BREACH OF DUTY AND CAUSATION REPORT ON XXXXXX

DATE

REFERENCE: XXXXX

NAME – dob XX XX XX

Address 1

Address 2

Address 3

Postcode

This report is prepared by Mr Paul Smith, FRCS, Consultant Plastic and Reconstructive Surgeon at the request of (Solicitor). The Breach of Duty and Causation Report is prepared to aid the Court in the case of (Claimant). I, Mr Paul Smith, understand my duty to the Court is to prepare an unbiased, honest and accurate report in this case and I believe I have complied with that duty.

For the purposes of this Breach of Duty and Causation Report, (Claimant) was seen via remote video consultation / seen at the Platinum Medical Centre XXXX on XXXXXX.

"The examination of the client took place remotely using a video method and was not performed face to face as it took place during the Covid-19 crisis. Before any confidential details were exchanged the patient was read the following statement:

"During the course of this remote consultation, information will be shared between myself and you. All information will be held in confidence and its use is covered by the Data Protection Act 2018. Information will only be used by and shared with those who have a legitimate need to access the information, such as (Solicitor) and your legal representative in order to facilitate your claim. Doxy.me is securely encrypted and by proceeding with this remote consultation, you confirm that you have taken the necessary security steps to protect your device, as advised. The option of proceeding with this remote consultation is entirely voluntary, and you may withdraw your consent at any stage. Are you happy to proceed?"

The patient confirmed at this point that they were happy to proceed with the video examination. The video examination presented no limitations of evidence for the purposes of production of the medical report herewith unless otherwise stated and by signing this report I confirm that the patient was happy to have been examined by video."

BREACH OF DUTY AND CAUSATION REPORT ON XXXXXX

DATE

BACKGROUND

Date of Accident: XXXXX

Date of Report: XXXXX

Date of Birth: XXXXX

Identification: XXXXX

Time off work: XXXXX

Current Occupation: XXXXX

Instructing Party: XXXXX

Documents available:

- General Practitioner Records
- X-rays, MRI and Scan images
- Photographs
- Hospital Records

BREACH OF DUTY AND CAUSATION REPORT ON XXXXXX

DATE

1. The circumstances of this accident as described to me by (Claimant) on (DATE).

HISTORY

2. This gentleman was injured on the 18th September 2019 whilst playing rugby. It was almost the last phase of the game when he was injured, he appeared to dislocate his left middle finger. He clearly remembers that it was deviated in what he described as an ulnar direction, in other words it was deviated sideways. He was assessed by an on pitch physiotherapist who eventually manipulated and strapped his finger.

3. As he was going home the following day, he waited until he could go to the accident and emergency department locally, the XXXX Hospital, the following the day, the 19th September 2019 where x-rays and a splint were applied. After his initial attendance at the XXXX Hospital accident and

emergency department, he was asked to return in two weeks.

4. In fact, he was seen in the plastic dressings clinic on the 25th September 2019 six days after initial presentation and he was noticed to have a diminished range of motion at the PIP and DIP joint. The question of a volar plate injury was raised and an ultrasound was requested. When XXX returned for follow-up on the 7th October 2019 (eighteen days after initial presentation), his finger was swollen and he was in a lot of pain. He was seen by a plastic surgical registrar who told him to commence mobilisation of his finger on the basis that this was a dislocation which had been reduced and now needed to be mobilised. The splintage was removed and he was referred to hand therapy. It documents in the notes that he was referred for hand therapy on the 20th September 2019 and the GP notes suggest that there was hand therapy attendance from the 19th September – 7th October 2019. He appears to have attended hand therapy between the 7th October and the 3rd December 2019 but I can find no notes of this. I have subsequently had confirmation that he had not received any hand therapy between the 27th

November 2019 and the 31st December 2019. However, the notes do confirm that he attending hand therapy until 14th September 2020 although latterly because of COVID-19, this was by video conference or telephone.

