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Our ref: ADH/CS/M313

Your ref:

Date 27 August 1997

Mrs M Murphy
GRO-C
Liverpool
GRO-C

Dear Mrs Murphy,

Re: Your Claim

We enclose copy Counsel's Opinion and would be grateful if you could telephone me upon receipt to discuss the same.

Yours sincerely,

GRO-C

IRVINGS

IN THE LIVERPOOL COUNTY COURT

B E T W E E N:-

MRS MAUREEN MURPHY

(ADMINISTRATRIX OF THE ESTATE OF WILLIAM

AUGUSTINE MURPHY (DECEASED))

Plaintiff

and

ROYAL LIVERPOOL AND BROADGREEN UNIVERSITY NHS TRUST

and/or

THE ROYAL LIVERPOOL HOSPITAL

Defendant

OPINION UPON MERITS AND QUANTUM

1. Mr. William Augustine Murphy died on 5th September 1994. No post-mortem was performed, and the exact cause of his death is not known. However, he was a haemophiliac, suffering from Hepatitis C, with cirrhosis of the liver and cancer of the liver. Mr. Murphy's widow wishes to pursue a claim for damages against The Royal Hospital or the NHS Trust on the basis that their management of his haemophilia, hepatitis, cirrhosis and cancer caused or contributed to his death. I am instructed to advise generally, with specific reference to the merits and potential value of the proposed claim. For this purpose I have the assistance of 2 Statements from Mrs. Murphy, dated 10th April 1995 and May 1997, together with the following Medical Reports.

(i) Doctor Mervyn H. Davies, Consultant Physician and Hepatologist at St. James Seacroft University Hospitals NHS Trust in Leeds, dated 9th July 1997. (I note that Doctor Davies is also a Senior Physician for the Liver Transplant programme).

(ii) Professor Samuel J. Machin, Professor of Haematology at the University College, London, dated 19th August 1997.

(iii) Mr. Gordon Little, Consultant General Surgeon at Manner Hospital, Walsall Hospitals NHS Trust, dated 16th August 1997.

2. The potential heads of claim are set out in Mrs. Murphy's statement of May 1997, and responded to by Doctor Davies. For ease of reference (and adopting my own phraseology) I set out the potential claims as follows:-

(i) the failure properly to assess Mr. Murphy's haematological/hepatological condition in December 1991 when considering his suitability for the very significant surgical procedure of a knee replacement operation;

(ii) a delay in the diagnosis of infection with Hepatitis C;

(iii) a delay in referral for the overview opinion of a liver specialist;

(iv) a delay in referring to a liver transplant team, and in arranging for a transplant;

(v) the delay in diagnosis of liver cancer;

(vi) the delay in initiation of chemotherapy.

In addition, consideration must be given to a possible claim against the Department of Health on the basis of a delay in the introduction of Heat Treatment of Factor VIII Concentrate.

KNEE SURGERY

3. Mrs. Murphy would say that her husband's mobility after the knee replacement operation in December 1991 was broadly speaking reduced. However, there is no Expert support for any criticism of the Orthopaedic decision making process to replace the knee, or of the surgical skills exercised in carrying out the replacement operation. The complaint in relation to the knee surgery is that Mr. Murphy's underlying haemophiliac and hepatological condition rendered him unsuitable for such surgery. The primary basis for such criticism springs from the view expressed by Doctor Hay, the Consultant Haematologist who was actually responsible for Mr. Murphy's care at the time. Mr. Murphy developed complications of surgery including recurrent haemorrhage into the prosthetic joint and possible infection.

The infection responded to antibiotics, but the overall stress of the operation and its complications temporarily altered the status of Mr. Murphy's liver disease, from being in a well compensated state to a decompensated state. Doctor Hay commented in the notes that if he had known of the severity of the liver disease, he would not have requested surgery in the first place. Two questions arise:-

(a) Was it negligent to have failed to diagnose the liver disease prior to surgery?

(b) Even in the event of such diagnosis, would this truly have contra-indicated surgery?

