Medical Report

Prepared for the Court by

Ramzi Freij FCEM FRCS MBBS

Below is a resumé of my work experience:

Degrees held:
Bachelor of Medicine, Bachelor of Surgery, University of London 1986
Fellowship of the Royal College of Surgeons of Glasgow 1993
Fellow of the College of Emergency Medicine 1996

Previous and current NHS positions:
Consultant and Head of Service Mayday University Hospital 1996-2000.
Consultant and Head of Service East Kent Hospitals NHS Trust running five A&E Departments 2000-2004.
Consultant (Head of Service from 2005 to 2007) for Nottingham University Hospitals Emergency Services from 2004 to the present time.

Past and present positions held:
Medical Director of the Essex and Herts Air Ambulance Trust.
Medical Director of the Kent and Surrey Sussex Air Ambulance Trust.
Past Medical Director of the North West Air Ambulance Trust.
Member and Co-Founder of UK Helicopter Emergency Medical Services (HEMS)
Chairman of the Clinical Sub Group of the Air Ambulance Association and UK HEMS
Past Lecturer at University of Hertfordshire and Paramedical Sciences
Past Examiner for London Ambulance Service IHCD (Stage 1/Stage 2)
Past Examiner at the University of London

Publications:
Twenty Scientific Papers published.

Current Medical Practice:
I work in one of the busiest A&E Departments in Europe (160,000 attendees per annum). My everyday practice consists of seeing patients who are seriously ill or injured. I review patients who have an injury severity score of over 16. I have expertise in the management of major trauma and major illness. I also have expertise in the management of minor illness and minor injuries such as spinal soft tissue injuries and limb injuries. I manage upper and lower limb fractures. I also have expertise in the management of traumatic chest injuries. I am currently the ENP clinical lead and thus responsible for training and mentoring their practice through case based discussions and leading on development days.

Personal details

Name

Date of Birth

Address

Date of incident 2nd July 2010

Report Reference RF/MJS/

Prepared at the request of

Ref:

Summary of Instruction

1. I have been instructed by to prepare a report regarding breach of duty and causation on Ms 's attendance on 2nd July 2010 and on the 3rd/4th July 2010.

2. I have been provided with the following documentation:

   i) Letter of Claim – 1st March 2011

   ii) Letter of Response – 4th May 2011

   iii) Particulars of Claim – Defence

   iv) Directions from the Court

   v) Condition and Prognosis Report from Mr– 6th March 2012

   vi) Condition and Prognosis Report from Mr 14th February 2012

   vii) Condition and Prognosis Report from Mr – 26th March 2012

   viii) Claimant's Schedule of Loss – undated

   ix) Witness statement of Claimant's Husband – 8th December 2012

   x) Witness statement from Claimant – 11th December 2012

   xi) Witness statement from Nurse– 25th February 2013

   xii) Witness statement from Dr.– 13th December 2012

   xiii) Witness statement from Nurse– 23rd February 2013

   xiv) Witness statement from Dr.– 22nd February 2013

   xv) Witness statement from Mr 21st February 2013

xvi) Copy of medical records

Review of A&E Records

3. Ms presented to the A&E Department of the Hospital on 2nd July 2010. She registered at 07:11 hours.

4. Ms had a set of observations which were normal. Blood pressure was 113/73 and she had a pulse rate of 76 and a temperature of 37.6. Saturations were 100% and BM6 was 5.5.

5. The triage nurse has taken a history that Ms had woken up at 2 am that morning with epigastric pain. She had vomited twice.

6. Ms was triaged at 07:19 hours.

7. Ms was reviewed at 08:05 hours by Dr. .

8. Dr. has taken a history that Ms had presented with abdominal pain since 2 am. She had woken up with pain in the epigastric region. This was constant and she described it to Dr. as a sharp squeezing pain. She had vomited twice. She had no diarrhoea. She had no dysuria. Although pain score is written down it is not documented. There was no cough or phlegm.

