Neutral Citation Number: [2019] EWHC 1898 (QB)

Case No: B90PL029

IN THE HIGH COURT OF JUSTICE
QUEEN'S BENCH DIVISION

Royal Courts of Justice
Strand, London, WC2A 2LL

Date: 26/07/2019

Before :

HIS HONOUR JUDGE McKENNA
(sitting as a Judge of the High Court)

- -

Between :

Ann Margaret FLANAGHAN	**Claimant**
- and -	
UNIVERSITY HOSPITALS PLYMOUTH NHS TRUST	**Defendant**

- -
- -

Christopher Wilson-Smith QC and **Harry Trusted** (instructed by **Wolferstans Solicitors**) for the **Claimant**
Jeremy Hyam QC (instructed by **Bevan Brittan Bristol**) for the **Defendant**

Hearing dates: 1, 2, 3 & 4 July 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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HIS HONOUR JUDGE McKENNA

HHJ McKenna :

Introduction

1. The Defendant is the statutory body which owns and runs the Derriford Hospital in Plymouth ("the Hospital") and Ann Margaret Flanaghan, the Claimant, was a patient at the Hospital.

2. This is a clinical negligence claim arising out of the treatment afforded to the Claimant at the Hospital, when the Claimant was first seen in May 2008 and then in October 2012 when she underwent spinal surgery at the Hospital following an admission consequent on her having tripped over a hole in the street, fallen and hit her head. Following that surgery, the Claimant is now tetraplegic.

3. This court is only concerned with preliminary issues of liability and causation, the parties having agreed different figures for quantum subject to liability and causation, depending on which of a number of allegations of breach of duty are found in her favour.

Factual Background

4. The Claimant was born on 26 March 1949. In October 2012, she was aged 63. She is now aged 70.

5. In 2007, the Claimant developed left-sided spasticity and was referred by her GP to a consultant neurologist, Dr Martin Sadler, who referred her for a head and neck MRI scan which revealed degeneration of the lower part of the neck. In his letter to the Claimant dated 28 April 2008, Dr Sadler explained that the MRI had revealed the cause of her problem which he described as follows:

> *"some degeneration of the lower part of your neck and the spinal cord at this level is being squashed. This is occurring at more than one level and is really being pinched quite severely….*
>
> *In the meantime, I would strongly advise you not to do anything that may lead to any damage to your neck and to let me or your GP know if thinks become any worse as this may be an indication for you to come into hospital."*

6. Dr Sadler in turn referred the Claimant to a neurosurgeon, Mr Paul Fewings, at the Hospital. His referral letter contained the following material passages:

> *"I wonder if you would be able to see this woman with quite severe cervical cord compromise as soon as possible. She is 59 and diabetic. She gives a history of a gradual increasing spasticity down the left side of about a year's duration. She said that she was nagged into getting something done about her "funny walk by her husband. She complains of problems catching her foot and difficulty walking down hill. When seen in clinic she walked with circumduction on the left. There is no*

> *clear weakness down this side or much in the way of sensory symptoms but she does have spasticity. The plantar goes down. Her MRI shows compression of her cord in a most impressive manner at least 3 levels of the lower cervical region. It was impressive enough for the neurologists to send me an email drawing my attention to the result."*

7. On 22 May 2008, the Claimant was examined by Mr Fewings. Following that examination and a review of the MRI, Mr Fewings wrote a detailed letter to the Claimant's GP summarising his consultation. The essence of the letter was that the Claimant was asymptomatic apart from an abnormal gait. Examination revealed hyper-reflexia with slightly increased tone in the lower limbs. Mr Fewings recommended conservative treatment and said that he had counselled the Claimant with regard to symptoms 'to look out for' and would necessitate urgent re-referral. The letter contains the following material passages:

> "*The patient's husband works away for three months of an episodic fashion, he (husband) has reported that recently he has noted a slight gait abnormality (slight circumduction of left leg when walking) is a little worse.*
>
> *From the patient's point of view however she is completely fit and normal with no pain, discomfort, sensory symptoms, weakness, sphincteric difficulties whatsoever. The patient reports that her 'minor waddle' only bothers her husband but does not bother her.*
>
> *On further in depth questioning she does not have any symptoms whatsoever of cervical myelopathy or cervical radiculopathy.*
>
> *Upon examination, the patient has normal sensation throughout. She is however hyper-reflexic from biceps jerks distally. The patient has bilateral positive Hoffmann's reflex. In her lower limbs there is slightly increased tone and there is four beats of ankle clonus on the left. Hyper-reflexia is present at the knee jerks and ankle jerks, plantar response however is interestingly downgoing.*
>
> *MRI scan shows significant cervical disc disease at C4/5, 5/6 and 6/7. C4/5 is mainly right sided and causing foraminal stenosis and slight cord distortion but no cord compression. C5/6 disc lesion again on the right causing exit foraminal stenosis, cord distortion and certainly a degree of cord compressions. At C6/7 there is the significant lesion of a central disc lesion causing cord compression, which is associated with cord signal change.*
>
> *Opinion/Plan – despite the rather striking appearance on MRI from the subjective point of view the patient is asymptomatic apart from needing a walk with slight circumduction on the left*

> *leg. Objectively there is hyper-reflexia with slightly increased tone in the lower limbs.*
>
> *I have explained to the patient that the MRI appearances may have been there for many years, a MRI scan merely represents a snapshot in time. I have explained that whilst there is evidence of cord compression on the images as confirmed by the presence of hyper-reflexia upon examination from the symptomatic and functional point of view she is very well indeed.*
>
> *I therefore think that the best way forward is to manage this case conservatively but I have carefully counselled the patient with regard to symptoms to look out for to necessitate her urgent re-referral. She will do this directly as I have given her my secretary's telephone number. These are obviously the symptoms of cervical radiculopathy and cervical myelopathy.*
>
> *The patient has been made aware because of the cord compromise were she to suffer and incident such as falling down stairs or being involved in a car crash/whiplash injury she may be rendered paralysed whereas somebody without cord compression would not.*
>
> *I am happy that the patient and husband are very intelligent, sensible people and I have left it to them to re-refer as and when rather than regular annual review in clinic."*

8. Following that consultation and up until the time of her accident in October 2012 the Claimant remained stable and suffered no functional deterioration.