4. Professor Machin (Professor of Haematology) deals with these issues commencing at page 12. He describes the decision to perform the elective knee replacement operation as being completely appropriate from an Orthopaedic and Haemophilia point of view. He confirms that pre-operatively Mr. Murphy had an anaesthetic review which showed from an anaesthetic point of view it was completely appropriate to proceed with the operation. Professor Machin also confirms that from a haematological point of view, pre-operatively Mr. Murphy was checked to see if he had not developed a Factor VIII inhibitor (he had not). Further, Mr. Murphy's liver function was checked and was effectively unchanged from results over the previous 2 to 4 years with an ALT level between 150 and 300.

However, Professor Machin points out that no check was made of Mr. Murphy's coagulation mechanism other than checking his haemophilia status which was well known. In particular, a prothrombin time or thrombin time to check his overall liver function was not performed.

> "We know from the tests that were performed in January that he had a significantly prolonged thrombin time which is an indication of a general impaired synthesis of coagulation proteins due to chronic liver cell failure or cirrhosis. Taken in conjunction with the known mild thrombopenia, which was also undoubtedly related to the liver failure and splenomegaly, this would have placed him at increased risk of peri-and-post operative bleeding (irrespective of the Factor VIII level) and the possibility of post-operative complications occurring.
>
> Although they knew he had post-viral Hepatitis they did not check his Hepatitis C status and although this probably would not have altered their management, this test I imagine would have been routinely available at 1991 at the Laboratories in Liverpool.

Therefore there were several factors in his pre-operative assessment prior to his elective knee surgery in December 1991 which was sub-standard and undoubtedly pre-disposed Mr. Murphy to excessive post-operative bleeding complications".

5. Mr. Little (Consultant General Surgeon) also considers the lead up to the knee surgery. He notes the increasing disability in the left knee which justified replacement, and the anaesthetic check prior to surgery. At page 20 of his report Doctor Little warns of the risks of re-considering cases with the benefit of hindsight, and whilst acknowledging his lack of expertise in terms of hepatic and haematological problems, he concludes that on the basis of the pre-operative work up, the problems that Mr. Murphy encountered could not have been foreseen pre-operatively and that, given his problems, it was a perfectly reasonable decision to proceed with the surgery providing the haemophilia was managed correctly.

6. If Mr. Little's overview is correct, therefore, it would not be possible to attribute any of the post-operative complications to any perceived negligent failure to assess Mr. Murphy's suitability for surgery. Mr. Little would not, of course, have the appropriate specialism or expertise to consider the possible need for a more detailed check of the overall liver function prior to surgery.

7. Doctor Davies (Consultant Physician and Hepatologist) give very detailed consideration to the adequacy of the pre-operative investigations. He concludes that the merits of surgery outweighed the inevitable risks of such surgery.
With the benefit of hindsight Mr. Murphy did not with stand the acute trauma of the post operative complications well and his previously unrecognised cirrhosis became manifest in that the status of his liver disease was temporarily altered from being in a well compensated state to a decompensated state. However, Doctor Davies does not criticise the failure to diagnose cirrhosis prior to the operation, and goes further in stating that cirrhosis per se is not a contra-indication to surgery. Notwithstanding Doctor Hay's note to the effect that had the Defendants been aware of the extent of liver disease they would not have operated, Doctor Davies concludes that Mr. Murphy's joint symptoms were severe and even if cirrhoses had been diagnosed pre-operatively, Doctor Davies expects that the recommendation would have been for surgery to proceed.

8. A number of issues were raised with Doctor Davies, and he provided a Supplementary Medical Report. I read the Supplementary Report as being a firm rejection of the suggestion of negligence in failing to diagnose the liver disease prior to surgery. He is of the view that there was not a high likelihood that the disease could have been picked up other than by a liver biopsy, with little to suggest that a biopsy was indicated. Further, he repeats his view that even if cirrhosis had been diagnosed, he does not think that the plan for surgery would have

altered. Mr. Murphy had well compensated cirrhosis, and it would have been anticipated that the surgery would have been relatively uncomplicated, though if the cirrhosis had been known of, this would have been discussed with the patient and presented as a relative risk.

9. Thus, Doctor Davies and Mr. Little do not criticise the pre-operative investigations, whilst Professor Machin feels that the pre-operative assessment prior to elective knee surgery was sub-standard in that no check was made of Mr. Murphy's coagulation mechanism, and no prothrombin time or thrombin time was taken to check the overall liver function.