5. An ultrasound was undertaken on the 16th October 2019 (approximately one month after his injury) and a diagnosis of a central slip attenuation was made. He continued to have physiotherapy sessions in October and November 2019 and then was seen again on the 19th November 2019 (two months after the initial injury) by one of the plastic surgeons Dr XXXX. He was noted to have a 40 degree fixed flexion contracture of his PIP joint and an established Boutonniere deformity. The ultrasound confirmed a ruptured central slip injury. He was referred for a Boutonniere splint and commence physiotherapy as well as to be reviewed by a Hand Consultant at which point Mr XXXX took over XXX care and he was seen on the 3rd December 2019.

6. Mr XXXX decided that this was an established Boutonnière deformity and fixed contracture and he

felt that surgical correction was indicated and he therefore undertook surgical correction of the Boutonnière on the 31st December 2019.

7. XXXX and his mother made multiple telephone calls following his surgery on the 31st December 2019 because XXXX was troubled with throbbing pain, could not sleep at night and felt like his finger was swollen and there was colour change at the tip of his finger. He was eventually seen on the 8th January 2020 when his dressing was removed, which appeared to be tight and photographs show bruising around the base of the finger, some erythema between the PIP joint and the base of the proximal phalanx, maceration of the skin on either side of the incision and the finger did not look normal. Over the next few days, frank infection became apparent. XXXX developed a post-operative wound infection and when seen on the 11th January 2020 at 17.22, he was noted, on examination to have the following: "There was a diffuse swelling, fusiform erythema of the left middle finger with cellulitis associated with pus and exudate from the wound." He subsequently underwent a washout and debridement on the 12th January 2020 with secondary looks and further

washouts on the 15th January and the 17th January 2020 and then a local flap reconstruction on the 21st January 2020. These are the dates given on the discharge letter on page 53 of the notes.

8. His subsequent procedures also included tendon repair, application of a vac dressing (this is a vacuum assisted dressing) and finally the application of a local flap to reconstruct the loss of skin. The local flap appeared to have vascular compromise and he received leech therapy form the 22nd January 2020 – 27th January 2020. He appears to have been discharged on the 29th January 2020 at 11.56 hrs.

9. He continued to have outpatient physiotherapy and there are hand therapy notes commencing on the 31st January 2020 and finishing on the 14th September 2020. These are documented on page 618 – 668 in the notes. COVID-19 interfered with his face-to-face physiotherapy and he also felt that he was not making any progress in that his finger had become permanently stiff with no increase in range of motion.

10. Similarly, his outpatient appointments were interfered with by COVID-19. He has experienced no change in his position since September 2020 and continues to suffer from a stiff, deformed left middle finger which does not participate in grip.

REVIEW OF RECORDS

11. The emergency department note from the XXXX Hospital on the 19th September 2019 documents that he had swelling and bruising to the proximal and middle phalanx, there was no erythema, no wound, there was tenderness to the middle and proximal phalanx, there was no tenderness to the distal phalanx, the finger was neurovascularly intact, there was a decreased range of motion on the distal interphalangeal joint (DIP joint), proximal interphalangeal joint (PIP joint) and metacarpophalangeal joints (MCP joint), due to swelling and pain. No fracture was seen and he was referred to plastics.

12. He was assessed by the plastic surgeons on the 19th September 2019 at 22.06 hrs. X-rays confirmed the correct position of the joint, he was provided with a Zimmer splint, an outpatient ultrasound was requested for a possible volar plate injury, hand therapy and clinic review was booked.

13. The hand written notes on the 19th September 2019 at 21.00 hrs, page 205/705 document the following: Left middle finger swelling PIP joint, unable to flex the PIP joint, actively or passively, unable to flex the DIP joint actively, better passively. Held in flexion, unable to fully extend, neurovascularly intact, closed injury. He was put in a Zimmer splint and outpatient for ultrasound, hand therapy the following day and to be seen in the plastic dressing clinic on the 25th September 2019.

