Neutral Citation Number: [2019] EWHC 1201 (QB)

Case No: HQ15C01195

IN THE HIGH COURT OF JUSTICE
QUEEN'S BENCH DIVISION

Royal Courts of Justice
Strand, London, WC2A 2LL

Date: 15 May 2019

Before :

ANNE WHYTE QC
(SITTING AS A DEPUTY HIGH COURT JUDGE)

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Between :

BARRY FREDERICK HEWES	**Claimant**
- and -	
(1) WEST HERTFORDSHIRE HOSPITALS NHS TRUST	**Defendants**
(2) EAST OF ENGLAND AMBULANCE SERVICE NHS TRUST	
(3) DR PANKAJ TANNA	

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Mr Martyn McLeish (instructed by **Anthony Gold Solicitors**) for the **Claimant**
Miss Erica Power (instructed by **Capsticks Solicitors**) for the **First and Second Defendants**
Miss Victoria Woodbridge (instructed by **MPS**) for the **Third Defendant**

Hearing dates: 19 – 22, 25-26 March 2019

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Approved Judgment

I direct that pursuant to CPR PD 39A para 6.1 no official shorthand note shall be taken of this Judgment and that copies of this version as handed down may be treated as authentic.

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Anne Whyte QC:

Introduction

1. This case concerns the clinical management of the Claimant on 12.3.12 by all three defendants. The case was listed for determination of breach of duty and causation only.

2. Cauda Equina Syndrome ('CES') is a condition characterised by dysfunction of the nerves supplying the motor and sensory function to the bladder, bowel, genitals and saddle area and is commonly caused by compression from a large central vertebral disc prolapse. Once diagnosed, it is deemed to be a surgical emergency because, without timely decompression surgery to remove the offending disc prolapse, there is a significant risk of further deterioration leading to permanent neurological injury. Diagnosis of CES is a clinical one, confirmed by MRI scanning.

3. There is a group of symptoms or signs, "red flags", whereby a diagnosis of CES should be suspected, if found. Usually the suspicion arises in the context, as here, of a patient with severe low back pain with sciatica. Red flags include reduced sensation (hypoaesthesia) in the saddle/peri-anal or genital region or urethra. The majority of patients who present to A&E with suspected CES do not have CES. There are categories of CES, including CES Incomplete (CESI) and CES Complete or Retention (CESR – the "R" standing for retention). How these two categories are defined and by what time, if at all on 12 March 2012, the Claimant's CES became complete are central issues in this case. Biological deterioration for patients in CES is continuous. It is agreed that the speed of progress in CES from (as here) a large disc prolapse to CESI to CESR is highly variable. In some patients it can occur within hours, in others CESI may never progress to CESR. It is also agreed as a matter of probability, that for patients with CESR, the outcome for surgery is unfavourable and for patients with CESI, the outcome for surgery is favourable. Once CES is suspected therefore, time is of the essence both in obtaining an MRI scan and if appropriate, in performing decompression surgery. All this being so, it is a condition which regularly features in clinical negligence litigation.

4. The Claimant alleges that the Third Defendant, a GP, failed to make the appropriate type of referral upon suspecting that the Claimant might have CES early in the morning on 12 March 2012. The Claimant alleges and it is admitted that the Second Defendant failed correctly to categorise his ambulance transfer from home to Watford General Hospital (WGH) on 12 March 2012 with a resulting 19-minute delay in arrival. Finally, he alleges that he was not managed quickly enough at the First Defendant's hospital, WGH, with the result that investigation and treatment of his CES was negligently delayed. Each Defendant, he submits, was responsible for causing him permanent and avoidable injury and dysfunction because he alleges that his condition had not developed to CESR by the time decompression surgery ought to have been performed. Had such surgery been performed in a timely manner, he submits that on the balance of probabilities, the outcome would have been far more favourable.

Background Facts

5. Because of the way in which this case has been advanced by the Claimant, both in terms of breach and factual causation, it is necessary to set out the facts and to summarise the evidence in more detail than is desirable. The below summary is generally not in dispute, save where indicated.

6. The Claimant is 50 years old with a history of low back pain. An MRI from January 2012 showed disc bulges at L4/5 and L5/S1. He had a caudal epidural injection on 22 February 2012. On 11 March 2012 he attended the Urgent Care Centre in Hemel Hempstead with worsening back pain where he was seen by the out of hours GP and prescribed medication. He was advised to consult his GP with any further concerns and that the development of numbness (locality unspecified) would indicate the need for immediate medical attention. Up until this point, his treatment had been provided at sites in Hemel Hempstead and St Albans.

7. The Claimant went to bed at around 0100 on Monday 12 March, having passed urine shortly beforehand, but awoke at around 0500 in pain and having developed numbness around his groin. The Claimant's wife, Kerry Hewes, called the Urgent Care Centre at 0543 and at 0602 she called 999 and spoke to an operator of the Second Defendant Ambulance Service. At 0604 the Third Defendant, an out of hours GP, spoke to the Claimant on the telephone for approximately 5 minutes. The out of hours working environment is generally very busy and at that time of day there was likely to be a queue behind Mr Hewes of some 10 to 20 outstanding calls.

8. At the outset of the call at 0604, the Claimant informed Dr Tanna that in the last hour he had *"developed a numbness in my bum and leg."* He explained that the numbness went down the left leg to his calf and that he had pins and needles in his foot. Upon direct questioning he said that he had not had any difficulty or accidents passing urine or opening his bowels but confirmed that he had not yet tried to urinate that morning and that sitting on the toilet caused pain.

9. Dr Tanna questioned the Claimant about precisely where the numbness in his "*bum*" was and was told "*in my left buttock and all the way down my* leg". Dr Tanna explained that numbness around the back passage, genitalia and groin would be of specific interest. The Claimant responded that he also had numbness in the testicular area to which Dr Tanna said: " *Ok, well if that's the case, then we would have to recommend that you go to the hospital, to the A&E department and get them to see you… It will need to be an A&E department, so if you are getting numbness in your genital area at this time, then you would have to go to the Watford General Hospital because that is where the A&E department is and that's where they can organise an urgent scan and get you seen by an orthopaedic doctor. So that's what I would recommend"*

10. Dr Tanna specifically told the Claimant that attending the Urgent Care Centre in Hemel Hempstead would not be helpful. The Claimant told Dr Tanna that he would attend Watford A&E. Dr Tanna then explained that there are important nerves which can be pinched and referred to this as "*more serious"* and that this could lead to bowel, bladder, anal or genital symptoms and said "*If that is what you are getting then Watford A&E would be the place to go".* Dr Tanna considered CES as a possible diagnosis having recorded "*?? Cauda Equina advised to attend Watford A+E for*

urgent review" in his notes. His notes also included the following observations: "*No abdo pain, no urinary/bowel sx [symptoms], no numbness in perianal area, reports developed numbness under genitals/saddle area. In the past 1 hour and pain increasing ++"*

11. Mrs Hewes spoke to the Second Defendant's clinician at 0632 who arranged for an ambulance to be sent under normal road conditions. The ambulance arrived at the Claimant's home at 0721, left at 0738, and arrived at WGH at 0819. Handover occurred at 0827. The ambulance handover sheet recorded symptoms of numbness to the left buttock, leg and foot. The Claimant was seen by Dr Roffey (A&E FY2) at 0920 in cubicle 7 of the "Majors" area of A&E. He noted the report of saddle anaesthesia and that there had been no obvious bowel/bladder disturbance. Upon examination he found that the Claimant had what is termed "good anal tone". He ruled out CES but referred the Claimant for orthopaedic assessment in light of the "new neurology". His plan included pain relief and admission for a further scan. His note refers to the Claimant being "accepted" by the orthopaedic department at 1040. No allegation of negligence is advanced against Dr Roffey.

12. The Claimant was then seen by Dr Kirkby (on-call orthopaedic FY1).

13. There is an issue about the timing of Dr Kirkby's assessment. The Claimant believes that it was around 1000 whereas Dr Kirkby believes that it was nearer 1040 and this is a factual tension that I must resolve because the Claimant alleges that every minute counted. In any event, Dr Kirkby took a further history and examined the Claimant noting the numbness in his groin area and that he had not urinated or opened his bowels since the previous evening. Relevantly, she noted that the Claimant's perianal sensation was intact and anal tone was normal. Mrs Hewes, in her witness statement recalled that a digital rectal examination was performed by Dr Kirkby but thought that when the doctor asked her husband whether he could sense that examination, he said he could not. Dr Kirkby's note included the details of the Claimant's recent medical history including his care under a Consultant, Mr Dyson who was a member of the Trust's orthopaedic team. Her note went on "*Presented to HH [Hemel Hempstead] UCC yesterday, given diazepam and Tramadol d/c [discharged] with advice if any anaesthesia to return to A&E".* Under the "Problems and Diagnosis" section of her notes, she recorded "*L4/L5 Bulging and L5/S1 protrusion, ? Cauda equina".* The note of her management plan which evolved with her discussions with Dr McKenzie, the Registrar, included an MRI, x-rays, pain relief, "*Bladder scan -? retention"*, nil by mouth (in case surgery was called for) and discussion with the registrar "*re cauda equina".*

14. The Claimant had been given morphine at 1045 which provided effective pain relief. The request forms for x-ray and MRI were completed by Dr Roffey, probably upon instruction. The spinal x-ray took place at 1123. At 1159 the MRI request form was scanned onto the radiological information system. It is agreed that the MRI Request Form did not refer to a diagnosis of CES or possible CES and it was not marked either as urgent or as an emergency. This is alleged to be negligent. A bladder scan was carried out at 1203 recording bladder volume of 621ml. The Claimant was instructed by a nurse to go to the toilet, but he was unable to urinate despite trying.

