrangements would have been made for appropriate investigations and possible treatment. The exact investigations carried out would have

> depended on the assessment made by the examining doctor. If the emergency physician thought that the chest pain was characteristic of coronary artery disease it is probable that admission for further assessment including cardiac enzyme levels / troponin would have been undertaken."

25. Mr Richmond is of the opinion that no responsible body of right minded doctors would have allowed someone potentially suffering from Acute Coronary Syndrome to leave the Department. He told me that the standard management of someone presenting with cardiac sounding chest pain, with a significant number of risk factors, following a history and examination, would include admission and observation, repeat ECG and cardiac enzyme / component testing.

26. Mr Paskins is of the opinion that it was reasonable to stream the Claimant to the SDTC. to be seen by a GP who would take a history and examine the Claimant. The Doctor could have referred the Claimant for any admission that was required

27. The difference in Opinion arises from their consideration of the initial complaints of the Claimant.

28. When giving evidence Mr Richmond considered that an Acute Coronary syndrome was top of the list of possible diagnoses. When cross examined Mr Richmond accepted that there were symptoms consistent with a gastric pain but he considered that it was necessary to exclude an Acute Coronary Syndrome given the importance of doing so.

29. Mr Paskins accepted that the symptoms were consistent with coronary artery disease but suggested it was not a typical presentation. He stated that patients presenting with Acute Cardiac Syndrome will typically have severe chest pain requiring analgesia, shortness of breath best treated with oxygen and characteristically will be anxious, sweaty and suffer nausea and/or vomiting. The bilateral arm pain was not a typical cardiac presentation and could arise from a musculoskeletal problem. Such a problem would also explain the "pain related to movement." The pain relief when passing wind was also suggestive of a gastric problem.

30. Professor Hall stressed the need to consider the whole picture. The symptom of central chest pain is paramount. Pain can radiate into one or both arms. Central Chest pain with radiation into the arms was a red flag

31. Dr Brecker confirmed the symptoms that are most often found when a patient has an Acute Cardiac Syndrome. Radiation to both arms is unusual and the least likely presentation.

32. Dr Brecker stressed that Cardiac chest pain requires a history. He found it difficult to evaluate the symptoms on the basis of the available information.

33. In my Judgment it is important, as Professor Hall stated, not to take too narrow an approach but rather to look at the total picture of symptoms. I accept the approach of Mr Richmond which fits with the evidence given by the Cardiologists. I consider that the evidence given by Mr Paskins is correct but does not make sufficient allowance for the fact that symptoms vary from patient to patient.

34. Taking such an approach I find that a reasonable doctor in Accident and Emergency would have considered the symptoms to be highly suggestive of Acute Coronary Syndrome. Although Mr Paskins describes the classic presentation of symptoms, the Claimant had sufficient symptoms of an Acute Coronary Syndrome.

35. In 2001 Dr Stewart prepared a Hospital Wide Guidance Protocol for Cardiology. At the time the SDTC was not in existence. The protocol is required to be followed "hospital wide" including by Accident and Emergency staff.

> Accident and Emergency Department The myocardial infarction protocol should be followed if the diagnosis is clear…In other patients, follow the unstable angina protocol, refer to medical on call team if admission is needed.
>
> History and examination: The history should confirm typical cardiac chest pain and a review of the patient's risk factors. The examination needs to exclude alternative diagnoses including muscular chest pain, lung disease and assess complications of myocardial ischaemia.

36. I have considered the extracts from the Oxford Handbook of Emergency Medicine and those from Emergency Medicine (Brown & Cadogan). The guidance stresses the need to admit patients with intermediate risk factors and there is a warning not to discharge a patient after a single normal troponin test.