10. To the extent that Mr. Murphy's liver disease was aggravated by the after effects of surgery, therefore, there may be a claim for damages - if the views of Professor Machin were to prevail over those of Mr. Little and Doctor Davies. However, even if the pre-operative assessments are correctly to be identified as negligently inadequate, 2 further issues would remain:-

(a) would the severity of the knee symptoms have still led Mr. Murphy to surgery, notwithstanding the perceived increased risks by reference to a known liver disease;

(b) the long term results from the joint replacement were (in Doctor Davies' view) excellent. The episode of decompensation of liver disease was not permanent, although liver function tests deteriorated acutely and

Mr. Murphy developed ascites. Following recovery from the acute effects of surgery and the variceal haemorrhage, the liver function improved and Mr. Murphy again entered a prolonged period of relative stability with well compensated liver disease. My reading of the various reports is that the surgery (whether or not ill-advised) did not have any long term harmful effect upon Mr. Murphy's liver disease, and was not causative of the development of liver cancer. Quantum for the harmful effects of the surgery will, therefore, inevitably be relatively modest. Professor Machin has made it clear in a recent telephone discussion of his Report that he would <u>not</u> support a contention that the complications from surgery prevented a long term return to work.

11. My overall conclusion as to the issues arising out of the knee surgery is that:

(i) Mrs. Murphy has an arguable claim in negligence for the failure to carry out the full range of available tests;

(ii) that the prospects of success on that individual issue should be assessed as no better than even - taking into account the lack of criticism from Doctor Davies and Mr. Little, together with Professor Machin's own cautious response to the question of whether he would

have advised that the surgery go ahead in any event; and

(iii) that quantum for what Professor Machin describes as the extra 2 months in hospital after the knee surgery will be limited, with a maximum realistic value in the region of £2500.00 - £2750.00.

DIAGNOSIS OF HEPATITIS C

12. Mr. Little is throughout his Report keen to identify the fact that primary responsibility for Mr. Murphy remained with the Haematologists rather than general surgeons. The closest that Mr. Little gets to commenting upon the date of diagnosis of Hepatitis C is on page 19 when he questions the absence of any Hepatitis testing between July 1989 and March 1992. He does not go so far as positively to suggest that the failure to test for Hepatitis C until March 1992 was negligent.

13. Professor Machin (at paragraph 11) narrates the timetable to the Hepatitis C test. At conclusion 3 on page 10, Professor Machin sets out the timetable for Hepatitis tests becoming available. He concludes that undoubtedly on the balance of probabilities the treatment with Factor VIII Concentrate in 1981 was responsible for the Hepatitis C infection. At page 12, he states that he imagines that the Hepatitis C test would have been routinely available throughout 1991 at the Laboratories in Liverpool, though he prefaces this with a concession that the failure to check Mr. Murphy's Hepatitis C status prior to surgery

would probably not have altered their management of him.

Thus, save for the possibility that the delay in testing for Hepatitis C may have been a contributory element in what might be asserted as a negligent decision to carry out elective knee replacement surgery, there does not appear to be any more general or long term consequence of such delay as could be asserted.

14. Doctor Davies includes the failure to diagnose Hepatitis C as one of Mrs. Murphy's stated key areas, and at page 15 he deals with this individual issue. He does not regard the delay between 1991 and March 1992 as particularly long, and does not think that earlier diagnosis would have influenced management. His blood tests etc were already being considered high risk because of his haemophilia. If Hepatitis C had been diagnosed prior to the knee surgery, Doctor Davies does not think that this would have altered the decision to proceed with the operation since the disease was well compensated. His view is that the benefits of surgery for such a debilitating knee condition would reasonably outweigh the risks of surgery (from which Mr. Murphy seemed to recover well ultimately - despite the protracted course).

If anything, the diagnosis of Hepatitis C would have a bearing on the issue of timing of transplantation. Because of recurrent disease post-transplant, the tendency is (according to Doctor Davies) towards less transplantation for symptoms in Hepatitis C disease.

Doctor Davies deals with the issue again at paragraph 2 of his

supplementary Report, and specifically states that he does not believe the delay between September 1991 when the Hepatitis C test was first introduced and March 1992 was unreasonable or negligent.

15. Thus, although Professor Machin concludes that the test should have been routinely available in Liverpool in 1991, none of the reporting Experts describes the delay as negligent, nor is any of them of the view that an earlier diagnosis of Hepatitis C would actually have altered the management of Mr. Murphy's overall health.