9. On 23 October 2012 at about 1300 hours, the Claimant, whilst going to collect her car from Slumen Garage at 22 Market Road, Plympton, tripped over a pothole in the road, fell forward and hit her head on the side of the rear panel of a stationary vehicle. Immediately after the accident, the Claimant was unable to move her hands or legs. She was taken to the Hospital.

10. MRI scans taken on the day of the accident revealed advanced degenerative disease with osteophytes encroaching into the spinal canal.

11. On 24 October 2012 (the day after the accident), it was noted that the Claimant had normal right upper and lower limbs with some distal weakness in the upper left limb and marked loss of power (between 0 and 1 out of 5) in the left lower limb.

12. The Claimant was reviewed by Mr Nagarajan Sudhakar on 25 October 2012 (two days post-accident). He discussed the case with colleagues at an MDT meeting and he recommended surgery to decompress the spine. At this time (according to Mr Sudhakar's note), the Claimant was unable to move her right leg and she could not move her hands properly and hence was unable to sign the consent form.

13. Mr Sudhakar performed an anterior cervical discectomy and fusion ('ACDF'). at three levels, C4/5, C5/6 and C6/7. In summary, the procedure was long and difficult. At C5/6, there was a large hard bony osteophyte on the right side which Mr Sudhakar recorded was densely adherent to the dura and extending to the rostral. A bony notch was made on the right side on the inferior aspect of C5 in an attempt to remove the hard osteophyte. About 80-90% of the osteophyte was removed and there was then a Cerebro-Spinal Fluid ('CSF') leak which caused him to abandon the surgery at C5/6. Mr Sudhakar states that decompression at the C6/7 level was the most difficult. At the time he was satisfied with the decompression achieved and inserted a prosthetic cage (or 'spacer') at each level. The decompression was performed with Kerrison rongeurs – a surgical tool with a blunt tip and side cutting edge of (in this case) 1mm – the smallest size available.

14. The anaesthetic record indicated that the surgery began at 1445 hours on 26 October 2012 and that the Claimant was extubated at 1930 hours. At 2042 hours, the on-call specialist registrar, Mr Almayali, reviewed the Claimant and found that she had normal sensation but could not move her limbs apart from a flicker of movement in the right thumb and index finger. At 2210 hours, Mr Almayali reviewed the Claimant again and found a similar picture. He telephoned Mr Sudhakar who advised the prescription of Dexamethasone and an urgent MRI scan which was undertaken at about 2350 hours.

15. The radiologist indicated in his report on the MRI scan that the cage was displaced posteriorly at C5/6 and C6/7 levels, a finding with which Mr Sudhakar disagreed when he reviewed the MRI scan. It was also noted that at C5/6 this caused mild spinal canal narrowing. At C6/7, the report stated that sagittal images demonstrated marked displacement of the cage posteriorly resulting in moderate to severe spinal cord compression.

16. During the night, Mr Sudhakar spoke to the Claimant and her husband by which time the Claimant reported that she could move her left foot which she had not been able to do immediately after the ACDF procedure. Mr Sudhakar decided that further surgical intervention was necessary. The Claimant consented to have a further decompression operation which was performed by Mr Sudhakar at 0830 hours on 27 October 2012 by way of a posterior laminectomy. Subsequent imaging showed that this had provided adequate posterior decompression.

17. Unfortunately, the Claimant has made a poor neurological recovery. It is common ground that a spinal injury of some sort occurred during the first surgical procedure, possibly bruising from the use of rongeurs.

18. A claim was brought against the highway authority (Plymouth City Council) but was discontinued because the expert evidence did not demonstrate sufficient prospects of success that the Claimant would establish breaches of duty.

Allegations of Breach of Duty

19. The allegations of breaches of duty are set out in the Amended Particulars of Claim at paragraph 22 as follows:

i) The failure by Mr Fewings when he saw the Claimant in 2008 either to recommend immediate decompression surgery at C4/5, C5/6 and C6/7 or to review the Claimant at least annually with repeat MRI scans every two years ("the 2008 allegations");

ii) the failure by Mr Sudhakar on 26 October 2012, wrongly operating without waiting for resolution of the swelling within the spinal cord caused by central cord contusion after the tripping accident;

iii) the failure by Mr Sudhakar on 26 October 2012, wrongly failing to order a pre-operative CT scan of the Claimant's neck so as to differentiate between bony osteophytes and soft tissue prolapse;

iv) the failure by Mr Sudhakar on 26 October 2012, wrongly attempting the cervical discectomy by using a drill and inserting Kerrison up-cut rongeurs despite the lack of sufficient space, especially at the C6/7 level, instead of performing anterior vertebrectomies at C5 and C6 when such a procedure would have improved access to the upper part of the C7 vertebral body and enabled him to drill away the upper part of the osteophyte by first getting below it;

v) the failure by Mr Sudhakar on October 26 2012, wrongly failing to appreciate the significance of the CSF leak and wrongly failing thereafter to convert to vertebrectomy; and

vi) the failure by Mr Sudhakar, failing to re-operate as soon as possible after the report of the MRI scan taken at 2351 hours on 26 October 2012 (collectively "the 2012 allegations").

