Medical Negligence and Personal Injury

Quarterly Newsletter – April 2018

A summary of the key judgments handed down by the Courts during the first quarter 2018 is set out below by category.

Liability

Judgment in *Cameron -v- Ipswich Hospital NHS Trust* was handed down on 18 January 2018. This case involved the alleged deterioration in the Claimant's neurological condition following surgery for Cauda Equina Syndrome. The factual background was: on 7 December 2010 the Claimant underwent discectomy and decompression at L4/5. This surgery took place in Chelmsford, Essex. The Claimant lived in Ipswich and it was more convenient for her to be followed up locally. On 22 February 2011 the Claimant suffered an onset of lumbar back pain following a twisting injury. Upon attending the Defendant's hospital it was noted that the Claimant had some temporary numbness down the legs but no alteration bladder or bowel function. The orthopaedic registrar also noted that there was "*No alteration bowel or bladder function feels normal when bladder opens*". The Claimant was allowed to go back home and no follow up was arranged.

On 17 March 2011 the Claimant attended the outpatient clinic for post-operative review. At this appointment she was referred for an MRI scan and thereafter further review. The next outpatient review took place on 21 July 2011 at which point the spinal surgeon had the results of the recent MRI scan to hand. He noted "*The MRI does confirm she remains with a significant disc prolapse at L4/5 and a lesser one at L3/4 … counselled her on this and she will report back urgently if there is any recurrence of her old symptoms for which she had her original emergency surgery at Chelmsford*".

On 22 September 2011 the Claimant was seen by a nurse at her GP practice. A history was given of weakness in legs and difficulty voiding urine. A diagnosis of Cauda Equina Syndrome was made and the Claimant was referred to the Defendant's hospital as an emergency admission taken by ambulance. At the hospital her problems were noted as "*on-going back problems, legs becoming increasingly weak, same symptoms as previous Cauda Equina*". Revision surgery was carried out that day. However, the outcome was poor and the Claimant suffered many problems including extensive pain in her legs and back, weakness in her legs, loss of bladder control as well as impaired mobility.

The key issues at trial were:

1. Did the Claimant suffer any neurological deterioration between March and July 2011?
2. Should early decompression surgery have been offered to the Claimant?
3. Would the Claimant have come to surgery before suffering her serious deterioration in September 2011?
4. If the Claimant had undergone earlier surgery would she have avoided her serious on-going limitations and loss of mobility that followed the surgery carried out on 22 September 2011?

Upon hearing evidence from the Defendant's surgeon (in addition to one of his colleagues) and two expert spinal surgeons (called for either party) the Judge concluded that the Claimant herself did describe the onset of new symptoms at the March 2011 appointment with the spinal surgeon. The Claimant's evidence was confused. She did not state with any clarity (either in her witness statement or during examination and cross examination) what her exact symptoms were, what she told the doctor at each appointment and the advice she received. The Judge concluded "*I do not accept that she described any change. Any change would have been important. It would have been recorded and acted upon*". Considering all of the evidence the Judge made a finding of fact that at the July 2011 appointment there had not been a deterioration in the Claimant's neurological symptoms.

The Judge then went on to consider (it was not necessary for him to do so) whether decompression and reconstructive surgery would have been offered had there been a deterioration in neurological symptoms at the July 2011 appointment. The Judge noted that the risks of this surgery were significant. It was revision surgery, the Claimant was obese and a smoker. In these circumstances he would have found that early decompression surgery was not a reasonable treatment option and should not have been offered to the Claimant. On all grounds the claim was not made out and Judgment, together with costs, were awarded in the Defendant's favour.

This case is a reminder of the difficulties practitioners face when pursuing claims involving Cauda Equina Syndrome, or alleged poor post-operative follow-up following spinal surgery. When Cauda Equina Syndrome is suspected timing is of the essence. In the legal context the ability to reconstruct, in painstaking detail, not only the sequence of events (including where, what, how and why) but also the symptoms that the Claimant presented on an hour by hour basis is critical to the success of a claim. It is only by taking this forensic and detailed approach cross referenced to the medical records and with input from medical experts that such cases can be formulated and presented with a view to establishing causation. Proceeding without such detailed evidence will always be an uphill struggle.

Another case involving a spinal injury was handed down on 6 February 2018. This case, *Hassell -v- Hillingdon Hospitals NHS Foundation Trust*, arose from injury caused to the Claimant during C5/6 decompression and disc replacement surgery performed by Mr Shaun Ridgeway (spinal surgeon) on 3 October 2011. During that operation Mrs Hassell suffered a spinal cord injury which left her with tetraparesis and permanently disabled.