15. The Claimant's details were entered onto the Computerised Radiology Information System (CRIS) at 1326, the MRI was started at 1333 and completed by 1350. This was some 90 minutes after the MRI request form was computerised.

16. At 1445 a urinary catheter was inserted although the Claimant was unable to feel this. Residual volume was 625ml. An orthopaedic Registrar review by Dr McKenzie was noted at 1500. It referred to the Claimant having "*Painless urinary retention*" (to which I shall return) and "*neurology worsening*". The plan was for an urgent discussion with the Consultant, Mr Langdon, for "*theatre today…Impression: cauda equiae"*. The MRI of the lumbar spine showed a massive L5/S1 disc herniation occupying most of the central canal. A further note timed at 1500 indicated a discussion with Queens Square, National Hospital for Nervous Diseases in London ("QS") who would review the scans and arrange transfer if necessary. A nursing note timed at 1800 indicated that CES had been confirmed and that the Claimant was to be transferred urgently to QS. An ambulance arrived at WGH at 1835, left at 1935, and arrived at QS at 2009. The Claimant was admitted at 2034, taken to theatre at 2230, and surgery commenced at 2300. Some 17 hours, or so, had therefore passed between the Third Defendant's suspicion of CES and decompressive surgery.

17. I am not dealing with condition, prognosis and quantum. For now, it suffices to say that the Claimant has persistent bowel, bladder and sexual dysfunction. It goes without saying, that the Claimant has suffered very significantly and will continue to do so. He is deserving of the utmost sympathy. His approach to this litigation has been entirely dignified.

Applicable Policy and Guidelines

18. In 2012 (as now), there was no defined pathway for primary to secondary care referrals in the context of CES either nationally or locally. This is relevant in a case where it is alleged that it was mandatory for the GP to refer in a particular way.

19. At the time of the Claimant's admission there were available "Standards of Care for Established and Suspected Cauda Equina Syndrome" published by the Society of British Neurological Surgeons. This brief publication noted that the clinical assessment of patients with suspected CES is difficult. The relevant standards of care read as follows:

Standard of care

> • *All cases of suspected CES should be referred to and assessed at the local Emergency Department or orthopaedic/neurosurgical service depending on local facilities and arrangements.*
>
> • *All Emergency Departments receiving patients with suspected CES should have an agreed protocol with their spinal service for the assessment, imaging and referral of CES cases.*
>
> • *The need for MRI scanning should be established and performed locally if at all possible. Access to a 24 hour MRI scanning service must be available for patients with suspected cauda equina syndrome.*

> *• If cauda equina compression is confirmed by MRI scan, the local neurosurgical or orthopaedic spine unit must be informed immediately and the images made available.*
>
> *• The patient should be transferred directly to this unit with appropriate documentation and images.*
>
> *• Decompressive surgery should be undertaken immediately whenever the clinical and radiological assessment indicates that long-term neurological morbidity might be reduced. Nothing is to be gained by delaying surgery and potentially much to be lost.*

20. These Standards, though well appreciated in Neurological and Orthopaedic Spinal Surgery communities, had not been nationally agreed or ratified by the British Orthopaedic Association or British Association of Spine Surgeons and were not, at the time, mandatory for Orthopaedic Units. The standards envisaged referring and assessing suspected CES cases to and at the local Emergency Department or orthopaedic/neurosurgical service depending upon local arrangements, which is relevant in the context of this case.

21. There was a WGH Policy for admissions to hospital with acute neck and back pain including cauda equina syndrome. It was dated September 2011. It was designed to apply to patients with spinal symptoms who attend the A&E department or who are referred for acute admission via Out Patients or following a GP referral. Its stated aims included:

    i) Providing a safe environment for patients whose neurological condition has the potential, as was the case here, to deteriorate between admission and the delivery of appropriate surgical care, particularly in cases of CES;

    ii) To ensure that post-admission, patients are investigated expeditiously, their pain requirements are managed optimally (including early surgery when necessary);

22. The policy applied to Foundation Year doctors, SHOs and Specialist Registrars, the Orthopaedic Surgeons involved in the on-call rota and the Orthopaedic Surgeons with spinal interest including Mr Langdon. It went on:

> *"Further specific advice with regard to cases of acute cauda equina syndrome:*
> *1. The on-call consultant must be informed as soon as this diagnosis is suspected.*
> *2. An urgent MRI scan is required. If this cannot be achieved at Watford on the same calendar day, the patient must be referred to a centre with a 24 hour scanning facility…It is not acceptable for these patients to be kept overnight waiting for an MRI scan to be performed locally, unless this has been specifically advised by the Neurosurgical Centre, and duly recorded in the patient's notes.*

3. If an MRI scan is performed at Watford, with Mr Langdon or Mr Dyson and the SPR attached to the spinal team should be informed at the earliest opportunity.
4. A urinary catheter should be passed if there is any evidence of retention"

23. Dr Roffey and Dr Kirkby said that they were unaware of the policy and I have no evidence before me that it was easily available to them. Inter partes correspondence suggests that it was not contained on the First Defendant's intranet, where such policies are usually stored. Mr Langdon told the Court that he did not consider the Policy to be suitable given the breadth of what it hoped to achieve but that in any event, it had never been ratified, in that it had never been approved or ratified by the relevant Trust Policy Ratification Group. He also considered that all junior doctors working in A&E and in Orthopaedics would know about the potential urgency of suspected CES, regardless of whether they knew about the local policy. He said that the accepted practice or pathway at the hospital was to refer any confirmed CES cases on, usually to QS but in any event to a tertiary unit for decompression surgery. Whatever the status or applicability of the policy, I find, as set out below, that any failure by the First Defendant to have an appropriate protocol (because it was not ratified) and any ignorance about it or non-compliance with it on the part of junior doctors such as Dr Roffey and Dr Kirkby has no causative effect for the reasons set out below.

24. There were NICE Guidelines in place at the time relating to Sciatica. They did itemise the red flags for CES and other spinal conditions in addition to sciatica and should have been familiar to competent GPs in the context of identifying serious conditions whose signs and symptoms may overlap with sciatica. The guidance on how to manage someone with sciatica who presented with red flag sign/s was at page 7 to "*admit or refer urgently for specialist assessment using clinical judgment"*. On Page 10 there is further guidance in the context of a patient with sciatica attending for "Follow Up". There are various options provided when reviewing the diagnosis of sciatica and considering alternative causes. The presence of a red flag retains the guidance of "*admit or refer urgently for specialist assessment using clinical judgment"*. If there is progressive, persistent or severe neurological deficit, the guidance is *"to admit or refer urgently to neurosurgery or orthopaedics for specialist assessment, depending on clinical judgment and local referral pathways"*.

25. The Claimant's GP Expert, Dr Swale, also referred to the BMJ 2009 Clinical Review "Cauda Equina Syndrome" which specified that new bladder, bowel or sexual symptoms in the context of a patient with a history of back pain and associated leg pain justified a "*timely referral for appropriate investigation and expert treatment*".

Summary of Allegations

26. It is convenient to summarise the case against each defendant in reverse order. The Claimant alleges that the Third Defendant was in breach of duty in that, having suspected CES, he should not only have advised the Claimant to attend WGH as soon as possible but he should have contacted WGH to ensure that an assessment by the orthopaedic team was expedited for the Claimant on his arrival as an "orthopaedic expected patient", effectively bypassing A&E and saving precious time.

27. The Second Defendant admits that the Claimant's condition warranted a "Green 2" emergency response within 30 minutes and that the failure to so assess him at 0632 was a breach of duty, resulting in a delay of 19 minutes. It is denied that this delay had any causative effect. It is agreed that if this is the only avoidable delay, it is *de minimis* and if it is not the only cumulative delay, I will need to apportion any loss arising from that 19 minute delay.