9. On examination Ms appeared to be well perfused. She was still complaining of pain. Her abdomen was soft. She had tenderness in the epigastric region and supra-pubically with no guarding. Murphy's sign was negative. Bowel sounds were positive.

10. A diagnosis of a query gastritis was made.

11. Ms was given Cyclizine, Buscopan and Gaviscon as analgesia.

12. Her current medication was documented as being Sertraline.

13. At 08:35 hours Ms had taken 10 mls of Peptac and then had vomited immediately approximately 200 mls.

14. At 09:05 hours Ms was reviewed. Her pain had slightly improved. Her abdomen was still soft. She had minimal tenderness in the epigastric region. She was discharged home with advice to come back if there were any further concerns. She was given Gaviscon on an as required basis.

15. It would appear this entry on 2nd July 2010 at 09:05 hours is made by Dr. .

16. Ms re-attended on 3rd July 2010 at 23:26 hours. On this occasion she was complaining of severe abdominal pain particularly around the umbilicus since 22:00 hours. She was seen and diagnosed one day previous with a possible food related problem. She had been brought in by ambulance on this occasion.

17. The doctor at that time has taken a history that Ms had been seen in A&E previously for gastroenteritis. She reported persistent pain. She had slimy and watery faeces. The vomiting had settled for twenty four hours and she had not vomited. She felt hot and sweaty and possibly feverish. She was alert.

18. Initial abdominal examination revealed that she was diffusely tender. Subsequent review revealed a more localised tenderness in the right iliac fossa and guarding was recorded.

19. A diagnosis of possible appendicitis was made and Ms was kept nil by mouth.

20. Observations on that attendance were not documented in A&E however there is an observation chart and although I cannot read the times at the top of the chart Ms had a pulse rate varying from 106 to 107 with a blood pressure varying between 90 systolic up to 110 systolic and diastolic varying from 40 and up to 60. Respiratory rate going up 43 and her temperature was documented at 37.3.

21. Ms was given analgesia in the form of Diclofenac, Buscopan and Morphine.

22. The Diclofenac was given 23:55 hours. Buscopan was given at 02:05 hours and the Morphine was prescribed at 02:35 hours on 4th July 2010, however it would appear not to have been given.

23. Ms was admitted on 4th July 2010 and at 12:30 pm it would appear she underwent a laparoscopy and then followed on conversion to a laparotomy and appendicectomy.

Review of Witness Statement from Ms

24. Ms indicates in her Witness statement that she woke up at 2 am on 2nd July 2010 with “strong pains in her stomach”. She felt the pain was originating from the top part of her stomach. She could feel the pain constantly with “spasm every so often”.

25. Ms called NHS Direct for advice. She was advised to use a hot water bottle and to take Paracetamol.

26. The pain did change in intensity but not in its location which was in the upper abdomen.

27. Ms felt that her stomach was swollen and tender all over and she found it difficult to get comfortable.

28. Ms indicates that she started to vomit at approximately 4 am. She telephoned the out of hours service and she was advised to go to A&E as they could not provide a doctor.

29. In point 8, Ms indicates that she could not keep still when she attended the A&E Department and she was in agony and was crying in pain.

30. Ms also found it very difficult to straighten out her body.

31. The fact that Ms was moving would not be in keeping with generalised peritonitis as patients who do have generalised peritonitis lie absolutely still.

32. Ms indicates that following examination which she found very painful she was given two injections, one as an antiemetic and one for analgesia. She was also given a cup of pink liquid to drink which she describes as Gaviscon and she indicates that she vomited this up in the presence of the doctor.

33. Dr. subsequently discharged Ms .

34. Ms re-presented to New Cross Hospital where she was placed in a cubicle. She was able to provide a urine sample but indicates that she had diarrhoea at that time.

35. Ms goes on to indicate her post discharge problems which I have noted.

Review of Statement of Mr.