The case was advanced on the basis that Mr Ridgeway had not given the Claimant the opportunity to give informed consent, that he failed to warn her in the pre-operative assessment of the risk of paralysis and that Mr Ridgeway did not perform surgery to the reasonable standard required. It was claimed had the Claimant been given the opportunity to provide informed consent she would have decided against the operation and would have avoided spinal cord injury.

During the operation Mr Ridgeway used a diathermy needle which used heat generated by electricity to free away material in front of the disc to expose the C5 bone in order to remove the offending disc. Mr Ridgeway was three quarters of the way through removing the material from the disc when he paused to ask the physiologist within the operating theatre to check the spinal cord monitoring readings. It was at this point that it was noted that the traces had stopped showing a detectable reading some 16 minutes after the

commencement of surgery. However, at this stage the discs had not been removed. Mr Ridgeway was still very much within the "*preparatory*" stages of the procedure.

Upon the severity of the Claimant's injury becoming apparent the Claimant made a complaint to the Defendant NHS Trust. Neither Mr Ridgeway nor the Trust were able to give an explanation as to the cause of the spinal cord injury. In the proceedings that followed various possibilities were advanced including injury caused by the electricity and heat generated by the diathermy needle, ischemic injury (unacceptably low blood pressure) and direct trauma.

Dealing first with the issue of informed consent, the Judge noted that Mr Ridgeway's evidence, both oral and written, was somewhat inconsistent. The Judge concluded that the Claimant was not told about the risk of paralysis flowing from cervical discectomy surgery. Furthermore, the Claimant had not been advised of conservative treatment options including physiotherapy and further injections. Mr Ridgeway had failed to take reasonable care and skill to ensure that the Claimant was aware of the material risks of the operation and the alternative conservative treatment options. Central to his decision were, amongst other factors, the following:

1. The Supreme Court's decision in *Montgomery* made it clear that there must be a dialogue between patient and doctor. Had there had been a dialogue between Mr Ridgeway and the Claimant he would have known that the Claimant had not yet had conservative treatment in the form of physiotherapy for her neck and upper arm problems.
2. The Judge had no confidence in the reliability of Mr Ridgeway's recollection about what he discussed with the Claimant and when.
3. Mr Ridgeway, during the consenting process, referred the Claimant to his website. However, the website did not contain information allowing the Claimant to understand fully the risks and benefits of the planned procedure. It was clear that the website referred patients back to discussions with surgeons. Unfortunately, the crucial information – about the risk of paralysis – was missing from Mr Ridgeway's website.
4. The risk of spinal cord injury and paralysis was not referred to within the outpatient clinic letter dated 28 June 2011 in circumstances where the letter was dictated in front of the Claimant to ensure that she was aware of the risks that she was running by choosing surgery. Mr Ridgeway's explanations about the risks were not clear or consistent.

The Judge found that the Claimant was only told about the risk of cord damage on 3 October 2011, but it was common ground between the parties that such a warning on the day of the operation was not sufficient for informed consent.

Turning to causation, would the Claimant have undergone the operation if she had been given the relevant information to give informed consent? The Judge noted that the Claimant was very concerned about the risk of paralysis and would have wanted to explore conservative options such as physiotherapy to safeguard against risk. The Judge accepted this finding. He found that the Claimant was able to relate to risks that were real to her and would have adopted conservative treatment before rushing to surgery.

The more difficult aspect of this case was the question of what caused the spinal cord injury. Mr Ridgeway stated in evidence that there was no reason for him to stop while removing the disc material but it was his

usual approach to do this before starting on the removal of the disc itself. Upon assessing the expert evidence and various explanations for the injury put forward the Judge was only able to say "*I am satisfied that it was one of the possibilities identified by the experts, that there is nothing on the material before me which enables me to find, on the balance of probabilities, one cause over another*".

The Judge concluded that Mr Ridgeway used reasonable care and skill in carrying out the operation and was unable to identify the cause of the spinal cord injury. However, the Claimant did not give informed consent to the operation and had she been given the relevant information about material risks and conservative treatment she would not have agreed to the operation on 3 October 2011. In these circumstances Judgment was given in the favour of the Claimant.

This case illustrates the difficulties practitioners encounter when seeking to establish spinal surgery (or indeed any other surgery) was performed to an unacceptable standard. This is because the evidence is somewhat limited and issues usually boil down to medical opinion regarding causation of injury.