28. The Claimant's case in respect of the First Defendant, is that he was potentially a surgical emergency and that his CES diagnosis ought to have been confirmed sooner. Time was of the essence and it was mandatory to investigate him as expeditiously as practicable. As such, following Dr Kirkby's assessment of the Claimant as suspected CES:

> (i) she should have contacted the on-call consultant (Mr Langdon);
>
> (ii) she should have arranged for an urgent MRI;
>
> (iii) she should have marked the MRI request form as urgent and it should have referred to CES or suspected CES;
>
> (iv) C was an emergency case, justifying interruption of the elective MRI list and an MRI should have been started in the next available slot in the list;

The Case on Causation

29. The Claimant's pleaded case on factual causation is that had steps been taken more promptly to diagnose his CES, surgery would have been achieved either at WGH or QS prior to 1500 on 12 March 2012. Various detailed timelines have been produced to identify the likely sequence of events, which it is said should have obtained, in any given permissible situation, depending upon my findings of fact and determination of allegations of breach of duty. Each timeline breaks down the alternative sequences of events into sixteen different steps. And by detailed, I mean that even 3 to 4 minute walks from one department to another have been factored in as separate steps. On differing alternative factual bases, the Claimant submits that decompression would reasonably have been achieved during a potential window between lunchtime and mid-afternoon. The First Defendant avers that the Claimant's suggested timescales are inappropriately speculative, "*wholly impractical and unrealistic*" taking into account "*the resources of a District General Hospital*". An MRI within 4 hours would have been reasonable and it is unlikely that surgery would have occurred before 1500. It was reasonable for Mr Langdon not to interrupt and circumvent his surgical list but rather to transfer the Claimant to QS for surgery in accordance with the established pathway in operation. The First and Second Defendants submit that WGH does not have an acute spinal emergency service although this is in dispute, in the sense that material now available to the Claimant suggests that acute spinal surgery can and does occur at WGH including, though very rarely, decompressive surgery for CES.

30. The Claimant's case on legal causation is that, if he had undergone surgery on or before 1500 on 12 March 2012, he would not have progressed to CESR, that is

complete CES. He would have retained voluntary bladder and bowel control and his sexual function would be near normal. He would have continued to suffer from some neuropathic pain in the saddle and genitals, but his symptoms would have been better than they currently are. The Defendants, collectively, deny that any negligence on their part was causative of injury. The First Defendant's case, which is supported by the Second and Third Defendant, is that on admission, it is likely that the Claimant was already in urinary retention but that in any event he had unavoidably progressed to CESR by 1203 and certainly by 1445/1500 when the MRI was seen by the Registrar, Dr McKenzie. It is therefore unlikely, say the Defendants, that any decompressive surgery before that time would have impacted upon his condition and prognosis. If I agree with the Defendants about legal causation, any findings of negligence will not sound in damages.

The Law

31. The "*Bolam*" test applies (*Bolam v Friern Hospital Management Committee* [1957] 1 WLR 582). A doctor must provide care which conforms to the standard reasonably to be expected of a competent doctor. He (/she) will not be in breach of his (/her) duty of care if a responsible body of medical opinion would have approved of the treatment given and it matters not that other experts might disagree.

32. In *Maynard v West Midlands RHA* [1984] 1WLR 634, Lord Scarman stated at 638E:

> "Differences of opinion and practice exist and will always exist in the medical and other professions. There is seldom only one answer exclusive of all others to problems of professional judgment. A Court may prefer one body of opinion to the other, but that is no basis for a conclusion of negligence."

33. In *Bolitho v City and Hackney Health Authority* [1997] UKHL 46, [1998] AC 232 the House of Lords held that the reference in *Bolam* to a "responsible body of medical men" meant that the court had to satisfy itself that medical experts could point to a logical basis for the opinions they were supporting. Per Lord Browne-Wilkinson: "*if, in a rare case, it can be demonstrated that the professional opinion is not capable of withstanding logical analysis, the judge is entitled to hold that the body of opinion is not reasonable or responsible. I emphasise that in my view it will seldom be right for a judge to reach the conclusion that views genuinely held by a competent medical expert are unreasonable…. It is only where a judge can be satisfied that the body of expert opinion cannot be logically supported at all that such opinion will not provide the benchmark by reference to which the defendant's conduct falls to be assessed".*

34. The *Bolam* test and its application, post *Bolitho* are usefully summarised at paragraphs 20 – 25 of the judgment of Green J (as he was) in *C v North Cumbria University Hospitals NHS Trust* [2014] EWHC 61 QB.

35. I pay especial heed to paragraph 25(vii) of Green J's judgment and have endeavoured to see beyond stylistic or inadvertent blemishes, to evaluate the written and oral expert evidence as a whole and as against other evidence before me. I naturally remind myself that any preference that I may have for one body of opinion over another is not

a sufficient basis for a finding of negligence. I bear in mind that where expert opinion considers that an act or omission alleged to be negligent is reasonable, I can, if I see fit, attach substantial weight to that opinion.

36. In the context of the present case, and the Claimant's hypothetical alternative timeline/s, it is agreed between the parties that the court should be guided by what would be regarded as the reasonable time(s) in which particular steps might realistically be taken, as opposed to the minimum achievable. Mr McLeish, on behalf of the Claimant, invites the Court to consider, with care, what that means in an emergency.

37. Following the provision of evidence, I have concluded (and the parties agree) that the essential issues which I must decide are as follows:

    i) Should Dr Tanna, the Third Defendant, have made a direct referral to the orthopaedic team at WGH rather than advising the Claimant to go to A&E? If so, what reasonably, should have happened in terms of timescales? This is the starting point for breach of duty because it will determine, in part, the stop watch for the purpose of factual causation.

    ii) What, if any, difference did the negligent 19 minute delay caused by the Second Defendant make, in the event that other avoidable delays occurred?

    iii) Whether or not Dr Tanna was negligent, should the Claimant have been referred for an urgent MRI scan sooner and if so what ought to have happened and when? This will include consideration of when factually he was seen by Dr Kirkby, whether he ought to have been seen by Dr Kirkby sooner, whether she ought to have spoken with Mr Langdon sooner, whether the pre-existing MRI list ought to have been interrupted to make way for the Claimant and whether the WGH spinal surgery list ought to have been interrupted to allow for decompressive surgery.

    iv) If any act of negligence is established, has it, on the balance of probabilities, caused the Claimant damage? What would have happened absent negligence? In the context of the case, this requires me to decide, whatever language or categorisation is deployed [such as CESI/CESR] whether, on the balance of probabilities, a more favourable outcome could reasonably have been achieved before 1500. If I decide that even by 1000, for example, the Claimant was in CESR and earlier surgery would have made no difference, then technically, there is no need for me to make findings about breach or even factual causation. However, given the way the Claimant has advanced his case, I have decided to address all matters relied upon by the Claimant in terms of breach and factual causation, regardless of legal causation.

Evidence Relating to Alleged Breach of Duty

38. During the trial, I heard evidence from:

    i) The Claimant and his wife;

ii) Dr Tanna, the Third Defendant;

iii) Dr Roffey who was a FY2 doctor at the time working in A&E, Dr Kirkby who was a FY1 doctor working in the Orthopaedic team at the time, Ms Devereux, Chief Superintendent Radiographer at WGH (who simply confirmed her signed statement), and Mr Langdon, Consultant Orthopaedic Surgeon at WGH, who was on call at the time;

iv) Two experts in general practice, Dr Russell and Dr Swale (on breach of duty), two orthopaedic experts, Mr Thorpe and Professor Fairbank (on breach of duty and factual causation) and three neurosurgeons, Mr Mannion, Mr Crocker and Mr Cowie (on factual, medical and legal causation).

39. I did not hear from the then Registrar, Dr McKenzie who reviewed the Claimant mid-afternoon. He is now a Consultant but for ease I shall use his previous title. With the agreement of the Claimant and upon the application of the First Defendant, I admitted his written evidence as hearsay under the Civil Evidence Act 1968. Inevitably, the parties disagree about the weight that I should attach to his signed witness statement.

40. In determining the issues summarised in paragraph 37 above, I will need to decide what weight to attach to Dr McKenzie's untested written evidence, what assistance the cited medical literature provides (all 26 separate papers/publications referred to by the parties) in assessing the experts' justifications for their views and to identify the features of the expert evidence that might lead me to conclude that one expressed expert view is more or less capable of withstanding logical analysis than another.

Breach of Duty: Third Defendant

41. The Third Defendant denies the breaches of duty summarised above. It is important to record that the Claimant's case is that the only course available to a reasonably competent GP on the known facts, was to refer the Claimant urgently to the orthopaedic department of WGH and to call that department to notify them of his impending arrival as a suspected CES patient.

42. Dr Tanna says that he considered a diagnosis of CES and his advice, namely urgent attendance at Watford A&E was in accordance with a responsible body of GPs. Dr Tanna also denies causation (see below). He disputes, as does Mr Langdon, that WGH's orthopaedic department would have accepted the Claimant without any prior face to face assessment by a GP or A&E practitioner. Even if the Claimant had been admitted directly to the orthopaedic team, he would have been assessed between 0845 and 0900 after the night/day shift handover. It is denied therefore that any negligence on the part of the Third Defendant caused any injury.