14. Unfortunately, there is no notification of whether passive extension of the PIP joint was possible and if it was possible, there was no further documentation of whether or not a central slip attenuation test was undertaken. The fact that the PIP joint could not be

passively flexed implies that there was something preventing the joint from moving, most likely to have been a volar plate problem.

15. X-rays revealed no fracture. He was put into a splint, plastic dressing station in two weeks, avoid contact sports for six weeks.

16. The likely outcome in an injury of this nature is a progressive volar plate contracture and so it is important to keep the patient under review for eight to twelve weeks and to deal with any developing volar plate contracture by the use of a Capener splint. The x-rays do demonstrate a posture which is associated with a Boutonniere deformity, namely flexion of the PIP joint and hyperextension of the DIP joint.

17. The outpatient note on the 7th October 2019 noted stiff +++ stable joint, no rotation or scissoring. Outpatient in three months.

18. I consider this to be inadequate supervision of a situation where there is potential for a volar plate contracture to develop.

19. There is a note on the 19th November 2019 where it is clear that he had an established Boutonnière deformity and that an ultrasound had shown central slip attenuation. *Reference: Listers The Hand, page 178, 179, 536)*

20. He was then seen on the 3rd December 2019 ,where it was noted that he had a central slip injury to his left middle finger and an established Boutonnière deformity. This was explained and it was suggested that he should have centralisation of the lateral bands, release of the joint and repair of the central slip and a k-wire to the proximal interphalangeal joint (PIP), a long period of splinting and he was warned that it may re-occur.

21. He was then admitted and had surgery on the 31st December 2019. The operation note documented on page 371 / 705 describes the following: dorsal curvilinear incision, volar plate freed, lateral bands freed, lax/attenuated but intact central slip, tightened using a 3/0 Juggerknot anchoring device inserted into the middle phalanx. At the end, the patient had a PIP joint which was straight and able to flex and was able to flex the distal interphalangeal joint. Wound

closure 4/0 Ethilon, two weeks for the removal of stitches. Plastic dressing station in two weeks, outpatient three months. (Again, I feel that this is far too long of a gap to leave a patient after such complicated surgery and that a much closer eye should have been kept on his progress by the hand surgeons. The responsibility for monitoring his post-operative progress cannot simply be offloaded onto the hand therapy department.)

22. The operation note correctly notes that it was possible to flex the DIP joint, this means that the conjoined lateral bands were not tight. It also correctly points out that the PIP joint was capable of being straight, but what it does not do, is tell us whether or not it was possible to fully flex the PIP joint, in other words, it does not tell us whether the central slip repair was too tight. He was dressed with cosmopore, cobane (this is a self-gripping circumferential dressing which does not expand), a Zimmer splint with the PIP joint in full extension but allowing him to flex the DIP joint.

23. He was seen in the plastic dressing clinic nursing station on the 8th January 2020. It was noted that the

dressing was very tight, the fingertip was dusky and the capillary refill was less than three seconds. (In view of the fact that the finger was dusky, I suspect that the nurse meant to say the capillary return was greater than three seconds as this would more closely correspond with the physical sign of duskiness.) The dressing was changed. He was seen on the 11th January 2020 at 19.27 hrs, they document that he had been seen in the plastic dressing clinic four days earlier, the wound had been redressed and placed in a splint, but he has been feeling unwell since Wednesday, fainted when removing the bandage, he has been off his food but no nausea and no vomiting.

24. Examination of his left middle finger showed that it was diffusely swollen, fusiform, there was erythema of the left middle finger with tracking cellulitis to the dorsum of the hand, pus +++ with exudate from the wound, sutures were released and a pus swab was sent. Impression – post-operative wound infection. Plan was to take bloods, given intravenous antibiotics, mark the extent of the erythema, elevation, he was given a Betadine bath and wound

review to be undertaken the following day to see if it was necessary to wash out the wound in theatre.

