

## HOW THE CLAIM WILL BE INVESTIGATED

As soon as the arrangements for funding your claim have been finalised and you have agreed to our terms and conditions of business, your claim will be allocated to one of our team of specialist lawyers who will then arrange to meet with you. At that meeting the lawyer will begin the task of preparing a detailed history of your medical treatment and the problems that you have suffered. You will be asked for information concerning your medical treatment, what you feel has gone wrong and the injury that you believe you have suffered. It will therefore be helpful if you have with you at the initial meeting all of the information and evidence that you have about your treatment.

### Witness statements

It is essential to obtain a fully detailed statement that sets out the history of your treatment as soon as possible and whilst memories are still reasonably fresh.

Therefore the lawyer to whom your claim is allocated will need to meet you as soon as possible in order to obtain all the information that is needed in order to prepare a comprehensive written statement for you, which sets out all of the relevant facts relating to your claim and in particular:-

- Your medical and social history;
- Why you sought medical treatment in the first place;
- The names of all of the doctors and hospitals involved in your treatment;
- What the doctors asked you, what you told them, what they told you, what diagnosis was made, what advice you were given and what treatment was prescribed.
- Whether you were given any explanation of the treatment you were to receive, what warnings were given to you about possible risks, what alternative treatment was offered to you and what information was given to you as to the likely outcome if you did not receive the treatment offered;
- What was said to you at any later medical consultations;
- The identity of all possible relevant witnesses.
- Whether you have made any complaint about your treatment.

Once prepared, this statement will be sent to you for your approval and signature and it will then form the factual basis of your claim and will be used to instruct the experts and barristers who will be employed on your case. It will also in due course form the basis of the evidence that you will give to the court. It is therefore essential that care is taken at this stage to make the statement as accurate as possible.

### Medical records

As soon as your statement has been prepared and approved by you we will set about the task of obtaining copies of the medical records that are relevant to your claim. These records are essential to our investigation. We will ask you to sign letters of authority for the disclosure of your medical records to us, which we can send to the doctors and hospitals to whom we make the requests. The Data Protection Act 1998 gives all patients the right to obtain a copy of their records. The Act fixes a maximum fee of £50 for the production of a complete copy of your medical records by each doctor or hospital from whom you have received treatment.

We may also use the Freedom of Information Act 2000 to obtain information that might be relevant to our investigations, e.g. hospital protocols, infection control records or the complication rates for a particular clinician.

The relevant medical records may be kept in a number of places.

All National Health Service patients have one set of general practitioner records. If you change your general practitioner your general practice records will be passed to your new doctor and therefore we will make the request to your current general practitioner. Although your general practitioner keeps the records they are in fact the property of the Secretary of State for Health. Once a patient dies, the general practitioner sends the records to the local Primary Care Trust who retain them for at least three years before destroying them.

Unlike general practitioners, each separate hospital keeps its own records for each patient that it treats. In relation to National Health Service patients, this comprises all of the medical records including the doctor's clinical notes, the nursing records and charts, the laboratory records and all of the correspondence. These records will always be retained by the hospital and will not usually be passed to any other hospital, even if your treatment is transferred. It is sometimes the case that different NHS hospitals operate services on other hospital sites, which can lead to confusion over which records are available and from where. However, we have considerable experience in this field and we are confident that we will be able to identify where your records are being held and obtain a complete copy of them.

If you received treatment in a private hospital, the hospital records will not include the doctor's own clinical notes and correspondence. Those will be retained by him or her separately. However, the private hospital will keep the nursing records and charts and the laboratory records.

Health Visitor records are usually kept by the local Primary Care Trust.

Dentists, opticians and pharmacists keep their own records which they always retain. They do not pass them on when a patient changes to a new dentist or optician.

The Department of Health has laid down guidelines requiring medical records to be kept for a maximum of 8 years after the conclusion of the treatment or the patient's death, although all of a child's records (including maternity records) should be kept until they are aged 25. 1

Obtaining your records often takes time. It can be several weeks, sometimes even some months, before we have them all despite the fact that the Data Protection Act 1998 requires copies to be provided within a maximum of forty days. This is particularly true if you are still receiving treatment at the relevant hospital because of the difficulties for them in arranging the copying of the records between appointments.