43. Dr Tanna is an experienced GP. He worked briefly for a few months in 2001 at WGH as an A&E SHO. He was familiar with the type of medical care and services available both in Hemel Hempstead and Watford. He was familiar with CES and its possible red flags and believes that he would consult patients presenting with symptoms suspicious of possible CES every 1 to 2 months. After speaking with the Claimant on the phone he felt that the possible numbness in the saddle areas was a red

flag and that Mr Hewes needed an urgent face to face review by a doctor who could conduct an examination and arrange further urgent investigations. He disputed that the only reasonable option in such circumstances was to circumvent A&E and call WGH in order to ensure that an assessment by the orthopaedic team was expedited upon the Claimant's arrival. Referral to A&E, he said would and should have afforded the Claimant reasonable and timely care and would permit urgent referral to the necessary specialist team. He considered A&E doctors to be sufficiently qualified and specialist to arrange an urgent MRI scan and to diagnose CES or upon receipt of the MRI to effect diagnosis within a more specialist team. He disputed that he had departed from the NICE Guidelines relating to Sciatica which include reference to CES. He included A&E departments within the reference to "specialist assessment" on page 7 of that publication. He considered that A&E doctors are specialists in emergency care and also considered that they can quickly signpost patients on to even more specialist care ie neurosurgery, spinal or orthopaedics. He did not feel as though matters had advanced sufficiently to manage the claimant in accordance with page 10 of the Guidelines ie to make an urgent neurosurgical or orthopaedic referral. He felt that he had a margin of discretion in terms of clinical judgment.

44. There was a large measure of agreement between the GP experts. They agree that the Claimant, when speaking with Dr Tanna on the 'phone, presented with the red flag symptom of saddle anaesthesia along with a relevant history of back pain, unilateral sciatica and numbness of the leg. During the 'phone consultation the Claimant was not complaining of any bowel or bladder symptoms and Dr Tanna elicited that the Claimant had passed urine and opened his bowels the day before. They found Dr Tanna's assessment to have been reasonable. In the light of the transcript and medical notes, the experts agree that referral for specialist assessment, diagnosis and management was necessary. The only relevant area of disagreement in respect of breach of duty, is whether it was reasonable for Dr Tanna to have referred the Claimant to the A&E department or whether it was necessary for him to refer the Claimant directly to an orthopaedic/spinal or neurosurgical specialist for assessment. Both had different experiences in practice of whether a direct orthopaedic referral might also result in delay.

45. Dr Swale's opinion, that there was no other option but to refer the Claimant urgently to an orthopaedic/spinal or neurological specialist (to the absolute exclusion of A&E), was based on (i) the obvious red flag of saddle anaesthesia in the context of a patient with established back pain and sciatica and (ii) on the NICE Guidelines, summarised above, which advocate the referral of patients with red flags for urgent "specialist" assessment using clinical judgment. An A&E referral was in his view illogical because although he agreed that it could and would result in specialist assessment, it injected unnecessary delay into a potentially time critical process. He was not suggesting that A&E doctors are not specialists in their own field and agreed that they could diagnose CES. Various written references to a common practice of GPs referring suspected CES cases to A&E were put to Dr Swale in cross examination. If there was a common practice of GPs referring suspected CES cases to A&E departments, Dr Swale did not agree with it. He fairly conceded that if I accept the factual evidence I heard from Dr Langdon (which I do) that any GP who tried at 0600 to refer a suspected CES directly to the orthopaedic department rather than the A&E department would be informed to go through A&E, then the GP would have

discharged his/her duty and the alleged failure to refer to a specialist would not have affected the outcome.

46. It is clear to me, despite the best efforts of Mr McLeish in closing submissions, that in forming his opinion, Dr Swale was referring to page 7 and not page 10 of the NICE Guidelines. Nowhere in the pleaded case, in Dr Swale's main report or in the Joint statement, is it suggested that any urgent referral specifically to a neurosurgical/orthopaedic department (rather than "specialist assessment") was mandated because Dr Tanna ought to have treated the Claimant as a patient with a different "Follow Up" status. Nor in fact, was this put to Dr Tanna in cross examination. Dr Swale did not advance his expert opinion through the prism of the Claimant being a "Follow Up".

47. Dr Russell, the GP expert instructed by the Third Defendant was of the view that having correctly identified a suspicion of CES, various options were available to the reasonably competent GP in Dr Tanna's situation and all of these options would lead to timely specialist assessment, diagnosis and treatment:

i) An urgent face to face GP consultation and then, if appropriate, an urgent referral to A&E or to appropriate secondary care specialist. By suggesting this, Dr Russell agreed that such a consultation was not necessary. He explained in his oral evidence that he was not suggesting that this was the best option either and that by "urgent" he meant if the patient could be seen within minutes;

ii) An instruction to the patient to attend the nearest A&E plus ringing A&E to notify them that on the basis of a 'phone consultation, the patient would be presenting with possible CES;

iii) As per (ii) above but arranging an ambulance (which independently occurred in this case, in any event);

iv) An instruction to the patient to attend the nearest A&E department with urgent MRI scanning facilities, with no further action taken (which is what Dr Tanna says he did though the Claimant disputes there was any communicated urgency about it)His opinion was based on a number of factors: Dr Tanna had not seen the patient and was triaging on the telephone, he therefore simply had a brief oral history and did not "know" Mr Hewes in the conventional GP/Patient sense; the reference to "specialist assessment" reasonably includes A&E and most reasonably competent GPs would read it that way, otherwise NICE would have been more prescriptive on page 7; A&E departments are capable of assessing suspected CES on an urgent basis; the imperative for specialist care arises more critically at the treatment stage than diagnosis stage of CES and A&E clinicians are perfectly capable of managing the suspicion on an urgent basis; making a telephone call to the orthopaedic/neurosurgical/spinal surgical units would inject very real delay in managing the primary care patients waiting to speak with Dr Tanna; going to A&E would not necessarily involve delay though it might; the duty on the GP was to ensure so far as was reasonably practicable that the patient underwent the relevant investigations, namely an MRI scan and this regularly happens in A&E; he agreed that anecdotal evidence always came with a health warning but that his colleagues' experience was the same as his.

48. Given all those considerations, he believed that there was a range of options rather than one mandated option. He agreed in oral evidence that referring the patient directly to the orthopaedic department would also be reasonable although, as he explained in his main report and in the joint statement, he had personal experience of this causing rather than reducing delay, hence the need for a range of options.

49. The Claimant is critical of Dr Russell for identifying at least one option (urgent further GP face to face consultation) when the NICE Guidelines advocate urgent referral for specialist assessment according to clinical judgment and also for relying upon anecdotal evidence.

50. Dr Tanna's evidence (which I find was given in a quietly impressive and non-defensive manner) does not dispose of this issue. It must be determined almost exclusively on the expert evidence and with reference to other independent markers of acceptable common practice. There are various aspects of the Guidelines and other publications that, in my judgment, support the more flexible approach articulated by Dr Russell. First, I note that if Dr Swale is correct that the only ie the mandated reasonable course for a GP faced with one CES red flag is direct immediate referral to either an orthopaedic/spinal surgical or neurological unit, it is surprising that there was in 2012 and is now, no defined pathway to this straightforward effect for primary to secondary care referrals. I do not consider this to be dispositive of the issue but it is a factor. Second, the NICE Guidance does not distinguish between direct and indirect referrals or identify the required mechanism/pathway for referral ie that it must be by telephone or ambulance etc or that it must not be via A&E. Third, the NICE Guidance on page 7 and 10 uses different terminology, as set out in paragraph 24 above. Arguably, this means that it is reasonable to interpret "specialist assessment according to clinical judgment" as <u>including</u> A&E assessment especially as Dr Swale accepted that A&E staff were capable of appropriately assessing and managing suspected CES cases. It is not clear to whom the 2009 Standards of Care from the Society of British Neurological Surgeons were directed but the view expressed in that document accords with Dr Russell's analysis rather than Dr Swale's because it permits urgent referral to A&E or to a more specialist setting. A 2014 Audit of MRI scans for suspected CES from Central Manchester University Hospital NHS Trust implied that such scans were arranged commonly by A&E. A Patient Leaflet on CES published by the British Association of Spine Surgeons informs the patient that s/he should be assessed upon development of a red flag by someone of suitable training and experience who can reassure or arrange an urgent MRI scan, as A&E doctors can. My attention was drawn to a 2007 article in the British Journal of Neurosurgery on CES and the correlation between clinical assessment and MRI scanning which observed:

> "The majority of episodes of CES in the United Kingdom will be referred from Primary Care Trusts (PCT)" to either Accident and Emergency departments or to local orthopaedic departments"

51. If Dr Swale is correct, there would never be a logical basis for sending such patients to A&E. The available Guidance and publications do not support such a prescriptive approach and I am not prepared to dismiss Dr Russell's evidence because he included in his range of options, one which he agreed risked causing minor delay and was outside the guidance contained in the NICE Guidelines. I also note that the GP who saw Mr Hewes the previous day, on 11 March 2012 had apparently advised him to

attend A&E if he experienced numbness although I do not view this, of itself, as in any way determinative.

52. Both GP experts gave their evidence in good faith and there is nothing about their experience to cause me to prefer the one over the other. I have concluded that Dr Swale's evidence is too inflexible when set against the evidence and publications and that Dr Russel's evidence accurately reflects a reasonable position in terms of the options available to Dr Tanna at around 0600 on 12 March 2012.