25. On the 12th January 2020, he was taken to theatre for a wound washout. He wound was dry, there was no pus, tendons were exposed, patient was well and comfortable, Betadine dressing was applied and second look planned for Tuesday. He was returned to theatre on the 14th January 2020 for a second look and he had debridement and washout as well as tendon repair. He underwent a third look under anaesthesia when the wound was debrided and washed again and a VAC dressing was applied. He was also on intravenous clindamycin and previously had been on intravenous co-amoxiclav.

26. On the 21st January 2020 he returned to theatre for a reconstruction of the soft tissue defect with a local flap and split skin graft. However, the flap became congested and leech therapy was commenced on the 22nd January 2020. His intravenous clindamycin was stopped on the 27th January 2020. All antibiotics were stopped by the 28th January 2020 and the leech therapy was stopped on the 28th January 2020. He was discharged, I believe, on the 29th January 2020.

27. The detailed operation notes read as follows:

28. 31st December 2019: (Page 371) Mr XXXX. Dorsal curvilinear incision, volar plate freed, lateral bands freed, lax/attenuated but intact central slip, tightened using 3/0 Juggerknot anchor into the middle phalanx, at the end, the PIP joint was straight and he was able to flex the DIP joint.

29. Page 383 – 12th January 2020. Left middle finger down to dorsal and wound explored, pus +++, pus swab sent, extensor tendon repair unreadable, unreadable, unreadable skin debridement. Washout with hydrogen peroxide and normal saline, Inadine dressing, may require second look.

30. Page 464 – 14th January 2020. Surgeon Mr XXXX. Second look, finger washout left middle finger. Findings – Extending necrotic skin edges, advancing volarly, extending necrosis of the extensor tendon, both central slip and lateral bands, black necrotic bone at insertion of central slip, pus exuding from the proximal interphalangeal joint (PIP), proximal interphalangeal joint very early evidence of chondrolysis, collateral ligaments OK, necrotic

tissue debrided, Juggerknot suture removed, bone specimen sent for microbiology culture. At this point, questions were beginning to be raised by Mr XXX about discussing everything with patients mother in regard to control of the infection, debridement of dead tissues, possible reconstruction, possible amputation.

31. Page 494 – 17th January 2020. Mr XXXX. Third look, debridement and VAC application. Wound looks clean, no pus, over granulation proximally over residual extensor tendon, joint open, no pus, thorough irrigation, minimal debridement of desquamated skin, VAC applied, good suction.

32. Page 521 – 21st January 2020. Mr XXXX. Defect dorsum left middle finger, post severe infection, local Quaba flap reconstruction and split skin graft. Very wide defect from metacarpophalangeal joint (MCP) to just short of the distal interphalangeal joint (DIP), swollen ++, clean, bone bleeding. Perforator identified by Doppler in the second web space. Two perforators identified. Flap raised at level of peritenon. Initially good bleeding, but the tip not perfused, therefore shortened, (meaning the flap), the

more proximal perforator ligated to allow flap to reach the defect. Swelling ++ of flap. Split skin graft harvested from the left thigh.

33. There is a diagram illustrating skin graft placed on either side of the flap. 4/0 Monocryl was used to close the dorsum of the hand, it was dressed with chloramphenicol Jelonet, a sponge tie over.

34. Page 550 – The Institution of leech therapy – this went from 22nd January 2020 through to the 26th January 2020.

35. Hand therapy notes are documented on pages 618 – 668 and it is clear that he had face to face hand consultations from the 29th January 2020 until the 16th March 2020. At the last visit, they were instructed by the medical staff to discontinue mobilisation as they were planning to fuse the PIP joint. At that stage, his active range of motion in his middle finger at the MP joint was 0 – 80 degrees, at the PIP joint, it was fixed at 80 degrees of flexion, the DIP joint it was fixed in neutral. He was subsequently noted on the 12th June 2020 to have wrist flexion of only 45 degrees compared to 90 degrees on the other side.