20. The Defendant, for its part, asserts that so far as the 2008 allegations are concerned, it was entirely appropriate for Mr Fewings to offer conservative management in conjunction with the advice as set out in the letter to the GP dated 2 June 2008 to which I have referred. In respect of the 2012 allegations, what is said on behalf of the Defendant is that the Claimant suffered a recognised complication of surgery about which she had been appropriately warned and for which she had been appropriately consented and the fact that her neurological function deteriorated post operatively is not evidence of any fault in the timing or nature of the surgery undertaken on 26 and 27 October 2012.

21. For the sake of completeness I should record that the allegation (vi) in respect of the timing of the procedure on October 27 2012 was abandoned by the time of closing submissions.

The Law

22. The classic test for breach of duty is that identified by McNair J in *Bolam v Friern Hospital Management Committee* [1957] 1 WLR 583 at page 586:

> *"The test is the standard of the ordinary skilled man exercising and professing to have that special skill. A man need not possess the highest expert skill; it is well established law that it*

> *is sufficient if he exercises the ordinary skill of an ordinary competent man exercising that particular art."*

23. Later at page 587, McNair J put it this way:

> *"…he is not guilty of negligence if he has acted in accordance with a practice accepted as proper by a responsible body of medical men skilled in that particular art. I do not think there is much difference in sense. It is just a different way of expressing the same thought. Putting it the other way round, a man is not negligent, if he is acting in accordance with such a practice, merely because there is a body of opinion who would take a contrary view."*

24. The practice relied on in defending an allegation of clinical negligence has to be "responsible, reasonable and respectable" and has to have "a logical basis" and where it involves weighing comparative risks it has to be shown that those advocating it had directed their minds to the relevant matters and reached a defensible conclusion. Lord Browne-Wilkinson explained and refined the Bolam test in this way in *Bolitho v City and Hackney Health Authority* [1998] AC 232 at page 243:

> *"These decisions demonstrate that in cases of diagnosis and treatment there are cases where, despite a body of professional opinion sanctioning the defendant's conduct, the defendant can properly be held liable for negligence (I am not here considering questions of disclosure of risk). In my judgment that is because, in some cases, it cannot be demonstrated to the judge's satisfaction that the body of opinion relied upon is reasonable or responsible. In the vast majority of cases the fact that distinguished experts in the field are of a particular opinion will demonstrate the reasonableness of that opinion. In particular, where there are questions of assessment of the relative risks and benefits of adopting a particular medical practice, a reasonable view necessarily presupposes that the relative risks and benefits have been weighed by the experts in forming their opinions. But 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 very seldom be right for a judge to reach the conclusion that views genuinely held by a competent medical expert are unreasonable. The assessment of medical risks and benefits is a matter of clinical judgment which a judge would not normally be able to make without expert evidence. As the quotation from Lord Scarman makes clear, it would be wrong to allow such assessment to deteriorate into seeking to persuade the judge to prefer one of two views both of which are capable of being logically supported. 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 bench mark by reference to which the defendant's conduct falls to be assessed."*

25. In *C v North Cumbria University Hospitals NHS Trust* [2014] EWHC 61, Green J (as he then was) gave a helpful analysis of the case law on breach of duty at paragraph 25 as follows:

> *"25. In the present case I have received evidence from 4 experts, 2 on each side. It seems to me that in the light of the case law the following principles and considerations apply to the assessment of such expert evidence in a case such as the present:*
>
> *i) Where a body of appropriate expert opinion considers that an act or omission alleged to be negligent is reasonable a Court will attach substantial weight to that opinion.*
>
> *ii) This is so even if there is another body of appropriate opinion which condemns the same act or omission as negligent.*
>
> *iii) The Court in making this assessment must not however delegate the task of deciding the issue to the expert. It is ultimately an issue that the Court, taking account of that expert evidence, must decide for itself.*
>
> *iv) In making an assessment of whether to accept an expert's opinion the Court should take account of a variety of factors including (but not limited to): whether the evidence is tendered in good faith; whether the expert is 'responsible', 'competent' and/or 'respectable'; and whether the opinion is reasonable and logical.*
>
> *v) Good faith: A sine qua non for treating an expert's opinion as valid and relevant is that it is tendered in good faith. However, the mere fact that one or more expert opinions are tendered in good faith is not per se sufficient for a conclusion that a defendant's conduct, endorsed by expert opinion tendered in good faith, necessarily accords with sound medical practice.*
>
> *vi) Responsible/competent/respectable: In Bolitho Lord Brown Wilkinson cited each of these three adjectives as relevant to the exercise of assessment of an expert opinion. The judge appeared to treat these as relevant to whether the opinion was 'logical'. It seems to me that whilst they may be relevant to whether an opinion is 'logical' they may not be determinative of that issue. A highly responsible and competent expert of the highest degree of respectability may, nonetheless, proffer a conclusion that a Court does not accept, ultimately, as 'logical' . Nonetheless these are material considerations. In the course of my discussions with Counsel, both of whom are hugely*