53. I should add that I have read the transcript of the call between the Claimant and Dr Tanna and I have listened to the audio recording. It is correct that the Claimant was advised that he would have to go to A&E for an urgent scan rather than there being a technical referral. The Claimant told Dr Tanna that he would go to Watford A&E. Disputes about how urgent this was do not take the matter further as an ambulance was in fact arranged at 0632 and the Claimnt was conveyed to Watford.

54. I have dealt with the Dr Tanna's alleged negligence in some detail because it has a direct bearing on the Claimant's case on factual causation. I have already indicated that I do accept Mr Langdon's factual evidence that had Dr Tanna rung the A&E department between 0600 and 0630 on 12 March 2012, on the balance of probabilities, he would have been advised to re-route the Claimant to A&E. Even if Dr Tanna had been negligent, I find on the facts that it would probably have made no difference.

55. It is not alleged that there was a negligent delay between the Claimant's arrival at Watford and Dr Roffey's request for an orthopaedic assessment. It is also not alleged that Dr Roffey was negligent. That being so (and allowing for the 19-minute avoidable delay caused by the Second Defendant), the next logical issue for me to determine is whether Dr Kirkby assessed the Claimant at 1000 or 1040 because this will amount to the start of the stop watch in the event that I find that the MRI scan ought to have been performed earlier.

The Time of Dr Kirkby's Assessment

56. Dr Roffey made a handwritten note that the Claimant was "accepted" into Orthopaedics at 1040. He gave evidence that because the Claimant was a clear orthopaedic case, he would be "accepted" before being "assessed" by orthopaedics. When he had examined the Claimant at 0920, he was unable to examine his co-ordination due to complaints of pain.

57. Dr Kirkby was junior to Dr Roffey in the sense that she was a FY1 doctor and commenced her rotation in orthopaedics at WGH in August 2011. She did not have authority, as such, to accept patients or to order MRI scans and would require the authorisation of her Registrar. She came on duty at 0800. Her written note of her initial assessment of the Claimant in the clerking proforma booklet cites a time of 1000.This is relied upon heavily by the Claimant who submits that there is no obvious reason for reading it any other way and that unless other external evidence undermines it, the court should conclude that she examined the Claimant at 1000. Dr Kirkby believes that the noted time is an error and is attributable to the fact that she wrote up the notes retrospectively during a busy working day. The First Defendant submits that there is other evidence from which the Court can infer that the time of the

assessment was likely to be closer to 10.40/50 (allowing ten minutes for the provision of pain relief to the Claimant).

i) The data contained within the available bleeper activity material confirms that an A&E number bleeped Dr Kirkby at 10.34. This was her first bleep from A&E of the shift. It is assumed that this was done so that the Claimant could undergo an assessment by a member of the orthopaedic team. Noting further Dr Roffey's hand written entry that the Claimant was "accepted" into Orthopaedics at 1040, Dr Kirkby believes the Claimant was accepted before he was assessed. This bleep is capable of providing some support for the times contended for by the First Defendant;

ii) She was, like Dr Roffey, clear in her oral evidence that there would be no need to assess the Claimant before accepting him as a patient as he was a clear orthopaedic case and I have no reason to doubt that. It is therefore evidence which is capable of supporting an assessment time of 1040/50.

iii) Her evidence was to the effect that she would have discussed the Claimant with her Registrar, Dr McKenzie, before seeing the Claimant. The Registrar will have guided her about the type of things she should look out for. Although I accept there is no evidence of her bleeping the Registrar, that assumes that any contact with Mr McKenzie was initiated by bleeper whereas it might not have been. There is likewise no evidence of her bleeping him before 1000 so this issue does not take matters very much further. There was probably time to permit such a discussion depending upon his physical proximity, which remains unknown given the passage of time;

iv) Dr Roffey had prescribed pain relief. The morphine was administered at 1045. Both Mr and Mrs Hewes stated in their written statements that this happened before seeing Dr Kirkby. Moreover, the fact that Dr Kirkby was able to undertake a more extensive examination (including testing for co-ordination) is consistent with her assessment taking place after 1045 once the morphine had started to take effect. The Claimant had a spinal x-ray at 1123. I work on the basis that Dr Kirkby's assessment probably concluded before that x-ray;

v) The data shows that Dr Kirkby bleeped Dr McKenzie at 1127 which is consistent with her evidence that after her diagnosis of suspected CES, she contacted him directly in order to discuss urgent management.

58. I have little hesitation, given the details recited above in finding, as a matter of fact, that on the balance of probabilities, Dr Kirkby's assessment of Mr Hewes occurred approximately between 1050 and 1120. It should be recorded that there is no allegation of delay in Dr Kirkby's assessment.

59. I have found that Dr Tanna was not negligent and that the clock for any subsequent allegations of negligence against the First Defendant did not start ticking until Dr Kirkby concluded her assessment of the Claimant at approximately 1120 (ie 1101 if one factors in the Second Defendant's culpable 19 minute delay).

Breach of Duty by First Defendant

60. The breaches alleged against the First Defendant can conveniently be dealt with collectively because they amount to an allegation that the MRI scan and follow up surgery were not performed soon enough. The Claimant alleged that Dr Kirkby should have interrupted Mr Langdon's clinic no later than 1110 to discuss the Claimant and that his senior involvement would have resulted in an MRI scan which would have been available for view by 1220 or 1255, depending upon whether another "urgent" scan patient was "bumped" in the MRI queue. He contends that this in turn, could and should have lead to a decision to operate and that therapeutic decompression could have occurred during a period between 1308 and 1525. His suggested times are based on how long it would take to walk various distances, to discuss the patient, to request the scan, for the imaging to take place, for the images to be uploaded on to the relevant "PACS" computer system and for surgery to occur. Within approximately 20 minutes of Dr Kirkby speaking with Dr McKenzie (rather than the Consultant), the MRI had been requested. It does not appear to be in dispute that upon Dr McKenzie's review of the scan, Mr Langdon was contacted.

61. Dr Kirkby agrees that she did not consult Mr Langdon as soon as she suspected CES. She spoke, instead to her Registrar, Dr McKenzie. It was invariably her practice to escalate any issue to her Registrar rather than to a Consultant. Dr McKenzie had a bleeper, Mr Langdon did not. Had she wished to obtain access to the Consultant, Mr Langdon, who was in clinic during the morning, she would have telephoned a switchboard and asked to be put through to his mobile telephone. That, she said, could take any amount of time but she would hope that if he were in the clinic (as opposed to in theatre), he might be able to respond to an urgent call within 10 minutes or so. The evidence before me was that the mobile telephone signal in the clinic was minimal and that it might have been necessary to walk there and interrupt him.

The Evidence of Dr McKenzie

62. Dr Kirkby's evidence about consulting Dr McKenzie and the timing of the MRI scan is bound up with the written evidence of Dr McKenzie. He is now based in Australia. Throughout key stages of this litigation, the First Defendant's solicitors remained in contact with him and he provided assistance and a signed statement dated 25 April 2018. In August 2018 he indicated that he did not feel able to give evidence either in person or by video link. Email communications from him at that time described his personal and professional situation both of which were causing him strain and he was additionally worried about the financial and family consequences of taking time off work to travel to the UK to give evidence. By February 2019 his personal and family situation had altered for the worse and he was plainly very anxious about the litigation. As described, his written evidence was admitted as hearsay.

63. Mr McLeish invites me to conclude that the explanation for not giving evidence is inadequate and that no weight should be attached to his written evidence. That being so, I must set out in sufficient detail my approach to this issue. Mr McLeish makes the valid point that the Claimant is prejudiced by the inability to cross examine Dr McKenzie, that not every contention within it is referenced in the medical notes and that it would be unfair to accept at face value what he says about obtaining, in particular, the MRI scan. I was referred to *Wisniewski v Central Manchester Health Authority* [1998] PIQR 324 and *Welsh v Stokes* [2008] 1 WLR and *Manzi v Long's College Hospital NHS Foundation Trust* [2018] EWCA Civ 1882. *Manzi* is not a

useful authority as in that case the relevant witness provided no evidence at all and was tangential in any event. In *Wisniewski* the absent witness provided a short written statement in which he said he had no independent recollection at all and failed to explain what he would have done had he been required to see the Claimant's mother. That is not the case here although I have applied the principles set out in the judgment of Brooke LJ. In *Welsh* the Claimant's case depended entirely on the hearsay evidence from the unknown absent witness and the judge's approach was not vulnerable on appeal. The Civil Evidence Act 1968at section 4(2) provides:

> "Regard may be had, in particular, to the following—
>
> (a)whether it would have been reasonable and practicable for the party by whom the evidence was adduced to have produced the maker of the original statement as a witness;
>
> (b)whether the original statement was made contemporaneously with the occurrence or existence of the matters stated;
>
> (c)whether the evidence involves multiple hearsay;
>
> (d)whether any person involved had any motive to conceal or misrepresent matters;
>
> (e)whether the original statement was an edited account, or was made in collaboration with another or for a particular purpose;
>
> (f)whether the circumstances in which the evidence is adduced as hearsay are such as to suggest an attempt to prevent proper evaluation of its weight."