The Oxford Handbook emphasises that:

> *With such a wide range of differential diagnoses, reaching the correct conclusion requires accurate interpretation of the history, examination and investigations bearing in mind recognised patterns of disease presentation….*
>
> *Atypical chest pain Cardiac chest pain may be poorly localised and may present with musculoskeletal features or gastrointestinal upset. In particular, patients with acute coronary syndromes commonly have chest wall tenderness. Some patients understandably play down symptoms in order to avoid admission to hospital. If the clinical history is suspicious of cardiac pain (especially in patients with risk factors, such as family history of IHD, hypertension, smoking) then refer for admission. Do not be fooled by a normal ECG, normal examinations or the fact that the patient is under 30 years old.*

37. The cardiologists Prof Hall and Dr Brecker both agree that the Claimant did in fact fall within the intermediate risk classification of the protocol. On the basis of the guidance given in the literature the Claimant also required admission to hospital.

38. I have considered Mulholland v Medway NHS Foundation Trust 2015 EWHC 268 (QB) in which Mr Justice Green, emphasised at paragraph 90 of the Judgment the importance of context. He stated that:

> "The assessment of breach of duty is not an abstract exercise but one formed within a context-which here is that of a busy

> A&E where the task of the triaging nurse is to make a quick judgement call as to where next to send the patient. The reasonable nurse is one who operates in a busy A&E which has a procedure which the nurse will follow for streaming and which does not contemplate an exhaustive diagnosis being formed"

39. In my judgment the triage nurse acted reasonably and appropriately. She has only a limited time, about 10minutes, in which to obtain a short history. She recorded the pain level at the time but made no record of the circumstances giving rise to the hospital attendance and the pain level at home. It is important that I stress that it was not her responsibility to decide whether the patient would receive treatment within the Accident and Emergency department or be streamed to the SDTC.

40. I keep in mind the same context when I now consider the position of the Accident and Emergency doctor. In my judgement the Accident and Emergency doctor did not have sufficient information to conclude that the most likely diagnosis was none acute cardiac.

41. I find that the Accident and Emergency doctor attached too much weight to the essentially normal ECG. All the experts recognised that such an ECG is a limited diagnostic tool. In my judgement the taking of a history was necessary and the obtaining of further information was demanded. Such a history could have been taken in a very short period of time and would have clarified the immediate history of the pain and identified several risk factors.

42. In my Judgment in the circumstances in which the Claimant presented a competent Accident and Emergency doctor would have obtained an appropriate history. The decision to send the Claimant to the SDTC without considering such a history was negligent.

43. On the basis of the information which would have been obtained I find that the Accident and Emergency doctor would then have arranged for immediate tests to be carried out which would have identified the existing cardiac condition. The Accident and Emergency doctor would have come to a different conclusion to the GP who saw the Claimant at the SDTC. The Cardiologists agree that intervention would have avoided the severe heart difficulties in 2010.

Summary

- I find that the Claimant did present with symptoms suggestive of Acute Coronary Syndrome.

- The decision to stream to SDTC was made by the Accident and Emergency doctor.

- The Claimant's presentation and limited history required the doctor to obtain further information. I keep in mind he was not making a final diagnosis.

- The asking of appropriate and relevant questions would have quickly identified significant predisposing factors.

- The Claimant should have been admitted into hospital. The usual and appropriate testing would have been carried out which would have revealed the existing cardiac condition.
- In the circumstances which existed no reasonable Accident and Emergency doctor would have streamed to the SDTC. In making this finding I have kept in mind the test set out in **Bolam v Friern Hospital Management Committee** [1957].

- The fact that the Claimant was streamed to be seen by a general practitioner who could have referred the Claimant back to hospital does not provide an answer to my finding of a breach of duty. The Claimant had an immediate and acute need. I keep in mind both context and reality but I repeat that the circumstances demanded more information before the Accident and Emergency doctor could reasonably make a decision to stream.

- For completeness and having regard to the submissions made on behalf of the Defendant I find that streaming to the SDTC is not equivalent to a discharge home.

44. Accordingly there will be judgment for the Claimant on the claim.