experienced in matters of clinical negligence, I queried the sorts of matters that might fall within these headings. The following are illustrations which arose from that discussion. 'Competence' is a matter which flows from qualifications and experience. In the context of allegations of clinical negligence in an NHS setting particular weight may be accorded to an expert with a lengthy experience in the NHS. Such a person expressing an opinion about normal clinical conditions will be doing so with first hand knowledge of the environment that medical professionals work under within the NHS and with a broad range of experience of the issue in dispute. This does not mean to say that an expert with a lesser level of NHS experience necessarily lacks the same degree of competence; but I do accept that lengthy experience within the NHS is a matter of significance. By the same token an expert who retired 10 years ago and whose retirement is spent expressing expert opinions may turn out to be far removed from the fray and much more likely to form an opinion divorced from current practical reality. 'Respectability' is also a matter to be taken into account. Its absence might be a rare occurrence, but many judges and litigators have come across so called experts who can 'talk the talk' but who veer towards the eccentric or unacceptable end of the spectrum. Regrettably there are, in many fields of law, individuals who profess expertise but who, on true analysis, must be categorised as 'fringe'. A 'responsible' expert is one who does not adapt an extreme position, who will make the necessary concessions and who adheres to the spirit as well as the words of his professional declaration (see CPR35 and the PD and Protocol).

vii) Logic/reasonableness: By far and away the most important consideration is the logic of the expert opinion tendered. A Judge should not simply accept an expert opinion; it should be tested both against the other evidence tendered during the course of a trial, and, against its internal consistency. For example, a judge will consider whether the expert opinion accords with the inferences properly to be drawn from the Clinical Notes or the CTG. A judge will ask whether the expert has addressed all the relevant considerations which applied at the time of the alleged negligent act or omission. If there are manufacturer's or clinical guidelines, a Court will consider whether the expert has addressed these and placed the defendant's conduct in their context. There are 2 other points which arise in this case which I would mention. First, a matter of some importance is whether the expert opinion reflects the evidence that has emerged in the course of the trial. Far too often in cases of all sorts experts prepare their evidence in advance of trial making a variety of evidential assumptions and then fail or omit to address themselves to the question of whether these assumptions, and the inferences and opinions

> *drawn therefrom, remain current at the time they come to tender their evidence in the trial. An expert's report will lack logic if, at the point in which it is tendered, it is out of date and not reflective of the evidence in the case as it has unfolded. Secondly, a further issue arising in the present case emerges from the trenchant criticisms that Mr Spencer QC, for the Claimant, made of the Defendant's two experts due to the incomplete and sometimes inaccurate nature of the summaries of the relevant facts (and in particular the Clinical Notes) that were contained within their reports. It seems to me that it is good practice for experts to ensure that when they are reciting critical matters, such as Clinical Notes, they do so with precision. These notes represent short documents (in the present case two sides only) but form the basis for an important part of the analytical task of the Court. If an expert is giving a précis then that should be expressly stated in the body of the opinion and, ideally, the Notes should be annexed and accurately cross-referred to by the expert. If, however, the account from within the body of the expert opinion is intended to constitute the bedrock for the subsequent opinion then accuracy is a virtue. Having said this, the task of the Court is to see beyond stylistic blemishes and to concentrate upon the pith and substance of the expert opinion and to then evaluate its content against the evidence as a whole and thereby to assess its logic. If on analysis of the report as a whole the opinion conveyed is from a person of real experience, exhibiting competence and respectability, and it is consistent with the surrounding evidence, and of course internally logical, this is an opinion which a judge should attach considerable weight to."*

26. A professional person is not to be judged by the wisdom of hindsight, so the breach of duty should only be judged prospectively based upon what was known or ought to have been known.

The Evidence

27. The court has had the benefit of hearing factual evidence from the Claimant herself and from her husband, principally as to their recollection of the examination and consultation with Mr Fewings in 2008, and from Mr Fewings and Mr Sudhakar.

28. In terms of expert evidence, the court has read reports including Joint Statements from experts in two disciplines as follows:

    Neuroradiology: Dr Neil Stoodley for the Claimant and Dr Catriona Good for the Defendant

    Neurosurgery: Mr Choksey for the Claimant and Mr Mannion for the Defendant

Neuroradiology

29. There is a good measure of agreement between the neuroradiologists. In particular, they both agree that:

    i) the 2008 MRI scan showed severe chronic degeneration with spinal cord compression, intrinsic cord signal change at C5/6 and C6/7 with multi-level chronic foraminal stenosis;

    ii) between 2008 and 2012 there was subtle progression of the chronic degeneration and spinal cord compression;

    iii) had an MRI scan been performed in (say) May 2012 it would have had similar appearances to the 23 October 2012 scan;

    iv) following the first surgery on 26 October 2012, the post-operative scan shows residual cord compression from osteophytes, improved at C4/5 and C5/6 levels but unchanged at C6/7 level with persistent severe cord compression; and

    v) a MRI scan taken on 19 August 2013 demonstrated that the surgery performed on 27 October 2012 provided adequate posterior decompression.

30. To the extent that there was disagreement, for example, as to whether the cage or spacer was misplaced and as to whether there was change in the cord signal between 2008 and pre-operatively, that disagreement evaporated so far as the cage was concerned with Dr Stoodley agreeing that subsequent x-rays and fluoroscopy demonstrated the correct placement of the cage and, in the case of the question of signal change, its significance diminished in the light of Dr Stoodley's concession that clinical findings were more significant than the presence or absence of signal change.

The 2008 Allegations

31. There is little by way of factual dispute between the parties as to what happened at the consultation with Mr Fewings in May 2008. The Claimant's evidence was that she had been dragging the tip of her left foot for some time and felt that she was waddling. She was completely unbothered by this but was persuaded by her husband to go and see her GP and then, following the referral and MRI scan, to see Mr Fewings on 22 May 2008.