64. I do not agree that the reasons given by Dr McKenzie for his non-attendance are inadequate. At the relevant time, his wife was ill, he had additional parental duties to his three young children and financial pressures. Just before the trial, all of that remained the case with yet further personal and family strain which he identified in communications with the solicitors. I do not agree that other evidence in the case entitles me to draw any sort of adverse inference about his evidence. We have a detailed enough note of his assessment of the Claimanty. True, it is, that I have no evidence before me as to what was said by anyone to the relevant radiographer and radiologist but this of itself does not prevent me from attaching weight to the bulk of his evidence. Much of his statement is couched in the language of what he would have done, interspersed with references to the available notes and bleeper records. This requires me to approach the evidence about his standard practice with care, particularly as he has not been cross examined, but I do consider that I am able to attach an appropriate amount of weight to his evidence, not least for the following reasons:

i) The bulk of his evidence is broadly consistent with other evidence in the case about practice and procedure in the orthopaedic department at WGH. It is also consistent with the available known timings;

ii) Mr Hewes' scan obviously was treated in accordance with the usual procedure, namely he was placed into the 11.30 to 1400 slot reserved for inpatients for whom a scan had been requested that morning ie urgent cases. He was listed next to two other "urgent" cases. The timing of the scan suggests urgency and by implication dialogue by someone suitable senior with the Consultant Radiologist;

iii) Mr Thorpe (orthopaedic expert for the Claimant) accepted that the time actually taken from orthopaedic acceptance to logging the scan request was reasonable and that the time taken from the logging of the scan request to availability of the images was reasonable. That being so, I cannot agree that Dr McKenzie's evidence was as central or as much in dispute as Mr McLeish submitted;

65. Accordingly, I accept the following features of Dr McKenzie's written evidence.

66. He was an Orthopaedic Registrar at WGH and had worked there since October 2011. He was responsible that day for the orthopaedic ward round of all inpatients and on call for Trauma and Orthopaedics. Given the circumstances of Dr Kirkby's assessment, he would have taken steps in any event to rule out CES and would have treated Mr Hewes urgently. His practice in such a situation would be to go himself to the radiology department to arrange the scan. Marking the Request Form as "urgent" would not make any difference in his view because what is required and what is standard practice is to speak directly with the Consultant Radiologist, the person who determines the order in which patients are scanned in order to try and "jump the queue". He believes that he would have gone at around 11.30 in order to ask the radiology department to interrupt the list. The timing of the scan indicates to him that his discussion had the effect of expediting the scan. He cannot recall when he became aware of the Claimant's urine volume of 621ml. It would have caused him to suspect that the patient was in retention though this would not have altered his management. He says, though there is no record of this, that he would have reviewed Mr Hewes again upon return from Radiology and possibly discussed his case with the on-call Consultant, Mr Langdon. If this roughly coincided with the bladder scan at 1203, the lack of a note may be explained by the notes physically being with the bladder scanner/nursing staff. Following the MRI scan, he would have reviewed the images and discussed the case with Mr Langdon immediately, probably face to face and probably at about 1410. After this he would have reviewed Mr Hewes again. The plan was to contact QS who would review the scan and make arrangements to transfer Mr Hewes if necessary. The note of his review includes reference to "*perianal sensation↓↓, no anal tone,,,Catheter in situ as went into retention*".

67. It is convenient to turn now to the evidence of the Consultant, Mr Langdon. He was employed by the First Defendant in 2012 as a Consultant Orthopaedic Spinal Surgeon having taken up his post in October 2011. At the time there were only two Consultant Spinal surgeons at the First Defendant's Trust, himself and Mr Dyson. Mr Dyson was absent on 12 March 2012 through ill health. Mr Langdon was therefore the only spinal surgeon available that day. He was on call as a general orthopaedic consultant. His evidence was to the effect that due to staffing structures had the Claimant presented on any other day, there would not have been a surgeon available to perform decompression surgery. Mr Langdon was busy all morning in a meeting, on the ward and in clinic with no-one else available to perform those duties. Anyone needing to speak with him on an urgent basis would have been best attending upon him given the lack of mobile telephone signal in the clinic. He did not consider that the WGH Policy was well written and confirmed that it had never been ratified. He said that there was a pathway, to the effect that spinal emergency surgery cases would be referred to QS. The Trust confirmed that in the past 2 years only 2 CES decompression procedures had taken place at WGH. Although he agreed, in principle,

that an urgent MRI scan could take priority over others in the list, there was a system in place where by urgent or emergency scans were managed between about 1130 and 1400-1430 and that the radiology department acted as arbiter in terms of priority after discussion with doctors. He disagreed that he would need to be consulted before a diagnosis of CES but that he could be useful after diagnosis in helping to arrange transfer on to a tertiary unit. His evidence was to the effect that if a patient has been physically seen by a GP who suspects CES, then it could be acceptable and normal practice to refer that patient straight to the orthopaedic department rather than to A&E. This however might involve delay due to the time of day we are concerned with, namely 0800 because at that hour the relevant junior doctor likely to the be the first port of call is usually "running around" a lot. Where a GP suspected CES after a telephone triaged consultation, he would expect the patient to be sent to A&E. His evidence was that from 1440 that day he would, reasonably, not have been free to perform decompression surgery because he had two urgent cases in his Theatre 2 list concerning patients who had been admitted over the weekend. Given the timescales, as we know them to have been, he believed that the MRI scan was obtained as quickly as it could have been and he struggled to see how the hospital could have delivered it sooner. Significantly, he said that Theatre 1 was basically available up until 1440 because he was in charge of that theatre and each case involved a relatively short procedure so, hypothetically, he could have amended his list to accommodate the Claimant in that theatre. After 1440, he felt that he was committed to the first of his two urgent cases in Theatre 2. By 1440 the patient in the first urgent procedure had been sent for. He agreed that the patient could have been cancelled to make way for the Claimant right up to the point of administering anaesthesia but considered that this would cause disproportionate distress in circumstances where WGH had a system in place for referring CES patients to QS and where it could not be known how quickly cancelled surgery could be re-scheduled. Cancelling the patient would have been reasonable, he said, as would transferring the Claimant to a tertiary unit, which is what happened.

68. In my view, Mr Langdon gave evidence in a measured and thoughtful manner. As with the Third Defendant, I did not find his answers to be at all defensive. It was obvious that he wished to be open with and to assist the court, regardless of the outcome.

69. I heard uncontested evidence from the Chief Superintendent Radiographer at WGH. Outpatient scans took place between 0900 and 1130. Thereafter 1130 to 1400 was reserved for inpatients. The consultant radiologist would have to consider and authorise an in-patient referral for a scan. Once authorised the referring doctor would take the referral form from the radiology department to the MRI scanner in the main hospital building. Mr Hewes' scan was the last of three in-patient referrals/requests made that morning. One related to a suspected cancer diagnosis (scan requested 1111 and patient attending for scan 1134) and the other related to a suspected cord compression (can requested 1130 and attended 1221). On arrival at the scanner a patient goes through safety queries and is then scanned. This takes about 30 minutes. The resulted images are checked and once approved placed on the relevant PACS computer system within about 10 minutes.

Failure to Consult Mr Langdon Sooner

70. I have concluded that it was not negligent for Dr Kirkby to consult the Registrar rather than Mr Langdon. For the avoidance of doubt, even if this was negligent, I do not consider that it has made any difference. I preferred the evidence of Professor Fairbank over that of Mr Thorpe for the following reasons:

    i) Mr Thorpe characterised the failure not to speak with Mr Langdon earlier as negligent because it contravened the WGH Policy set out at paragraph 21 above. That policy was probably not even in force but leaving aside any confusion about its status and applicability, I was not satisfied that using a Registrar to effect a quicker MRI scan rather than a Consultant constituted negligence. Mr Thorpe remained adamant that Mr Langdon should have been contacted sooner but on the facts of this case, there is nothing to demonstrate why "earlier ownership" by a Consultant would in this case make any practicable difference. I note that in oral evidence Mr Thorpe essentially asserted that steps "could have been" taken earlier and that this "might have" made a difference. That may be so, but those are not the principles that I am required to apply;

    ii) Professor Fairbank's opinion was I find more nuanced. He agreed that on the face of it, it would be reasonable to contact a Consultant upon suspecting CES but having heard Mr Langdon's oral evidence, he felt that there was very little the Consultant could have added and that not contacting him until the MRI result was known was not negligent. His view was that going via the Registrar was one of a number of reasonable options and was not outwith standard practice. A consultant was not required to add weight to the pressure to scan initially and getting the consultant involved too early, unless a specific problem arose, could also be seen as a waste of precious consultant time and here there was no such specific problem.

71. In any event, there is insufficient evidence to suggest that involving Mr Langdon earlier, would, on the balance of probabilities, have resulted in a quicker scan.

Failure to Mark the Scan Request Form as "Urgent" and to refer to CES

72. It is not in dispute that the referral form did not contain a reference to CES and it was not marked urgent. Mr Thorpe, fairly, offered in evidence that the contents of the form did not inform his opinion. Professor Fairbank considered that a failure to mark the form as urgent did not constitute negligence because it was abundantly clear that verbal discussion between relevant doctors and radiologists is the trigger for achieving urgent scan status. In any event, he says, this scan plainly was treated as urgent.