On 22 February 2018 judgment was given in the case of *Saunders -v- Central Manchester University Hospitals NHS Foundation Trust*. This case concerned the alleged clinical negligence during surgery to reverse an ileostomy in March 2012. Shortly after this surgery the Claimant became seriously unwell and it was discovered that his entire colon was ischaemic. The colon had to be removed causing a permanent ileostomy.

It was the Claimant's case that the surgery was negligently performed resulting in damage to the blood flow to the bowel. The Defendant denied liability, claiming that the damage was caused by a naturally occurring blood clot.

This was a difficult case because the Claimant himself was unable to give evidence as a result of the alleged negligence taking place while he was anaesthetised. However, the Claimant's expert produced his evidence on the basis that there was an association between the surgery and onset of symptoms, which meant something must have happened during surgery. Upon analysing the evidence of both experts the Judge was unable to conclude that the timing of the onset of symptoms was consistent with an acute event occurring during surgery causing immediate arterial occlusion. Indeed, there was no sign of an evolving problem until the Claimant's discharge home. He had been eating and drinking and had opened his bowels prior to discharge. Some four days had passed before the Claimant became significantly unwell. As a matter of logic the onset of symptoms due to iatrogenic injury would likely have been expected to have occurred earlier. Analysis of the expert evidence as to the aetiology by reference to the pattern of damage, proximal relationship to the surgery and the Claimant's anatomy and past medical history did not produce a clear answer. There were factors pointing both ways.

In these circumstances the Judge was unable to exclude conclusively the possibility of either of the rare events by reference to the expert evidence alone. The Judge then had to "*stand back and ask whether the Claimant has proved his case that the damage was caused by surgical negligence on the balance of probabilities.*" The real difficulty, according to the Judge, for the Claimant was the absence of a clear explanation of the likely mechanism of injury during surgery which was anatomically remote from the site of the injury. The Judge was not satisfied that the Claimant had established, on a balance of probabilities, that his injury resulted from surgical damage. The claim failed and was dismissed.

The cases of *Hassell* and *Saunders* are good examples of how difficult surgical cases are given the lack of evidence to be adduced from a claimant. The claimant naturally is unable to give an account of the steps the surgeon took when they were anaesthetised. Although claimants can give post-operative accounts it is always difficult to assert that certain acts or omissions occurred during surgery. Both cases also remind practitioners of the burden on the claimant to establish, on the balance of probabilities, not only the cause of injury but that the injury was negligently caused.

Furthermore, matters were not made easier in the *Saunders* case due to the large gulf between the experts and lack of defined and agreed issues with a view to narrowing the points to be determined at trial. The Judge, Mrs Justice Yip, gave a somewhat critical analysis of the expert joint statement that comprised some 60 pages. She noted that the joint statement did not achieve the objectives set out within the Practice Direction to Part 35 and did not narrow the issues at all. In essence, she noted that the joint statement added nothing to the evidence. This is a clear reminder to practitioners of the importance of creating sensible agendas for expert discussions. Agendas for expert discussions are not an opportunity to cross examine an expert. More often than not a 'less is more approach' is to be favoured. Practitioners on both sides are becoming accustomed to using agendas to mark out clear parameters for the battleground. This approach is not only costly but unhelpful. Those who adopt this approach should take heed from Mrs Justice Yip's comments.

Costs

JMX -v- Norfolk and Norwich Hospitals NHS Foundation Trust was a case that was heard at liability trial by Mr Justice Foskett on 31 October 2017. The Judge found in the Claimant's favour and a subsequent hearing on costs took place in November 2017 in respect of a Part 36 Offer that the Claimant had made on 6 October 2017. Although the offer was made 25 days before trial, the relevant period as defined within Part 36 of the Civil Procedure Rules came to an end on Friday 27 October 2017, which was effectively one working day before the trial began.

The terms of the Claimant's offer was that the Claimant would be prepared to accept 90% of the damages to be agreed or assessed in due course. Effectively, the Claimant was prepared to agree to a 10% reduction on liability issues in order to reflect litigation risk. The Claimant sought the consequences of the Defendant failing to obtain judgment that was more advantageous to the terms of the Part 36 Offer as set out within CPR 36.17. This included a provision that interest should be payable on the costs from the expiry of the relevant period at a rate not exceeding 10% above base rate. The Defendant's submission was that the Claimant's offer was no more than a tactical offer and was not a genuine attempt to settle proceedings. The Defendant alleged that an assessment of the litigation risk being limited to 10% was a significant undervaluation of the litigation risk and accordingly could not have been a genuine attempt to settle.