36. Photographs – page 658 / 705 how the state of the wounds on the 21st January 2020 when there has clearly been a complete breakdown of all the dorsal tissues. There is significant skin loss, exposure of bare bone, the joint is exposed, there is no central slip and the extensor apparatus has been extensively damaged.

37. The photograph number 2/19, provided by the claimant shows subcutaneous bruising around the base of the finger, an extremely soggy area over the dorsum of the finger. There is some erythema of the skin over the proximal phalanx. There is no evidence of pus appearing, but this appearance should have alerted the nurse to obtain an opinion from one of the medical staff. No antibiotics were provided at this stage and three days later, frank pus was seen to be emerging from the wound. It is important to note that the very soggy area which is white and does not look particularly viable, is exactly the area that coincides with subsequent ski loss.

38. Photograph 3 taken on the 11th January 2020 – shows a finger that is undoubtedly infected.

39. 12th January 2020 – one can see the dehisced area.

40. 13th January 2020 – it is clear that there is de-vascularised bone, an open joint, destruction of the dorsal apparatus.

41. By the 23rd January 2020 – one can see the Quaber flap which has become grossly swollen. Clearly, this flap has significant circulatory problems.

42. By the 31st January 2020 – the photograph shows most of the flap has survived but there are significant open wounds with flexion deformity at the PIP joint.

43. By the 17th February 2020 – there are still open wounds on either side of the flap and again on the 21st February 2020 and even similar on the 13th March 2020.

44. By September 2020, there is clearly significant deformity of the finger with radial deviation of the tip of the finger, supernation of the tip of the finger and a flexion deformity at the PIP joint.

45. Cultures taken on the 12th January 2020. MRSA Multisite screen culture, methicillin, resistance

staphylococcus aureus not isolated. Report date 15th January.

46. There is report on the 23rd January 2020 about a specimen collected on the 12th January 2020 and this grew a heavy growth of staphylococcus aureus, sensitive to flucloxacillin and tetracycline and resistant to erythromycin. A similar report collected on the 15th January 2020 and reported on the 22nd January 2020 confirmed the same organisms.

47. 25th March 2020 MRI hand with contrast, patient with devasting soft tissue infection of left middle finger, now has x-ray changes in the middle and distal phalanx. Urgent MRI with contrast to rule out osteomyelitis of the distal phalanx. Finding: There is distal cortical destruction of the middle phalanx with scalloping of the distal cortex marked enhancing medullary signal alteration. There is destruction of the third distal interphalangeal joint and proximal interphalangeal joints (by this he means the middle finger joints), with and cortical destruction of the distal aspect of the proximal phalanx of the middle finger and enhancing medullary signal alteration.

There is marked enhancing surround soft tissue inflammation with periosteal reaction. No collection demonstrated. Impression – Liver – the patient has the leak, appearances are compatible with (can't read text). (Clearly from impression onwards, this is an error on the report).

48. X-ray Left hand 26th March 2020 – osteopenic appearance of the middle finger. There is a large amount of soft tissue swelling of the dorsal aspect of the middle finger. The middle phalanx of the finger shows a loss of bony cortex and irregular erosion within the dorsal aspect of the middle phalanx. There is periosteal reaction seen. The middle phalanx also appears to be subluxed from the proximal interphalangeal joint. It is noted that the patient has had a subsequent MRI.