Although the Data Protection Act provides for a maximum period of forty days in which the data holder must produce the records the procedure for enforcing compliance cannot be taken up until the forty days has expired and the procedure itself can take several weeks. That is why there can often be delays of several months before a complete copy of all of the relevant records has been obtained.

If however, the doctor or hospital unreasonably refuses to send us a copy of the records, we can ask the court to order them to disclose the records and provide copies to us. However, we will always first try to get the records that we need by agreement because the cost of making an application to the court for a court order can be quite considerable.

Once we have received the records the lawyer dealing with your claim will read them, sort them, collate them and paginate them and also make sure that we have copies of everything that is relevant to your claim. Some solicitors arrange for outside agencies to carry out this task. We believe that is bad practice.

We will then provide a copy to you and will probably need to see you again at that stage in order to go through the records and, if necessary, add to or amend your statement in the light of the information contained in the records.

## Expert reports

Having obtained all the medical records that we need, we will submit copies together with your statement to an independent and suitably qualified and experienced medical expert in the appropriate field who will consider whether or not there is any evidence that you have received sub standard medical treatment.

Obviously choosing the right expert is crucial. We have an extensive database of medical experts with whom we have worked over many years on a large number of claims and who are known to be sympathetic to clinical negligence victims. We also have access to expert databases held by other organisations.

It is important that we ensure that any expert who we propose to use in connection with your claim has not already been consulted by the Defendants, that he or she is not a friend or colleague of the doctor whose conduct we are investigating, that he or she has the relevant experience and expertise and is also supportive of clinical negligence claims.

In the first instance we will probably ask the expert simply to let us have a preliminary view as to whether or not there appears to have been sub standard treatment and if so whether it has caused injury. If this preliminary view is that there does not appear to have been any substandard treatment or if there has, that the lack of proper treatment has not caused any significant injury, then we will probably not be willing to take the claim any further.

On the other hand, if the expert believes that there is evidence that you have received sub standard medical care then we will ask him or her to produce a comprehensive report with detailed reasons and will also then need to obtain a further expert opinion dealing with causation, i.e. whether the sub standard care has in fact resulted in injury and if so, to what extent. Sometimes the same medical expert can provide an opinion relating to both the standard of care and causation but it is often necessary for a second expert to be employed to deal with causation. It may also be necessary to obtain reports from additional experts if there are additional overlapping issues of medicine to consider. This of course will all take time, firstly because the experts have to prepare their reports out of normal working hours and secondly because these reports often have to be obtained in sequence, one after the other.

It is possible that one or more of the experts may wish to see you before their report can be provided. If so an appointment will be arranged at your convenience but you will have to meet your own travel and subsistence costs even though the expert may be based (and will need to see you) in a different part of the country.

Unfortunately, because some of the very best experts are in great demand, this may mean that they have lengthy waiting lists. However, we will always try to use the most appropriate expert in your case and will tell you by what date the expert has promised to provide the report.

## Valuing your claim

Before any court action can begin it is necessary to obtain a report dealing with your relevant medical history, present medical condition and prognosis. The purpose of this report is for the court and the Defendants to see how the negligence has affected you and what the future holds for you because this will enable us and them to know the likely value of your claim. This report will also have to be obtained from an appropriate medical expert who will need to see you before that report can be prepared. Again, you will have to meet your travel and subsistence expenses, even if the expert is based elsewhere in the country.

It may also be necessary for us to arrange for you to be seen by other non medical experts who will provide us with reports with regard to your future nursing, housing and other therapy and equipment needs. Many of these experts will need to see you at home in order to assess your needs fully.

## The decision to start legal proceedings

It is our responsibility to co-ordinate the obtaining of all this expert evidence and to interpret it for you. We will then advise you as to whether or not you have a claim that can be pursued and if so what compensation you can expect to receive if it succeeds. It may be necessary for us to arrange a meeting with you together with some or all of the experts, ourselves and a barrister before a final decision to start court proceedings is taken.