Mr Justice Foskett concluded in the circumstances of this case a 10% discount for litigation risk was not a token discount, particularly at the time when the level of damages in serious injury cases is very significant. This was an indirect reference to the discount rate being at a minus percentage figure, with the knock-on effect of creating large lump sum awards. Mr Justice Foskett went on to say "*I do not know what the likely value of the Claimant's claim is in this case, but it is likely to run into several million pounds on a traditional*

lump sum basis. Ten percent of such a sum will, in itself, be a not insignificant sum that would have been saved from the public purse had the offer been accepted. Equally, of course, most of the costs of the 5-day trial would have been saved."

The Court held that the Claimant's offer was a genuine offer of settlement and this offer should not militate against ordering the normal consequences of the Claimant having achieved more than his Part 36 Offer. By reaching this conclusion the Judge was at pains to say that an Order of this kind does not carry any condemnation by the Court of the Defendant's position. Part 36 was drafted in a way that provides incentives for the parties to view seriously and, where appropriate, accept an opponent's Part 36 Offer. The decision not to accept the offer may be perfectly understandable and reasonable even if, following trial, it turned out to be the wrong one. This, according to the Judge, was a reflection on litigation risk that each party has to evaluate.

Interestingly, while making submissions to the Judge, both parties referred to comments and positions taken by their opponent at a settlement discussion meeting. These comments did not feature as part of Mr Justice Foskett's reasoning in this case, and it is clear from the Judgment that he felt reference to such material to be uncomfortable. He reminded parties to litigation that settlement discussions are on a without prejudice basis and if the practice were to adopt a "open house" approach in subsequent correspondence, then this would endanger the long-recognised utility of the without prejudice negotiations and this, he noted, "*can be in no-one's interests*".

Turning to the penalty applied for failing to beat a Claimant's Part 36 Offer, Mr Justice Foskett awarded 5% above base rate from 28 October 2017 and considered that that figure would do justice to the applicable considerations.

The judgment in the case of *Ballard -v- Sussex Partnership NHS Foundation Trust* was handed down on 28 February 2018. This was a case that went to trial in March 2017. The trial concerned the issue of quantification of the Claimant's claim. The year before trial the Defendant made a Part 36 Offer comprising a net sum payable of a little over £49,000. This offer was rejected and the litigation continued. On 8 February 2017 the Defendant's solicitors withdrew their previous Part 36 Offer and made a further offer comprising a net sum payable of a little over £29,000. The Claimant rejected this offer and the case proceeded to trial, where damages in the sum of £23,315.13 were ordered.

Following trial, the Judge ordered that the Claimant should pay the Defendant's costs from the date of the expiry of the relevant period to the first Offer. This meant that the Claimant was required to pay all costs from 12 February 2016 which was more than a year before date of trial.

The Claimant appealed this decision, stating that the Judge had erred on the basis of claiming that the second Offer (the only Part 36 Offer that remained on record) was irrelevant. The Appeal was heard by Mr Justice Forskett who departed from the trial Judge's conclusion on this matter. He noted the wording of the second Offer which clearly stated "*For the avoidance of doubt, if the Claimant fails to obtain a Judgment more advantageous than the offer made in this letter, then the Defendant will seek an Order that the Claimant should pay both parties costs from 01.03.17*". The Judge's reasoning was that the Offer by the Defendant was made from a very reputable and experienced firm of solicitors, especially in the context of clinical negligence matters. That Offer should be read at face value. The terms of the second Offer made

no reference to the fact that if the Part 36 Offer was rejected, the Defendant would seek payment of their costs not only from the date of the current Offer, but also from the date of the relevant period within the withdrawn Offer. In these circumstances Mr Justice Foskett held that the Defendant could not escape from the precise terms of their second Offer, and in fact it was the first Offer that becomes irrelevant, not the second.

The Claimant was entitled to her costs up to 1 March 2017, but was ordered to pay the Defendant's costs of trial on the basis that she failed to beat the second Offer which was in fact the only Part 36 Offer that remained on record.

This judgment confirms the relevance of the provisions relating to withdrawal of Part 36 Offers. Careful consideration should be given prior to withdrawing a Part 36 Offer, especially because this action will run the risk of losing the costs protection that are available in the event that the opposing party fails to beat a Part 36 Offer at trial. Mr Justice Foskett's judgment simply gives a literal interpretation to the workings and provisions of Part 36.

If you have been affected by the issues discussed in any of these cases, please contact Richard Lodge or a member of our Clinical Negligence team. Alternatively, you can contact us on 020 7814 1200 or email us at enquiries@kingsleynapley.co.uk.

Richard Lodge
Partner
Clinical Negligence and Personal Injury
T +44 (0)20 7814 1249
E rlodge@kingsleynapley.co.uk