49. *Refer to appendix for diagrams of operation*

BREACH OF DUTY

50. **1 - The initial diagnosis: Dislocation versus central slip injury.**

51. This is complex and is the remit of a consultant plastic or orthopaedic surgeon who specialises in hand injuries. Dislocations affect the structures around the proximal interphalangeal joint (PIP) depending upon in which direction the injury occurs. If the middle phalanx is dislocated posteriorly, (backwards), then the central slip would be intact and volar plate would be injured. If it is displaced anteriorly (forwards) in a palmar direction, then there is likely to be damage to the central slip. If it is displaced laterally, then at least two structures would be damaged namely at least one collateral ligament and either the volar plate or central slip, or all three. *Reference: Listers The Hand.* Whilst the diagnosis of this can be made immediately by ultrasound, that is not commonly available and therefore the diagnosis depends on clinical assessment. Central slip attenuation can be tested by using the clinical test that I described in *Reference: Listers The Hand, page 178, 179, 536)* I would not expect a casualty doctor to have knowledge of this. This is the province of a well-trained hand surgeon. Volar plate injuries are obvious if attempted dorsal pressure on the middle phalanx produces pain, but contractures take six to

eight weeks to develop and so the patients need to be carefully monitored over the next eight weeks. I have no criticism of the accident and emergency doctor, he correctly referred to the plastic surgeons.

52. **2 - The interpretation of the x-ray of xxx's finger taken on the 19th September 2019.**

53. This shows that the joints are all congruous, however it shows flexion deformity at the PIP joint and hyperextension at the DIP joint. This is the beginning of a Boutonniere deformity and this should be obvious to a trained hand surgeon. The plastic surgeon correctly raised the possibility of a volar plate injury and splinted the finger in extension.

54. **3 - The initial treatment immobilisation which changed to removal of the splint and full mobilisation on the 7th October 2019.**

55. The initial treatment of immobilisation was correct, but he should have been kept under review to monitor the possible development of a volar plate contracture. On removal of the splint, if there was evidence of central slip attenuation as evidenced by the central

slip test (you do not need an ultrasound to diagnose this), if it was possible to passively extend the PIP joint to full extension but actively it lagged and could not achieve full extension and the central slip test was positive, then the patient should have been put into a Boutonniere splint, namely a Capener splint or other variant and monitored until on removal of that split, the central slip had tightened up and the patient was capable of full extension. This splint would have also prevented the development of a volar plate contracture. I feel there was a breach of duty in the care provided at this time and but for that breach he would not have developed a fixed flexion deformity at the PIP and a fixed Boutonniere deformity and would have avoided the necessity for further surgery with the consequences that ensued. On the balance of probabilities, his finger range of motion would not have reached perfectly normal, but it would have been functional and the finger could have been incorporated into grip.

56. Ultrasound of the hand on the 16th October 2019 – clinical history – reduced closed dislocation of the left middle finger PIP joint 1 day ago. Unable to flex extend joint query volar plate or collateral ligament

injury or tissue obstructing joint. Ultrasound – there is a near full thickness tear in the central slip of the left middle finger extensor tendon 6 mm from the middle phalanx attachment, measuring approximately 3 mm longitudinal dimension. Lateral slips and the distal extensor tendon are intact, no bony avulsion. There is also evidence of partial tear of the deep surface of the PIP volar plate with no bony avulsion. A small amount of fluid is seen in the proximal interphalangeal joint. The ulnar and collateral ligaments are intact.

57. X-ray 19th September 2019. Clinical History – Query dislocated and then relocated PIP joint today at rugby. Query fracture middle phalanx. X-ray finger middle left. No acute fracture demonstrated.

58. Cultures taken on the 12th January 2020. MRSA Multisite screen culture, methicillin, resistance staphylococcus aureus not isolated. Report date 15th January.

59. There is report on the 23rd January 2020 about a specimen collected on the 12th January 2020 and this grew a heavy growth of staphylococcus aureus, sensitive to flucloxacillin and tetracycline and

resistant to Erythromycin. A similar report collected on the 15th January 2020 and reported on the 22nd January 2020 confirmed the same organisms.