36. Mr indicates that Ms woke up at approximately 2 am on 2nd July 2010 with “very strong pain in her stomach”. This was constant in the upper regions of her abdomen and would not abate. She telephoned NHS Direct who advised her to use Paracetamol and a hot water bottle. She called the out of hours service in the hope that somebody would see her. At that stage Ms had started to vomit.

37. Ms subsequently attended New Cross Hospital.

38. Ms 's husband indicates that she was given two injections, one as an analgesia and one for antiemetic and she vomited the pink fluid that she was given.

39. Mr goes on to give a statement about the rest of the medical episode which I have noted.

Review of Witness Statement of Nurse

40. Nurse indicates the process of triage and assessment of the patient during her first attendance. She indicates that Ms 's vital signs at that stage were within normal limits and there was no indication that Ms was unwell at that stage.

Review of Witness Statement of Dr.

41. Dr. indicates that he has obtained Part 1 and Part 2 of MRCS and also spent ten months in General Practice at High Wycombe following immigration into the UK in 2003.

42. Dr. commenced his assessment of Ms at 08.05 hours on 2nd July. He noted that she had woken up with epigastric pain.

43. He goes on to indicate the examination and the history that he has taken which I have reviewed previously.

44. Dr. indicates that when he moved on to deep palpation he drew all the nine quadrants of the abdomen and he drew in the notes that there was tenderness in the epigastric and supra-pubic region but no guarding. He has also indicated that Murphy's sign was negative. He would push hard on the right side of the abdomen to illicit this sign.

45. Dr. goes on to indicate that he prescribed two separate injections, one as an antiemetic and one as an anti-spasmodic which was Buscopan and the antiemetic was Cyclazine.

46. Ms was given the two injections. She did vomit before she could take all the Peptac which was the pink medicine she was referring to.

47. Dr. subsequently went to reassess Ms and noted that the pain was improving slightly. The abdomen remained soft at that stage and she had minimal tenderness in the epigastric region only.

48. Dr. goes on to indicate that Ms re-presented.

Review of Dr. 's CV

49. The contents are noted.

Review of Nurse 's Witness Statement

50. Nurse indicates that she was on duty on 3rd/4th July 2010.

51. At that time Ms was noted to have a blood pressure of 80/54 which indicates that she was hypotensive.

Review of Dr. s Witness Statement

52. Dr J has reviewed Ms on 3rd July 2010 and the contents of his witness statement are noted.

Review of Mr. ’s Witness Statement

53. Mr is a Consultant General Surgeon and was appointed in 1995.

54. Mr has indicated that having considered the notes pertaining to the first attendance, there would have been no reason for him to have admitted the patient for further observation and even if she had been admitted for further observation then no operation would have taken place.

55. Mr also makes a very good point that CT scanning would have irradiated Ms and as a 25 year old female a CT scan of the pelvis and abdomen for suspected appendicitis is a high radiation dose.

56. An ultrasound scan is operator dependent and not as specific as a CT scan but as stated above a CT scan carries a high dose of radiation.

Standards of care

57. I work in one of the busiest A&E departments in the UK. I was appointed as an A&E consultant in 1996. I have direct knowledge of patient flow and care within A&E. I manage cases like Ms 's on a regular basis.

58. It is normal practice in A&E for patients to be triaged. The systems for triage are based on history, physiological parameters and clinical appearance of the patient.

59. The Manchester Triage system is a well recognised system and I have used it previously, but not within the last 10 years. Our current system at Nottingham University Hospital A&E is based on the Early Warning Score and clinical assessment.

60. Once the patient has been assessed, they are then categorised based on the criteria noted above. The New Cross Hospital uses the Manchester Triage which as I stated is well recognised and validated and is used widely so is perfectly safe to use.

61. In a case like Ms 's I would expect a doctor to obtain a history which is focused on the presenting complaint and also a general history. Following history-taking, examination would normally follow. This process has been followed in this case.