73. I have little doubt that it would be possible and helpful to include a suspicion of CES and a request for urgency but the factual evidence before the court, which I accept, is that dialogue takes precedence over such matters. The fact that Mr Hewes was inserted into the "urgent" in-patient 1130-1400 slot demonstrates that dialogue probably played its part. I do not find that this constituted a breach of duty but in any event, it made no difference in terms of factual or legal causation.

MRI Scan should have been performed earlier

74. I turn now to the allegation that the scan ought to have been performed earlier. Given my previous finding, that involving Mr Langdon sooner would not have speeded up the process of deciding to scan, this now amounts, on the decided facts and timings, to an allegation that the Claimant's scan ought to have been performed before the other 2 "urgent scans" referred to in paragraph 70 above or least before the second one.

75. There was no further information before me about the cancer diagnosis and cord compression in-patients listed for scan before the Claimant and no evidence that there had been a conversation with the Radiologist about "bumping" them in the queue. The Claimant's case on this issue is simply that I should draw an inference that the Claimant's scan ought to have had priority. In concluding that I should not draw that inference, I have considered the expert evidence. Mr Thorpe suggested that because the Claimant was a "suspected CES" he ought to have jumped the queue despite Mr Thorpe knowing relatively little about the other two patients. Professor Fairbank explained that there is a reasonable variety of practice concerning scanning from hospital to hospital. This District Hospital had one scanner and what he considered to be a rational system for scanning out patients up until 1130 and then making daily space for urgent in-patient cases. This system allowed the hospital to regulate both elective and more urgent work. He accepted that theoretically Mr Hewes could have been scanned ahead of the other two patients but he disagreed that cancer or cord compression cases should necessarily take a back seat in such circumstances, especially where it was not yet known whether the Claimant had CES but he qualified this by observing that he knew very little about those two patients. He considered that the scan was performed within the limits of what he considered to be an urgent scan. I note that Mr Thorpe agreed that the time taken from logging the scan request to availability of the images was reasonable. Again, I found Professor Fairbank's evidence to be more balanced on this issue and that he paid more reasonable attention to the workings of this type of hospital, to oral lay evidence and to the relevant legal test than Mr Thorpe seemed to. There is no evidence that prioritisation of the scan was unreasonable. This allegation fails.

76. As I have rejected the allegations of negligence against the First and Third Defendant, it follows that the 19 minute delay caused by the Second Defendant has made no difference in terms of outcome for the reasons set out in paragraph 27 above.

77. For the sake of completeness, however, I turn to factual and legal causation.

Factual Causation

78. Factual causation can be dealt with briefly. Mr Thorpe accepted that the time taken from orthopaedic acceptance to the logging of the scan request was reasonable (1 hour 19 minutes). He also agreed that it would reasonably take some 2 hours 10 minutes from logging the request to scan, scanning, uploading the results to taking the decision to operate. It would take another 90 minutes to prepare the patient for surgery including anaesthetic induction. The time taken to reach decompression was variable, potentially 60 to 90 minutes. In short, a period of some six and a half hours could reasonably elapse between orthopaedic acceptance and decompression.

Given my findings on legal causation below, it follows that even if the First and Third Defendants were negligent, the outcome based on timings conceded by Mr Thorpe, would have been no different.

Legal Causation

79. All three expert Neurosurgeons commented on some aspects of breach of duty even though they were instructed to opine on causation alone. I do not intend to rely upon their views about liability. Likewise, each has commented upon issues of urinary function in this case including for example, average urine production and retention rates. I accept entirely, as do they, that these witnesses are not expert Urologists. They have been invited to express an expert opinion upon factual and legal causation and in those circumstances, given their experience of assessing urinary function, albeit from a neurosurgical perspective, it is difficult to see how they could not stray into quite detailed analyses of the Claimant's actual urinary presentation and what that might reflect about CES progression, not least because bladder function is a very important indicator in CES diagnosis. Each has long experience of patients with CES and of preparing medico-legal reports. Each is responsible and competent and, I am quite satisfied, gave their evidence in good faith. It has not been suggested that the career and experience of one should merit more respect, in terms of the quality of his opinion, over that of the others.

80. They disagree in stark terms about the chronological point at which, on the balance of probabilities, the Claimant's prospects for a favourable outcome vanished. The root of this disagreement is the classification of CESI versus CESR and how, if at all, available medical literature should inform such classification. Mr Mannion believes that up until 1500, the Claimant did not fulfil the definition of CESR and that the Defendants' experts have succumbed to inappropriate hindsight because the surgical outcome in this case was unfavourable. The Claimant, relying upon this expert opinion, submits that had surgery occurred before 1500, his outcome would have been more favourable.

81. Mr Crocker, the Neurosurgeon instructed by the Second Defendant and Mr Cowie, instructed by the Third Defendant came to the view that the Claimant may well have reached CESR by 0800 but that salvageable bladder function was certainly absent by 1203 when the bladder scan was performed and when, it is agreed, the Claimant's bladder was distended and he was in painless retention.

82. It follows that if the Defendants' experts are to be preferred, the Claimant's case fails on causation because even on his counter factual case, surgery at his earliest suggested time of 1308 would post date the progression to CESR and therefore not prevent the current unfavourable outcome.

83. Why, in a nutshell, do these experts disagree? Essentially because one (Mr Mannion) relies steadfastly, using literature, on a definition of CESR which includes the bladder symptom of overflow incontinence and some bowel dysfunction. Th Claimant never presented with these symptoms before 1500 and therefore remained in CESI up until that point. He also considers that patients who have lost both the desire and ability to void can fit into either category of CESI/CESR. Mr Cowie and Mr Crocker consider that such steadfast adherence to the literature is unreliable and certainly of incomplete practical use in the modern era when CES tends to be diagnosed earlier than used to be the case. They believe that the definition of CESI/CESR has softer edges than either Mr Mannion or the literature allow even though they are content to identify and agree working definitions. They believe that it is better to take a cautious approach to the literature, given the complexity and controversy around CES and to focus more on

the pathophysiological indicators in this particular case. Where, as here, a patient has numbness from very early in the day and has likewise lost the ability and desire to void despite having a very full bladder, CESR has probably been reached. Whilst all the experts acknowledge that trying to time progression from CESI to CESR is very difficult, the Defendants' experts feel that Mr Mannion is trying too hard to put "people into boxes".

84. When giving evidence, these experts were taken by counsel to a significant number of medical articles about CES (some of which had been foreshadowed in the single and joint reports), essentially to undermine or cement the respective approaches. In closing submissions, the parties cited in some detail extracts from these articles for the same reason. I shall return to this literature briefly below.

85. The experts in their joint report agreed on the following definitions:

> "**CES incomplete (CESI):** patients have CES symptoms and signs, with concordant imaging, but have not lost executive control over the bladder and bowel function. For example, a patient might report reduced sensation (hypoaesthesia) in the saddle area, bladder or urinary tract causing altered sensation during micturation or a reduced desire to void, some difficulties passing urine, reduced stream, but they retain control. There is a wide range in the severity of CESI.
>
> **CES complete (CESR):** these patients have complete loss of bladder function, and develop an insensate, non-contractile bladder (neurogenic bladder). The experts agreed that CESR is diagnosed when patients present with painless urinary retention and overflow incontinence. However, the experts also agreed that not all patients develop overflow incontinence, because although the bladder is paralysed and insensate in CESR, some patients are catheterised before incontinence occurs. Incontinence is therefore not a prerequisite for the diagnosis of CESR"

86. Notwithstanding this, Mr Mannion maintained, citing literature, that incontinence is critical in defining CESR and that the definition agreed in the joint statement was a biological one rather than a working one.

87. Mr Crocker referred to bladder function being the best surrogate marker for autonomic function. Salvageable bladder function was absent by 1203 and had been lost at some point between passing urine the night before when he went to bed and the bladder scan at 1203.This is based on the following factors:

i) The bladder scan at 1203 showed a residual volume of 621ml. Given the average retention of 300-400ml before the urge to urinate is experienced, this suggests an excess of volume during a period of bladder denervation. Normally adults produce 50ml urine per hour so back calculating, it might be said that the Claimant was at 400ml volume at around 0800 yet felt no need to

void. This suggests CESR was established by 0800. In expressing views about average retention, Mr Crocker qualified his view by observing that his experience of this has been gained in neurosurgery and obviously not as a urologist. Even so, 621ml is a large volume when coupled with lack of sensation and need to void and the bladder by 1203 had become pathologically distended;

ii) When asked to pass urine after the scan, he was unable to do so, on his own case;

iii) Prior to this he had not tried to go to the toilet and had not felt that he wanted to;

iv) Although change in rectal tone is a relevant feature in the progression from CESI to CESR, it is nowhere near as reliable an index as bladder function. Sexual function, for obvious reasons, is not usually described or assessed in the acute setting;

88. Mr Cowie is the Neurosurgeon instructed on behalf of the Third Defendant. He said that it is always difficult to know exactly when a non-functioning bladder becomes irretrievably damaged. Independently, he came to the same conclusion as Mr Crocker, namely that the Claimant probably developed loss of bladder control early in the morning of 12 March at or near the time he developed saddle numbness and that from then irreversible nerve cell damage progressed and was established by mid to late morning. He also observed that, unusually, the Claimant had been able to describe the onset of perineal numbness, namely an hour before his telephone call at 0543, ie at 0453. This meant that the degree of pressure exerted by the disc material onto the nerves in the spinal canal was sufficient to interrupt electrical function. Irreparable nerve damage/death proceeds in a continuous fashion after electrical conduction stops, some nerve fibres succumb early, others later. He felt that it was relevant that the Claimant had been unable to feel the catheter when it was passed at 1445.