60. 25th March 2020 MRI hand with contrast, patient with devasting soft tissue infection of left middle finger, now has x-ray changes in the middle and distal phalanx. Urgent MRI with contrast to rule out osteomyelitis of the distal phalanx. Finding: There is distal cortical destruction of the middle phalanx with scalloping of the distal cortex marked enhancing medullary signal alteration. There is destruction of the third distal interphalangeal joint and proximal interphalangeal joints (by this he means the middle finger joints), with and cortical destruction of the distal aspect of the proximal phalanx of the middle finger and enhancing medullary signal alteration. There is marked enhancing surround soft tissue inflammation with periosteal reaction. No collection demonstrated. Impression – Liver – the patient has the leak, appearances are compatible with XXX. (this is clearly an erroneous entry into this report).

61. X-ray Left hand 26th March 2020 – osteopenic appearance of the middle finger. There is a large amount of soft tissue swelling of the dorsal aspect of the middle finger. The middle phalanx of the finger shows a loss of bony cortex and irregular erosion within the dorsal aspect of the middle phalanx. There is periosteal reaction seen. The middle phalanx also appears to be subluxed from the proximal interphalangeal joint. It is noted that the patient has had a subsequent MRI.

62. *Refer to appendix for diagrams of operation*

63. **4 - The timing of the ultrasound and its findings.**

64. As I have already pointed out, the diagnosis of central slip attenuation can be made clinically. Whilst it is always good to have confirmatory evidence such as an ultrasound, it is not necessary to make the clinical diagnosis. The findings of the ultrasound suggested that there was some central slip attenuation. I can find no fault with the timing of the ultrasound, however, there appears to be a gap between the 16th October 2019 and the 19th November 2019, during which

time, the results of the ultrasound should have been available to the plastic surgeons and with such results, more careful monitoring should have been undertaken.

65. **5 - The subsequent treatment and any delays.**

66. When XXXX was eventually seen by Mr XXXX on the 3rd December 2019, the diagnosis was firmly established of a Boutonniere deformity with a fixed flexion contracture of the PIP joint. At this point, the dye was cast. The choice to be made was between conservative treatment using a Capener splint, the majority of surgeons would have attempted a Capener splint, even chronic Boutonniere deformities can respond to the use of a Capener splint and I feel that the majority of surgeons would have utilised that as their initial treatment.

67. However, a significant minority would move onto surgery and surgery is an entirely reasonable approach and I have no criticism of the decision to move onto surgery. It is clear from the operation note

that this was done with great care and I have no criticism of the surgery that was undertaken.

68. The problem arises of the failure to respond to the patients concerns following his surgery on the 31st December 2019. Telephone calls had been undertaken between the 3rd and the 8th January 2020 in regard to the amount of pain that XXXX was in. He had throbbing pain which prevented him sleeping at night. To an experienced hand surgeon, that is diagnostic of pus, *(reference page 321, Listers The Hand Diagnosis and Indications, Paul Smith 4th Edition Churchill Livingston 2002, ISPN 0443064164)* I feel there is a breach of duty on behalf of the Trust in that their system with dealing with a patient who had been operated on under their care and who is raising the issue that they are in severe pain, failed to have a mechanism whereby they can be seen immediately.

69. Having operated on someone, there is a duty of care to ensure that any post-operative problems with are dealt with promptly. It is unacceptable to be told that he could not be seen earlier. This appears to be a

system failure rather than the failure of any particular individual.

70. He was seen on the 8th January 2020 at a nurse led clinic. The photographs show a finger which is clearly abnormal. There is maceration, complete pallor covering an area which subsequently corresponded with the area of skin loss. There was proximal erythema, there was circumferential bruising around the base of the finger and this should have raised alarm bells, he should have been seen by a member of the plastic / hand surgery team urgently.

71. In my view, XXXX qualified for a second opinion on the basis of the Trusts' own stated response:

i. That a review by a doctor is only requested if the patient is presenting with a complex, extensive wound, where analgesia taken at home is not working. This was clearly the case.
ii. Or, where the past history of a patient requires a doctors attention.