DELAY IN REFERRAL OF OVERVIEW OF LIVER SPECIALIST/LIVER TRANSPLANTATION TEAM

16. Mr. Little draws attention at page 21 to the intervention of Doctor Hay in 1992. Mr. Murphy had been admitted for a liver work up, at a time when he had developed his oesophageal varices, which had been successfully treated and were no longer bleeding. Professor Machin notes at paragraph 6 (page 13) the successful course of intermittent sclerotherapy to prevent and control excessive bleeding from the oesophageal varices, but questions whether an attempt should have been made at that stage to consider alternative treatment such as a liver transplant. However, Professor Machin goes on to state that unfortunately he is unable to comment on whether this rather major decision should have been considered at that time, and indicates that for this

issue those instructing me will have to rely upon the opinion of a Consultant Hepatologist with experience in liver transplantations.

17. It may seem difficult to understand (with the benefit of hindsight) what justification there can have been for preventing the liver work up in 1992, and for waiting until 1994 before referring for assessment of suitability for a Liver Transplant. Mr. Little records Doctor Hay's views at page 11, stating that Doctor Hay was not happy for the full liver work up to happen, and "considers it essential to restrict investigations to OGD and Sclero and anything else vital. Clearly prognostic indicator assessment is not vital".

18. Doctor Davies deals with the question of the timing for referral for a liver transplantation or obtaining a specialist liver opinion at paragraphs 10 and 11 of his Report. The following conclusions may properly be extracted:

(i) cirrhosis of the liver was presumed to be present from the time that liver function tests deteriorated post-surgery;

(ii) none of the objective indications for liver transplantation were present in the case of Mr. Murphy until the time of referral to Doctor Gilmore and then on to the Freeman Hospital;

(iii) there are no clear or absolute guidelines as to when patients should be referred for a specialist liver opinion;

(iv) Mr. Murphy's management included Professor Shields who enjoys an international reputation in the management of patients with a liver disease, cirrhosis and oesophageal varices. In the absence of objective indications for liver transplantation for referral for a specialist liver opinion, the only specific reason for a referral would have been if Professor Shields did not feel competent to treat the oesophageal varices - on which he made a very favourable effect by endoscopic variceal sclerotherapy;

(v) the role of liver transplantation for patients with subjective symptoms is also modified by diagnosis. Being a patient with Hepatitis C would usually mean that the Plaintiff is Counselled against early transplantation for subjective symptoms;

(vi) the timing of the referral to Doctor Gilmore was not due to natural deterioration from sclerosis of the liver, but from the unexpected complication of primary liver cancer;

(vii) by this stage Mr. Murphy was dying of Hepatocellular Carcinoma - with a survival time of between 2 and 5

months;

(viii) (page 14 of the report) the timing of referral for transplantation was not negligent. In the event it was too late, but this was through nobody's fault but due to a complication of liver disease accelerating due to malignant transformation;

(ix) screening patients with chronic biral hepatitis for hepatocellular carcinoma is widely practised, but of unproved benefit. It cannot be considered negligent not to have carried out routine screening during this time.

19. The only expert opinion available to me, therefore, is that there was no negligence in the timing of the diagnosis of liver cancer, the referral to a liver specialist, or the referral to the liver transplant team. Whilst the hepatoma was effectively diagnosed shortly before transfer to Newcastle but overlooked, the delay in acting upon diagnosis of the tumour a month later would not have altered the final outcome. This is evidence of an omission that amounts to negligence, but has had no causative effect.

DELAY IN INITIATION OF CHEMOTHERAPY

20. The only pertinent expert opinion is that of Doctor Davies. In simple terms, he does not criticise the delay in initiating treatment. More significantly, he is not of the view that the

earlier introduction of chemotherapy would have been likely to have had more than a palliative effect.

CONCLUSIONS AS TO THE ISSUES INDIVIDUAL TO MR MURPHY'S TREATMENT

21. With hindsight it may be the case that an earlier diagnosis of liver cancer or an earlier assessment of suitability for liver transplantation might have altered the nature and outcome of Mr. Murphy's management.

22. However, there is no expert support upon which to base any assertion that the delay in referral to a liver specialist, delay in diagnosis of liver cancer, delay in referral to a liver transplantation team, or delay in initiation of chemotherapy could properly be categorised as negligent.