62. Treatment for pain and symptomatic relief for vomiting should be administered; this was done.

63. A diagnosis would be based on history and examination of the patient in the first instance. Other factors to be considered include the age and gender of the patient. In this case the pain was in the epigastric region and appendicitis would not have been high on the diagnostic criteria. The gender of the patient is a factor as the majority of abdominal pain in women of child bearing age is gynaecological in nature and not usually surgical.

64. The abdomen is divided into nine regions for ease of reference in transferring patients and documenting site of pain. The regions in the midline are called from the head end: epigastric, umbilical and hypogastric (suprapubic). On either side are the left and right hypochondriac, lumbar and iliac.

65. Appendicitis commonly presents around the umbilical region and is described as a non-specific abdominal pain. The patient is usually anorexic and may describe nausea. The pain is gradually then localised to the appendix region which is in the right iliac fossa. At this stage the patient is usually in significant pain and finds walking painful. The abdominal findings are usually right iliac fossa tenderness and rebound tenderness which indicates the peritoneum (the internal lining of the organs) is inflamed. If the appendix bursts, then the patient is systemically very unwell and signs of generalised peritonitis will be found. The signs are the patient lying completely still with shallow rapid breathing so as not to move the peritoneum during breathing.

66. The diagnosis of appendicitis is clinical and blood tests may be normal. A CT scan is useful but carries a high dose of radiation and in a younger female of child bearing age should not be undertaken lightly.

Consideration of the facts

67. It is for the court to determine the facts and not for the medical expert.

68. I will deal with the facts as they are presented in the statements.

69. The statement of Dr indicates that Ms presented with epigastric pain and he was able to palpate the abdomen including doing a Murphy's sign, which means that he was able to palpate the abdomen in the right hypochondrial quadrant quite deeply. This means that the patient did not have peritonitis. Ms indicates that her pain was severe and indicates that she was not able to lie still; this indicates that there was no peritonitis as patients with peritonitis do not tend to move, but lie completely still.

70. I have read the documentation made by Dr and this is well documented. This agrees with Ms 's description of the site of her pain which she describes as in the upper regions of her abdomen, Dr documents this as in the epigastric region.

71. The observations taken on the first attendance are within the normal range.

72. Ms indicates that she was in severe pain and was still so, despite being given analgesia. Dr indicates that Ms felt better after the analgesia. I would have expected some relief of pain with the analgesia even with peritonitic patients, which Ms did not have as Dr was able to deep palpate.

73. On the second presentation Ms clinical presentation had altered: she had a low blood pressure and a high pulse rate, indicating that she was systemically unwell and had generalised abdominal pain.

Allegations of breach

74. I will now pause to consider the points made by the claimant in her particulars of claim.

75. *Failing to heed adequately or/at all the significance of claims history that she had been woken up from her sleep by abdominal pain*

Whilst the fact that Ms was woken up from sleep is Significant, it does not necessarily mean that she had appendicitis.

76. *Failing to heed adequately or/at all the care claimant's complaint of severe abdominal pain*

Ms woke up with pain in the epigastric region which was sharp and squeezing. The history that Dr. took was adequate.

77. *Failing to heed adequately or/at all the claimant's response to palpation of the abdomen that was indicative of extreme pain*

Having looked at the A&E records Dr. has indicated that Ms had tenderness in the epigastric region and supra-pubic region with no guarding and the abdomen was soft.

78. *Failing to elicit guarding*

Dr. has documented that there was no guarding.

79. Failing to perform a rectal examination

Whilst I accept that a rectal examination is part of the complete abdominal examination, Ms was complaining of epigastric pain at that time with vomiting so therefore a rectal examination was not strictly indicated in that situation.

80. Failing to initiate baseline investigation to include a full blood count, C-reactive protein

Whilst these are important themselves, the white cell count does not particularly indicate significant disease. C-reactive protein is a non-specific test and will indicate generalised inflammation. However on Dr. 's examination and certainly with normal vital Signs, there would be no reason to undertake a full blood count or a C-reactive protein at that stage.