32. She recalled that Mr Fewings reviewed the MRI scan, took a full history from her and examined her. She expected that some sort of surgery would be recommended and was therefore surprised when Mr Fewings advised her to leave it well alone and only seek further attention if her condition deteriorated. She did not remember him saying anything specifically about offering surgery but she did recall that he explained that there were risks inherent in surgery which could make things worse. He also warned her that because of her condition there was a significant risk that if she had fallen or was involved in a car crash, she could be severely injured, and that such injury could include paralysis.

33. She also accepted that Mr Fewings advised her to watch out for increased pain in the neck and legs, but couldn't recall whether he also referred to her arms in this context

as well as for any functional problems and that if that did happen, she was to contact him. He gave her a mobile phone number to facilitate such contact. Otherwise she said he told her she was to go and enjoy her life and not have a car accident.

34. As I have indicated she described herself as being surprised that surgery was not recommended and said that if it had been recommended she would have accepted the advice and had the surgery, but she was of course relieved that it was not recommended. She also confirmed that she was not aware of suffering any deterioration in her symptoms between the date of the examination in May 2008 and the tripping accident which occurred in October 2012.

35. Both the Claimant and her husband had a recollection of asking Mr Fewings what level of deterioration should trigger a re-referral. They say Mr Fewings suggested 40 per cent and, when asked what that meant, suggested that he had said that it meant when the symptoms were very much worse; for example, paralysis, not being able to walk, loss of mobility and pain.

36. Mr Fewings, for his part, explained that after he had reviewed the MRI scan but before he had seen Mr and Mrs Flanaghan he had expected that he would have been recommending surgery. That view, however, changed as a result of his history taking and examination of the Claimant. Her disability was in his view minimal; a slight left leg circumduction which did not bother her at all and otherwise she was asymptomatic. He therefore formed the view that surgery was not appropriate and would not become appropriate unless and until the Claimant deteriorated clinically and there was an even chance that she would never suffer any such deterioration. Balancing the risks of surgery on the one hand with the benefit of avoiding potentially significant injury if the Claimant were to experience a fall or be involved in a car crash, he concluded that the appropriate course of action was conservative management.

37. He had a thorough and balanced discussion with the Claimant weighing up the known quantification of risk of surgery in general and of nerve root injury in particular along with the unknown, unquantified risk of (for example) the Claimant falling down stairs or being involved in a car crash which might lead to paralysis. He was confident that the Claimant understood the respective risks.

38. Mr Fewings accepted that he did not offer surgery as such but if, in light of the discussions, the Claimant had asked for surgery he would have obliged. He also expressed the view that if he had recommended surgery he was confident that the Claimant would have accepted his advice.

39. As for the reference to 40 per cent, he said that he was confused by it and was adamant that he wouldn't have said that or anything like that since such a level of deterioration would have meant that any re-referral was far too late. As he eloquently put it, in such circumstances the Claimant would have missed the boat.

40. Mr Fewings advised the Claimant carefully as to the symptoms to look out for, such as increased pain and/or functional difficulty, and made it clear that if there was any such deterioration she should re-refer. He gave her his secretary's mobile telephone number to facilitate such a referral.

41. Had he decided that surgery was the appropriate course of action, the procedure he would have undertaken would have been a single level ACDF at the C6/7 level, his rationale being that, looking at the MRI scan, there was clear signal change at that level but not above.

42. So far as the suggestion that he should at least have recommended annual reviews and/or biannual MRI scans, his response was that annual reviews were old-fashioned, inefficient and illogical. Much better, he said, that the Claimant herself should re-refer if she noticed any deterioration in symptoms.

43. There is no doubt in my mind that both Mr and Mrs Flanaghan were entirely honest and straightforward witnesses who answered questions clearly and to the best of their respective recollections, although Mr Flanaghan candidly conceded that his wife's memory was generally better than his own. Mr Fewings, too, gave clear and cogent evidence and that evidence was supported by a detailed contemporaneous letter written to the Claimant's GP which to my mind demonstrates that there was a full discussion of the nature of the treatment, the risks and benefits of surgery compared with the risks and benefits of conservative treatment, and the symptoms which the Claimant was to look out for and which would prompt re-referral. On the issue of the reference to 40 per cent, I am satisfied that Mr and Mrs Flanaghan's recollection of a reference to 40 per cent is mistaken. I accept the evidence of Mr Fewings that such a level of deterioration would have meant that any re-referral was far too late and is totally out of keeping with his careful and considered advice as evidenced by both his oral evidence and by his letter to the Claimant's GP. It is in no way surprising that Mr and Mrs Flanaghan should be mistaken in this regard, given that they are doing their best to recall what happened at a single consultation over 11 years ago.

44. There is a significant dispute between the neurosurgeon experts in respect of the 2008 allegations on this issue. Mr Choksey's opinion is that the decision not to offer surgery in May 2008 was substandard since, in his view, the Claimant had absolute indications for surgery. He expressed his view in these terms in his report:

> *"She had a history of a stumbling gait. The absence of pain was irrelevant, because she did not have radiculopathic features at that time. The examination findings demonstrated features of pyramidal tract compromise. Her MRI scan showed signal change within the spinal cord, and very severe multi-level compression by disc/osteophyte complexes at C4/5, C5/6 and C6/7. She had critical spinal cord compression.*
>
> *She should have been reviewed regularly. In keeping with the witness evidence from Mr and Mrs Flanaghan, it was important to 'watch her like a hawk'. In my opinion, she should be reviewed by a neurosurgeon at least annually, with an MRI scan every two years. The object would be to look for any evidence of clinical or radiological progression, and to counsel the patient repeatedly about the importance of prophylactic surgery in her particular case."*

