

Managing a Patients Financial Affairs

Following an award of compensation to a client unable to manage their own finances a Deputy (formerly Receiver) will be appointed to look after the clients financial affairs. Occasionally a close relative will take the role of Deputy but for many this is too onerous a task. At JMW the Partners in our Private Client department regularly act for incapacitated clients as Deputies. Their wealth of knowledge and experience in dealing with Deputyship matters helps take the strain off close relatives who can devote more time to their loved ones.

For further advice about Deputyship matters please contact **Fiona Dillon** (fiona.dillon@jmw.co.uk) or **Ged Wilson** (ged.wilson@jmw.co.uk) on **0845 402 0001**.

More New Staff for JMW Clinical Negligence Department

The Clinical Negligence Department at JMW continues to expand and is delighted to welcome 2 new members of staff.



Angharad Hughes

Angharad Hughes has recently qualified as a solicitor and has previously worked in child abuse and personal injury litigation. Although she is new to clinical negligence Angharad is already proving to be a very capable and valuable member of our team.



Tracy Otterman

Tracy Otterman is a member of the Institute of Legal Executives as well as a nurse and joins our expanding team of nurse/paralegals. She is also new to clinical negligence, having previously worked in personal injury, and has quickly become a hard working and valued member of staff.

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The Mental Capacity Act

An assessment that a person lacks capacity has major implications. It gives clinicians (and indeed lawyers also) an influence over that person that could potentially be abused.

The Mental Capacity Act 2005 (implemented 2007) provides important safeguards to patients' rights and also provides help for clinicians in dealing with capacity issues.

It is estimated that about 2 million people in the UK lack capacity through mental illness, learning difficulties, dementia and physical illness that affects brain function. In general hospitals more than 30% of patients on acute medical wards may lack capacity.

For a person to be considered incompetent he/she must have an impairment of or disturbance in the functioning of the brain or mind, and this defect must result in the inability to understand, retain or weigh information relevant to a decision or to communicate a choice. Capacity can be assessed only in relation to a specific decision and a patient cannot be deemed to lack capacity just because the treating clinician disagrees with his/her decision. People are entitled to make unwise decisions – what matters is not the decision itself but the way it is reached.

Much of the Mental Capacity Act simply codifies previous common law, but it also introduces several new concepts and services. It is now a criminal offence to wilfully neglect or ill-treat a person lacking capacity.

A key premise of the Act is that any decision taken on behalf of a person who lacks capacity to make the relevant decision must be made in the **best interests** of that person.

Brain Damaged by a Cerebral Bleed

Often a serious brain injury will leave a client unable to manage their own affairs or instruct a solicitor. At JMW we have a wealth of experience in acting for incapacitated patients and their families.

P had suffered from fairly severe rheumatoid arthritis for a number of years. This had limited his ability to work and had resulted in a number of joint replacements but despite this he was an active and involved member of his family.

He was 48 years old when he was investigated for hearing loss and problems with balance. As part of routine investigations he underwent a CT scan of the head that demonstrated a middle cerebral artery aneurysm (approx 5-6 mm). This was a wholly coincidental finding unconnected to his symptoms.

The aneurysm was recorded in his medical records but for reasons that are unclear neither P nor his GP were informed and no follow up was arranged despite it being recommended.

11 years later the aneurysm ruptured resulting in a sub-arachnoid haemorrhage. After several days the aneurysm was clipped but by this time P had sustained a severe brain injury resulting in left hemiparesis and significant cognitive impairment.

If P had had a neurosurgical review when the aneurysm was first discovered it is likely that it would have been surgically clipped. This would have greatly reduced the chances of a cerebral bleed with the resulting brain damage and disability.

P remained in hospital and underwent rehabilitation for over a year and was left with a dense weakness of the left arm and leg and a supra - pubic catheter. Initially he had epileptic seizures although these eventually resolved.

P is cognitively impaired, unable to manage his own affairs and is wholly dependent on others for all aspects of daily living including, dressing, feeding and mobility.

Liability was admitted by the defendant Trust despite an expert opinion that the bleed might have occurred anyway even if the aneurysm had been clipped when first discovered. Damages of **£2.25 million** were eventually agreed (some of this in periodic payments).



Bleeding into the Brain Diagnosed as a Simple Headache

Mrs W had a stroke when she was 70 years old which left her with a right sided hemiplegia and a degree of dysphasia and dysarthria (disturbance of speech and language). She needed assistance with washing and dressing but had a reasonable quality of life that included tending the garden and going on holiday. She could read and enjoy the television and was capable of running her own affairs.

Routine investigations had revealed an anterior communicating artery aneurysm in the brain but intervention was not considered necessary.

5 years later Mrs W was referred to hospital because of a severe headache of sudden onset, neck stiffness, raised blood pressure and photophobia. Not surprisingly her son, a GP, thought she had suffered a sub-arachnoid haemorrhage (SAH).

The hospital doctors were made aware of the aneurysm and the first 2 physicians to examine Mrs W both suspected a cerebral bleed. However, a CT scan showed no evidence of a recent bleed. Later the same day Mrs W was seen by a consultant physician who diagnosed a simple headache and told her she could go home.

4 days later Mrs W bled into her brain when the aneurysm ruptured and she was readmitted to hospital. She had a respiratory arrest and was resuscitated. A subarachnoid haemorrhage was confirmed by CT scan and she underwent a coil embolisation (occlusion of the blood vessel) to prevent further bleeding.

Had Mrs W been investigated appropriately a lumbar puncture would have been performed which would have led to the correct diagnosis. She would have been referred immediately to the neurosurgeons for emergency surgery. Despite an initial negative CT scan she had all the classic symptoms of SAH.

Mrs W had a very stormy post-operative recovery. She is very seriously disabled with no mobility and is entirely dependent on others for all her needs. She is not fully conscious and is in a minimally aware state. She is doubly incontinent and receives all her nutrition via a gastroscopy tube directly into her stomach. Clearly she is wholly incapable of managing her own affairs.

There was a radical difference of opinion between the neurosurgeons instructed by the claimant and the defendant as to what would have occurred had Mrs W been properly treated. The claimant's expert concluded that she had a 75% prospect of making an uneventful recovery, whereas in the view of the defendant's expert she would have been cognitively impaired and would have required support for all activities of daily living on a 24 hour basis. Because of this, plus a short life expectancy, damages were agreed at £300,000.