23. Although Doctor Davies does not regard the delay in testing for Hepatitis C as having been negligent, Professor Machin is of the view that the test should have been routinely available in 1991, and was merited prior to surgery given the Health Authority's knowledge that Mr. Murphy had post-viral Hepatitis. On the other hand, however, he doubts that checking the Hepatitis status would have altered the management in December 1991.

24. Whilst Mr. Davies does not criticise the failure to diagnose the extent of liver disease prior to elective surgery in December 1991, Professor Machin identifies other tests which could and

should have been performed. It is Doctor Hay's recorded view that had he been aware of the extent of liver disease he would not have supported the knee replacement surgery.

Even if that had not actually proved to be the case, and Mr. Murphy had chosen to undergo the elective knee replacement surgery despite the increased risks of the procedure, different haematological cover could have been adopted, which might have protected Mr. Murphy from the trauma induced deterioration of his liver disease.

25. Nevertheless, the height of the actionable claim arising out of the failure properly to diagnose the extent of pre-existing liver disease will - in the view of Professor Machin - be limited to 2 months of significant deterioration in health that required 2 extra months in hospital.

26. Whilst appreciating the very significant impact of the decompensation of liver disease, I would not expect quantum for such a 2 month period to exceed £2500.00 - £2750.00.

It must, of course, be remembered that the Trial Judge will investigate whether:

(a) the knee replacement surgery would have been undertaken in any event, and

(b) if so, whether the post-operative complications could

truly have been avoided through different haematological cover.

27. There is a significant risk that the proposed claim - even if limited to this one aspect of inadequate pre-operative assessment - might fail because the Trial Judge:

(a) prefers the approach of Doctor Davies and feels that Professor Machin sets too high a standard of pre-operative assessment, or

(b) concludes that even though Mr. Murphy's consent to surgery may not have been fully informed, he would on a balance of probabilities have consented even with knowledge of the increased risks, and

(c) the complications and post-operative trauma would not on the balance of probabilities have been avoided through different haematological cover.

28. This aspect of the proposed claim is one which can properly be argued, but I would restate my view that the prospects of success could be regarded as no better than even.

GENERIC COMPLAINTS

29. I am asked to consider whether there is any possibility of a claim based upon treatment of Mr. Murphy by using up old stocks of impure products.

30. It has been generally accepted within the papers before me that Mr. Murphy became infected with Hepatitis C in 1981. Heat treatment was not introduced until 1985, and thus the question does not arise of whether Mr. Murphy was treated with non-heat treated blood product at a time when he ought to have been provided with a heat treated product.

31. Further, it is within my knowledge gained from conduct of other associated claims that expert opinion will not support the assertion that by 1981 NHS product was to be regarded as safer from infection with Hepatitis C when compared with commercially produced product from abroad. The proportion of asymptomatic carriers of Hepatitis C within the donating population, together with the method of production of Factor VIII renders it statistically as likely that NHS product would be so infected as its foreign commercially produced counterpart.

FAILURE TO INTRODUCE HEAT TREATMENT AT AN EARLIER STAGE

32. My Instructing Solicitor and my lay client may well be aware of ongoing associated claims against the Department of Health for a failure to introduce a heat treated product earlier than 1985. In a small number of such cases, protective Writs have been issued and I have drafted Statements of Claim in order to prevent such actions from being struck out. However, I have accompanied such Draft Statements of Claim with Advice of great caution, to the general effect that no further costs should be

incurred in prosecuting the claims unless and until detailed expert opinion becomes available to support the assertion that this Country ought to have developed at a stage that would have been early enough to prevent infection of a patient such as Mr. Murphy in 1981. If a protective Writ is to be issued against the Health Authority in relation to the failure properly to assess Mr. Murphy for the suitability for his elective surgery, then those instructing me may wish to include the Department of Health as a Second Defendant for a failure to introduce heat treatment of Factor VIII Concentrate prior to 1985. However, I would very firmly advise against service of such a Writ immediately, and repeat my view that the Prosecution of such claim would be dependent upon expert evidence that is not thus far available.

33. This has been a long and complex advice. If there are any queries that arise, or there is any further way in which I can assist at present, my Instructing Solicitor knows that he should not hesitate to contact me at the telephone.

GRO-C

GRANT LAZARUS

27 August 1997

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