45. In paragraph 49 of his report he summarised the position in this way:

> *"In my opinion, the clinical and radiological features, taken together with what we know about the natural history, indicate that she had a significant and severe spastic myelopathy in 2008 and was at high risk of deterioration after a trivial injury. Such trivial injuries are relatively common. In my opinion, the counselling he [Mr Fewings] gave Mr and Mrs Flanaghan was simply wrong. From Mrs Flanaghan's own statement, it is clear that she left the consultation confused about the natural history, and how she was to avoid the possibility of further damage: particularly sudden deterioration. Either, she needed immediate decompressive surgery, or regular review."*

46. Mr Mannion's opinion is very different. The decision on surgery would usually be dictated by clinical symptoms and signs and some context as to the rate of any progression of symptoms. The Claimant was at low risk of deterioration. Surgery was not mandated for a patient who was as well clinically as the Claimant was, despite the radiology findings. The CSM was very mild. He continued:

> *"The contemporaneous records demonstrate a fair appraisal of the situation having been explained to the Claimant at the time, including the small risk of abrupt deterioration in the event of trauma. The risk of such a deterioration is very low and impossible to quantify, although I refer to a recent study from 2016 of patients with a similar condition to the Claimant, which showed an overall incidence of spinal cord injury of 0.2 per cent per year in patients with CSM (Chen et al., 2016)."*

47. He also suggested that there was no proven utility for surveillance imaging in patients with CSM and that it was not widely practised. His reasoning was firstly that imaging rarely changes from one year to the next, and that that is particularly so if patients remain clinically stable, which the majority do; and secondly, and more importantly, that the key factor in determining surgical management is the patient and their symptoms and given that she was at low risk of deterioration potentially, if Mr Choksey's approach were to be adopted, she would have required many years of follow up when she was clinically stable.

48. Whilst it would not have constituted a breach of duty to have offered the surgery in 2008, in his view there is a range of opinion where the risks of surgery in a reasonably healthy patient must be balanced against the risks of not operating and how any serious complication, if it were to occur, could be justified. The relatively mild impact that the Claimant's symptoms had on her quality of life were such that a reasonable body of spinal surgeons would offer non-operative management with appropriate advice.

The 2012 Allegations

49. It was Mr Sudhakar's evidence that he became a consultant in 2004 and had practiced exclusively in spinal surgery since 2010/11. He first saw the Claimant on 24 October 2012 and noted that she had significant weaknesses in all limbs, worse in the right lower limb. He discussed the case with three neurosurgeons and two orthopaedic

surgeons and a neuro-radiologist in a MDT meeting where it was agreed that the appropriate surgical technique would be an ACDF at the C4/5, 6/7 and 6/7 levels.

50. Timing was discussed and Mr Sudhakar was aware that there were two schools of thought among spinal surgeons as to whether it was preferable to wait a week or two or even longer to allow for any spinal cord swelling to subside or to operate straight away if the patient showed no improvement. The advantage of the former course of action was that it was believed that a swollen spinal cord could be more vulnerable to damage caused by even minimal compression caused by surgical instruments which would inevitably occur whilst the advantage of the latter course of action was that it is considered that the sooner the pressure on the cord is reduced, the less the chance of irreversible damage to the spinal cord. In the particular circumstances of the Claimant, given her relatively young age and the fact that although there had been some initial improvement in her symptoms at best that had plateaued or even, he felt, deteriorated, Mr Sudhakar decided on early surgery to give the Claimant the best chance of recovery.

51. He did not order a pre-operative CT scan. He explained that he would have ordered one if the MRI scan was suggestive of compression behind the vertebral bodies indicative of ossification of the posterior longitudinal ligament (OPLL), but that was not the case with the Claimant.

52. The choice of technique agreed upon at the MDT meeting was he felt the appropriate technique where, as here, the Claimant's compression was at the level of the disc space. Vertebrectomy, which is a much more complicated and extensive procedure, would be a technique he would consider if the compression had been at the level of the vertebral body and if the vertebral body need to be removed. Examples of when he would adopt such a procedure would be where the patient had tumours or OPLL

53. The surgery was difficult but at the end of the day he felt that he had achieved good decompression at all three levels. In that view he was mistaken.

54. Although conversion to a vertebrectomy would have been possible it would have added to the length and complexity of the surgery and would not have avoided the use of the rongeurs and was not in his view necessary. He dealt with the CSF leak in his usual manner and had never encountered a post-operative problem with such management.

55. Mr Sudhakar is plainly a conscientious and experienced neurosurgeon who demonstrated throughout his evidence that he was concerned to do the very best for his patients. He was, if anything, too self-critical (as Mr Mannion observed during the course of his evidence).

56. The thrust of the 2012 allegations, based on the opinion of Mr Choksey, is that on the Claimant's admission in October 2012 a CT scan should have been ordered which would have confirmed that the spinal cord was being compressed by osteophytes and not soft tissue, and therefore that the surgery would be difficult.

57. Furthermore, the surgery should have been delayed by two to three weeks with the Claimant being kept in a hard collar in the meantime whilst being closely monitored for signs of deterioration. In Mr Choksey's view, there were a number of factors

which mandated this period of delay: it was thought that the Claimant's neurological picture was improving; there had been no increase in the amount of signal change in the spinal cord between the April 2008 MRI scan and the MRI scan undertaken on 23 October 2012; there would have been swelling within the spinal cord and in the particular circumstances of the Claimant surgery should have been delayed until that swelling had died down.