72. Again, this is clearly the case. His diagnosis had been made late. On the 10th January 2020, XXXX called the plastic surgery outpatients requesting an earlier

appointment as the colour of the tip of his finger changed and he felt unwell. Again he was told he could not be seen earlier, but to go to the XXXXX Hospital accident and emergency department which he attended and was told to then attend the XXXX Hospital. Again, the XXXX Hospital here had a clear duty of care to see XXXX and investigate the problem.

73. By the 11th January 2020, he was exuding pus from the joint and was admitted for subsequent surgical washout debridement, tendon repairs, dressing, flap coverage and leech therapy. It is clear that the change between the 8th January 2020 and the 11th January 2020 means that there was undoubtedly infection present on the 8th January 2020.

74. I have no criticism of his treatment once the wound infection had been diagnosed, he appears to have been given appropriate treatment with debridement, wound washout, intravenous antibiotics and then eventually with flap cover. Clearly, the flap was compromised in terms of its vascular supply, almost immediately. A Quaba flap is an accepted method of skin cover given in these circumstances. It would not

be my personal preference because I do not like the idea of twisting a pedicle 180 degrees as I feel this is liable to lead to vascular compromise, as it indeed did, but it is an accepted method of treatment by a significant number of hand surgeons and it is not an unreasonable method of treatment.

75. His subsequent treatment was entirely acceptable however, the dye was cast from the moment he developed this severe infection.

CAUSATION

76. But for the failure to monitor XXXX between the 7th October 2019 and the 3rd December 2019, he would not have developed an established volar plate contracture and a PIP joint contracture which became fixed. Careful monitoring at that time would have picked up the fact that a volar plate contracture was developing. Capener splintage or other splintage, would have corrected that problem or significantly reduced the degree of contracture and would have

also allowed tightening of the central slip and he would have avoided the necessity for surgery.

77. Following his surgical correction of the established Boutonniere deformity on the 31st December 2019, but for a failure to respond to his frequent calls regarding excessive pain, throbbing discomfort, inability to sleep, discolouration of the tip of his finger, he would have had a dressing that was too tight, reduced earlier, he may well have avoided the compromise to the circulation on the dorsum of his finger with the resultant creeping necrosis and infection.

78. But for the failure of the system in place which displayed no flexibility for dealing with emergency problems following surgery and but for the failure of the nurse to recognise that there was a significant wound abnormality on the 8th January 2020, as evidenced by the fact that pus was exuding from the joint a mere three days later, it may have been possible for XXXX to have had early decompression of a tight dressing, early recognition of wound infection and more rapid treatment with intravenous

antibiotics. I believe the vascularity of his finger was compromised by the tight dressing, the dressing may not have been tight initially but, it become tight once the finger became swollen (Coban the inelastic circumferential dressing) the vascularity was undoubtedly compromised, witness the change of colour that XXXX noticed in the fingertip which was also documented. There was clearly ischaemic damage to the skin and tissue died. Dead tissue in the presence of a foreign body (the Juggaknot suture) is a recipe for infection.

79. Appropriate early monitoring following his attendance at accident and emergency and his early reviews in plastic surgery department on the 19th September 2019, the 25th September 2019 through the 7th October 2019 and the recognition of a developing volar plate contracture, plus the use of appropriate Capener splintage or other splintage, would have avoided all necessity for surgery.

"I confirm that 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 own 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. I understand that proceedings for contempt of court may be brought against anyone who makes, or causes to be made, a false statement in a document verified by a statement of truth without an honest belief in its truth"

*I confirm that I understand my duty to the Court and have complied with it and will continue to comply with it and am aware of the requirements of Part 35 and Practice Direction 35, the Protocol for the Instruction of Experts to give evidence in civil claims 2014, as amended, and the practice direction on pre-action conduct. (**Dated XX.XX.XX)***

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