89. In assessing the expert neurosurgical evidence, I wish to make it clear that I do not simply approach this issue on the basis that as two experts agree, their view must necessarily prevail (see paragraph 25 (vii) of the judgment in *M*, cited above). I have had the opportunity to watch and listen to these experts and that has, in part, informed my assessment of them.

90. I have the following concerns about the evidence given by Mr Mannion:

i) As a witness, he did not confine his evidence to the questions he was being asked in cross examination. From the commencement of cross examination, he made statements in support of his position without focusing entirely on the proposition being put to him. Although I do not doubt, as I have said, his good faith, this gave the unfortunate impression that he was being unnecessarily inflexible in a medical context where there is flux and difficulty;

ii) Despite reciting in his report, in some detail, the contents of the Claimant's medical notes and some of the witness evidence as contained in statements, Mr Mannion omitted to recite significantly relevant features, namely:

a) the details of the Third Defendant's interaction with the Claimant ie his initial presentation even though this was relevant to progression;

b) The fact that Dr Kirkby had noted a suspicion of urinary retention during her assessment of Mr Hewes in the mid-morning and ordered a bladder scan;

c) The results of the bladder scan at 1203 which pointed to retention;

d) The fact that at no stage on 12 March had Mr Hewes felt any desire to void or that upon being instructed to try and urinate after the bladder scan, had been quite unable to do so;

iii) When asked about these relevant omissions, Mr Mannion explained that they were in the interests of well-intentioned brevity, that he relied upon the Particulars of Claim to set out the chronology and that his report was written before the case had fully evolved. I accept that his report will have evolved, but it is dated November 2018 and the pleadings had clearly identified urinary retention as a highly relevant issue. Whilst I do not doubt the integrity of Mr Mannion's approach to report writing and I do not presume that he was trying to minimise this evidence, these omissions were rather surprising and his explanation for them less than satisfactory and a little defensive;

iv) He was somewhat forced to concede that urinary retention plays no part of the definition of CESI, either in the literature or the agreed joint statement whereas it does in the definition of CESR. He agreed that there was clear evidence of painless urinary retention by 1203 but this conclusion is not contained in his report;

v) In his oral evidence, he placed very real reliance on the fact that the Claimant's "anal tone" was normal when subject to digital rectal examination (DER) by Dr Roffey and Dr Kirkby. His view was that if the Claimant's condition and neurological insult was as advanced during the morning of 12 March as the Defendants' experts believed, then anal and perineal tone would have been absent. This tone was not absent then and this pointed to the Claimant falling into the CESI category at that time. He accepted that anal tone is not a reliable indication in diagnosing CES but thought it relevant in defining progression. He also had to accept that one of the papers he had relied upon (2015 Shrikandarajah) did not require complete perianal sensory loss for a definition of CESR. He said that anal tone is usually a late indication in CESI but agreed that he had not included this in his agreed definitions.

vi) He relied more than once on the proposition that had the Claimant been part of a study, then on the literature, he would not have been categorised at any point prior to 1500 as CESR because he had not presented with urinary overflow. This fixation with overflow may be explained by the fact that many of the articles refer to painless urinary retention with overflow incontinence but in my judgment, it does ignore the agreed position that CESR patients (with painless urinary retention) are nowadays regularly catheterized before overflow/dribbling commences. The combined evidence from Messrs Crocker

and Cowie was that overflow incontinence is now rarely seen in modern hospitals.

vii) He accepted that the Claimant's condition progressed quickly.

91. I have concluded that on the balance of probabilities, the Claimant's condition had progressed to CESR by the time of his bladder scan at 1203. Given the effect of that conclusion on causation, I do not need to make a ruling about whether in fact the Claimant had progressed to CESR by 0800 that day. I have come to this conclusion for the following non exhaustive reasons:

i) The concerns about Mr Mannion's evidence itemised in paragraph 91 above;

ii) I found Mr Crocker, in particular, to be an impressive and lucid witness who balanced the literature (some of it dated) with pathophysiology, practice and experience. He was entirely uncomplicated in the manner of his responses and answered the questions he was asked. I accept the criticism made by the Claimant that he did not refer to the literature cited by Mr Mannion in his main report and he could have done so. I also accept his explanation that he considers the literature (of which he had detailed knowledge) to be of limited utility in this context. Ideally, he should have said this in his report but his failure to do so does not diminish the quality of his evidence.

iii) The definitions of CESI and CESR in the voluminous literature presented to me differ. This suggests, as Mr Crocker said, that patients do not always fit neatly into defined categories and I accept his contention that in 2019 neurosurgical medico-legal experts can and should look to their own expertise, to the patient history and pathophysiology to assess what was happening to this Claimant and that this is better than trying to fit a patient objectively into one of the many different definitions in the literature, as Mr Mannion has. The Claimant, like other patients, cannot be identified as typical within any of the patient cohorts in the studies cite. Clinical judgment must be used both at the time of presentation and in the retrospective medico-legal context to try and assess progression and that, logically means looking closely at the pathophysiology. For example, the Claimant did not meet the definition of CESI as set out in the 1990 Gleave & McFarlane paper or the 2015 Shrikandarajah paper but he did meet the definition of CESR quoted in 2008 the DeLong paper and the 2015 Todd paper. The 2002 Gleave & McFarlane paper contains a definition of CESR that makes no reference to bowel function whereas the 2014 Sun paper does. In my judgment, this cautions against too much or sole reliance on the literature, retrospectively, to determine the Claimant's likely progression. Mr Cowie agreed with Mr Crocker's position on this. A more logical approach, I conclude, is to be aware of the literature, to consider its content, limitations and vintage and to consider it, where appropriate, against other known features of this case. That being so, I am unable to accept as logical, Mr Mannion's requirements of overflow incontinence and loss of anal/perineal tone before CESR can be confirmed. Overflow is a secondary marker of a loss of executive bladder control which is a surrogate marker occurring hours earlier. I accept the evidence of Mr Crocker that bladder function is the most reliable aspect when trying to distinguish CESI from CESR. The absence of overflow incontinence in the

presence of demonstrable painless urinary retention does not downgrade a patient to CESI. Further I accept that changes in anal tone do not confirm that someone has CES although they might prospectively signify deterioration of CES. But if digital rectal examination ("DRE") is notoriously unreliable as a determinant of the presence of CES (as Mr Mannion states), it is difficult to see how he can place quite so much reliance upon it as a determinant of progression. In fact, the Claimant underwent four DREs, each performed by different individuals. The first two were normal, the third by Dr McKenzie, I was told included loss of anal tone whereas the fourth at QS suggested only partial absence of tone thereby demonstrating the lack of reliability to be attached to such findings because the Claimant's tone would only deteriorate, it would not improve pre-surgery. The combined evidence of Mr Crocker and Mr Cowie was that a finding of preserved perineal sensation is not inconsistent with the Climant having lost control of his bladder much earlier in the day. I accept Mr Cowie's evidence that some nerve fibres are more resilient to compression than others and that this helps explain why bladder function might be lost whilst anal tone is maintained;

iv) Mr Hewes last emptied his bladder at 0100 on 12 March. He had no desire to void at all upon waking (or thereafter). Both Defendants' experts believe that loss of bladder control occurred around the time he experienced saddle anaesthesia ie 0500-0545. This would take some time to manifest itself. By 1203 his bladder contained 621ml volume suggesting a normal hourly urine production rate.

v) All experts agree that the bladder scan was consistent with CESR;

vi) All experts agree that patients with CES can progress to nerve death within 6 hours (even though in closing submissions, Mr McLeish sought to qualify this on the basis that the underlying literature was based on a study concerning monkeys). The Claimant had lost executive control of his bladder before 1203. That was, directly, as a result of the underlying compression.

vii) CESR is plainly difficult to time and diagnose. Anyone diagnosed with CES is generally treated as a surgical emergency. The more advanced the CES/R, the less likely it is that surgery will affect outcome. That said, I do not accept the Claimant's submission that just because the First Defendant continued to view the Claimant as an emergency after the MRI images had confirmed CES, that signifies either (a) that he was still in CESI or (b) that they viewed him as CESI rather than CESR. The Claimant's presentation at QS was arguably CESR and yet they proceeded to emergency surgery.

92. On this basis, the time for beneficial surgical intervention predated any alleged factually causative negligence. It follows that this claim must fail.