58. When surgery was attempted, it should have been a vertebrectomy and not the ACDF procedure in fact adopted by Mr Sudhakar. Mr Choksey's reasoning for suggesting that a vertebrectomy was mandated in this case was that there was extremely severe cord compromise within the spinal canal, particularly at the C6/7 level; no visible cerebrospinal fluid ("CSF") around the spinal cord and, therefore no cushion and therefore no margin of safety. Mr Choksey went so far as to characterise the choice of ACDF as "indefensible" and "dangerous". A vertebrectomy by contrast would have provided safe access for instruments while the ACDF procedure involved damaging trajectories and gave the surgeon reduced visibility, which in fact led to Mr Sudhakar not appreciating that he had, in fact, failed to decompress at the C6/7 level.

59. Having embarked on the ACDF procedure, Mr Choksey suggested that Mr Sudhakar fell into further error in failing to appreciate the significance of the CSF leak, a rare event, which he says should have alerted Mr Sudhakar to the danger to the Claimant's cord since it indicated that there was less fluid cushion between the osteophyte and the spinal cord, rendering the Claimant's cord *"at extreme hazard of further surgical trauma."* In such circumstances, Mr Sudhakar should have changed course and converted his surgery into a vertebrectomy.

60. Mr Mannion's view on these matters is markedly different. In his view, a pre-operative CT scan was not mandated before surgery not least because whether the compression was due to soft disc prolapse or bony osteophytes would not materially change the appropriate surgery.

61. So far as the timing of surgery was concerned, Mr Mannion's view was that there is (and was at the material time) a range of opinion among spinal surgeons on this issue, with some advocating early surgery. In his view, Mr Sudhakar's management accorded with a reasonable body of spinal opinion. He pointed out that there is a risk that patients deteriorate if surgery is delayed and some evidence, although disputed, that outcomes are better with early as opposed to late surgery. In short, there are pros and cons for both approaches.

62. So far as the choice of procedure is concerned, Mr Mannion's view was that (again) there is a range of opinion but that it would be uncommon to advocate a vertebrectomy over the ACDF procedure. In the absence of compression behind the vertebral body, as opposed to the disc space, decompression could usually be achieved with ACDF even in severe cases and even if the osteophyte was not removed completely because the point of maximal decompression at the level of the disc space had been dealt with, and the segment fused so there was no longer movement at this level.

63. In support of his view, Mr Mannion referred to two meta-analyses of published literature comparing ACDF to vertebrectomy. One concluded (Wang et al., 2016; hereafter "the Wang paper") that ACDF was a better choice in radiographic outcomes

and total complications for the treatment of multi-level (cervical) myelopathy. The other (Han et al., 2014) found reduced complications with ACDF versus vertebrectomy.

64. As for the significance of the CSF leak, Mr Mannion suggested that although rare, it was nevertheless a recognised complication of ACDF surgery and well within the remit of a competent neurosurgeon carrying out such operations. A leak can happen for several reasons and is usually straightforwardly dealt with, with very few post-operative sequelae.

65. Dural tears occur where there are adhesions between the dura osteophytes. This makes the surgery more difficult but is not something that can be predicted preoperationally by imaging and in Mr Mannion's view it was certainly not an indication to convert the surgery to the much bigger and more morbid procedure of vertebrectomy.

66. Mr Mannion also pointed out that the vertebrectomy would still have required the removal of the osteophytes at C4/5 and C5/6 and C6/7 levels as well as the vertebral bodies in between so that the critical stage with regards to decompressing the dura would have been the same. The adhesions with the dura would have been the same and the risk of tearing the dura would have been the same or he suggests greater. In those circumstances he did not believe that the more significant operation would have reduced the risk.

Discussion and Conclusions

67. The allegations made against Mr Sudhakar in the amended Particulars of Claim are markedly different from those originally advanced in the original Particulars of Claim which were based on the evidence of another highly experienced consultant neurosurgeon, Mr Peter Kirkpatrick, rather than Mr Choksey. Specifically, the original Particulars of Claim made no allegations whatsoever in respect of Mr Fewings and as against Mr Sudhakar the alleged breaches were:

    i) wrongly placing the disc prosthesis too deep in the posterior vertebral body or wrongly failing to remove all of the osteophyte which was protruding so that it caused compression in the cord;

    ii) following the MRI scan at 2350 hours on 26 October 2012, failing to return the Claimant at the operating theatre to remove the wrongly placed prosthesis or the osteophyte;

    iii) on 27 October, wrongly taking the posterior approach since "an interior approach would have been correct for an interior cervical discectomy";

    iv) during the operation on 27 October, failing to decompress the spinal cord at C6/7 by moving the disc prosthesis to an appropriate position or by removing compressing osteophyte;

none of which are now pursued.

68. It can be seen, therefore, that in the original Particulars of Claim, as well as there being no complaint at all about Mr Fewings, there was no suggestion that vertebrectomy was the only reasonable approach; no suggestion that the operation should have been delayed; no suggestion that a pre-operative CT scan was mandatory; no suggestion that on discovery of the CSF leak the operation should have been converted to a vertebrectomy; and no suggestion that the Claimant should have been re-operated upon in the early hours of 27 October. Not surprisingly, reliance is placed on these matters by the Defendant to support its central contention that there was a range of opinion on all these matters and that neither Mr Fewings nor Mr Sudhakar were negligent in their decision making. There is force in that submission as it seems to me.