81. Failing to seek surgical opinion

Based on my reading of the examination, there was no reason for Dr. to seek surgical opinion at that stage.

82. Discharging the claimant

The claimant's pain had slightly improved. Her abdomen was soft and there was minimal tenderness in the epigastric regions so therefore it was reasonable, given the records that I have had sight of, for Dr. to discharge Ms .

83. *In the circumstances failing to provide the claimant with reasonably skilful treatment*

> Based on the records I have had sight of and based on the Examination, this would not have indicated appendicitis at that stage.

84. The claimant's solicitors have indicated that on 2nd July 2010 an ultrasound scan and/or CT scan would have confirmed acute appendicitis.

85. Based on reading the clinical records and clinical examination there would have been no reason to have requested either an ultrasound scan or a CT scan at this stage, and I must stress that this is based on my reading of the medical records.

86. It must be noted that the majority of abdominal pain in women of childbearing age is not gastrointestinal but is gynaecological, and in a lot of patients a diagnosis of non-specific abdominal pain is also made quite frequently.

Opinion

87. The attendance on 2nd July 2010 was, in my opinion, appropriately clerked and handled.

88. The doctor at the time took a reasonable history, performed an appropriate examination and it would appear at that time that Ms was complaining of epigastric pain.

89. It should be noted that appendicitis is usually quoted as starting around the umbilicus.

90. Ms did not have any diarrhoea. She did not have any temperature on the 2nd July 2010. Her main presenting features were epigastric pain associated with vomiting which appeared to settle slightly. There would appear to be no guarding on examination of the abdomen.

91. It was therefore reasonable to discharge Ms following examination, with the advice that she should return if she had not settled down.

92. It would appear that Ms did return approximately thirty six hours later, her pain having not settled. Within two hours of her presentation it became clear that a diagnosis of appendicitis was correctly queried. Her symptoms became systemic with a high pulse rate and low blood pressure which was significantly different to the initial presentation.

93. I therefore do not believe that Ms 's care on the first attendance was sub-optimal.

94. I am unable to comment on any surgical intervention as this is an area outside my remit of expertise. It is within the surgical specialties, and not within emergency medicine's remit, to comment on surgery undertaken following admission and whether an operation on 2nd July 2010 may have resulted in a less complicated procedure with fewer side effects.

Declaration and Signature

1 I understand my overriding duty is to the court, both in preparing reports and giving oral evidence. I have complied with and will continue to comply with that duty.

2 I am aware of the requirements of Part 35 and practice direction 35, the protocol for instructing experts to give evidence in civil claims and the practice direction on pre-action conduct

3 I have set out in my report what I understand from those instructing me to be the questions in respect of which my opinion as an expert is required.

4 I have done my best, in preparing this report, to be accurate and complete. I have mentioned all matters that I regard as relevant to the opinions I have expressed. All of the matters on which I have expressed an opinion lie within my field of expertise.

5 I have drawn attention to all matters, of which I am aware, that might adversely affect my opinion.

6 Wherever I have no personal knowledge, I have indicated the source of factual information.

7 I have not included or excluded anything which has been suggested to me by anyone, including those instructing me, without forming my own independent view of the matter.

8 I will notify those instructing me if, for any reason, I subsequently consider that the report requires any correction or qualification.

9 I understand that this report will be the evidence that I will give under oath, subject to any correction or qualification I may make before swearing to its veracity and I may be cross-examined on my report by a cross examiner assisted by an expert.

10 I have not entered into any agreement where the amount of payment of my fee is in any way dependant on the outcome of the case.

Statement of truth:

I confirm I have made clear which facts and matters referred to in this report are within my own knowledge and which are not. Those that are within my knowledge I confirm to be true. The opinions I have expressed represent my true and complete professional opinions on the matters to which they refer.

Ramzi Freij, FCEM, FRCS, MBBS