69. As leading counsel for the Claimant candidly conceded in final submissions, the reality is that the Claimant cannot succeed unless the court prefers the evidence of Mr Choksey to that of Mr Mannion. That course of action was urged upon me on the basis that Mr Choksey was plainly a highly experienced neurosurgeon whose position has been consistent throughout, in contradistinction to that of Mr Mannion. In this regard, much was made of the contents of paragraph 33 of the original Defence; Mr Mannion having been instructed throughout in contrast to Mr Choksey who was not, as I have already indicated, instructed at the time that the original Particulars of Claim were served. It was said that the contents of paragraph 33 demonstrate that at that time Mr Mannion shared Mr Choksey's subsequently held view about the need for the use of a vertebrectomy to remove osteophytes from behind the vertebral body where they were exerting retro-vertebral pressure and it was submitted that Mr Mannion's attempt to distance himself from the pleading was unattractive and criticism was made of him for omitting to make reference to having seen the original Defence in his Report. For my part, I do not accept the force of that criticism in the light of the evidence that the point of maximal decompression was at the disc level (Good and Mannion) and that the worst stenosis was at the disc space and not behind the vertebral body. In this regard it is also to be remembered that the factual evidence of Mr Sudhakar was to the effect that the osteophytes had formed at the edge and might have extended slightly upper or lower and to some extent behind the vertebra but he would not characterise them as retro-vertebral, evidence which I accept.

70. However, even if there was some force in that criticism of Mr Mannion, nevertheless I have no hesitation in concluding that his opinions are to be preferred where they differ from those of Mr Choksey. In coming to that conclusion, I do not doubt Mr Choksey's eminence or his experience and indeed it is fair to say that Mr Mannion fairly and rightly expressed his admiration for Mr Choksey when giving his evidence.

71. As it seems to me, however, Mr Choksey plainly feels or felt very strongly about this case. That strength of feeling has led him to express himself in very strong terms and, it is fair to say, in my judgment, that his analysis has been premised on an exaggerated assessment of the factual situation which pertained in 2008 which tended to cast doubt on the reliability that can be placed on his opinions in respect of the 2008 allegations and which inevitably seeps into a consideration of his views in respect of the 2012 allegations.

72. By way of example so far as the 2008 allegations are concerned, he characterised Dr Sadler's reaction to what could be seen on the MRI scan as "alarming" when the word he used was in fact "impressive"; he described the cord compression as being

extremely severe, whereas that is not a finding that has been made by anyone else and he suggested that the Claimant had "a history of a stumbling gait" which is plainly an exaggeration of what was described to Mr Fewings as a minor "waddle" which only bothered Mr Flanaghan and certainly did not bother the Claimant. Mr Choksey described the Claimant as having "critical spinal cord compression" in circumstances where radiological findings cannot tell anything about symptoms generally still less their severity. He described the Claimant's condition inaccurately as "a significant and severe spastic myelopathy". Significantly, Mr Choksey misstated what Mr Fewings had said about the Claimant's symptoms and in particular as to whether or not she was asymptomatic. He also described the Claimant's symptoms as improving prior to the 26 October operation, and put the word in block capitals for emphasis even though this was not the case. There had been some improvement initially, it is true, but the Claimant's condition had in fact plateaued between the evening of 23 October and the surgery on 26 October.

73. As it seems to me, therefore, and contrary to the opinion expressed by Mr Choksey, who was unable to point to any local or national guidelines mandating annual review or bi-annual MRI scans, the decision to offer conservative management in conjunction with appropriate advice as to re-referral if there was any deterioration was plainly within a reasonable range of opinion, supported as it is by Mr Mannion.

74. So far as the 2012 allegations are concerned, Mr Mannion's evidence was balanced, logical and reasoned. More importantly, his opinions were supported by relevant literature (whilst Mr Choksey's were not), which was referred to in his Report and which demonstrated that there was indeed a range of reasonably held opinion with respect to early versus late surgery, surgical intervention itself and as between ACDF and vertebrectomy. For example, the Wang paper says as follows as to choice of ACDF over vertebrectomy:

> "*the selection of optimal surgical treatment for CSM especially for multi-level cervical spondylotic myelopathy remains controversial. ACDF may have a high risk of incomplete decompression limited visual exposure and risk injury to the cord. While ACCF (corpectomy) provides a more extensive decompression, it is a more difficult spinal surgery to perform, and has a higher incidence of complications such as injury to the spinal cord or nerve root, excessive bleeding, graft displacement or exclusion*."

75. In my judgment it is plain that there are pros and cons to each approach. In this case the location of the compressive pathology was at the disc level as is plain from the photographs at P1, as confirmed in evidence by Dr Good from a neuroradiological point of view and Mr Mannion both in writing and in his oral evidence and Mr Sudhakar. In those circumstances, accepting as I do the evidence of Mr Mannion, ACDF was not just a reasonable choice: it would have been the preferred choice of the majority of neurosurgeons in the particular circumstances of this case.

76. The fact that in the event Mr Sudhakar was not able to remove all the osteophyte is not evidence of negligence or of the use of a negligent surgical technique. Mr Sudhakar removed what he saw and he reasonably thought he had achieved adequate

decompression. In this regard, it is significant that it is not suggested that the remaining osteophyte was in any way the cause of the Claimant's paralysis.

77. It is in my judgment significant that no allegations of the nature supported by Mr Choksey were made against either Mr Fewings or Mr Sudhakar in the original Particulars of Claim; that Mr Fewings in the course of his evidence indicated that if he had decided to carry out surgery, the surgery he would have carried out would have been ACDF, albeit at a single level; that when the operation was being discussed at the MDT attended by three neurosurgeons, two orthopaedic surgeons and a radiologist, the conclusion that was reached was to remove the osteophytes at areas of maximal compression by means of an interior multi-level ACDF; that vertebrectomy was not even discussed; and that Mr Choksey felt able to support the criticism of Mr Sudhakar in not undertaking further surgery in the early hours of 27 October, an allegation which the Claimant was forced to abandon in the light of the oral evidence.

78. In conclusion, as it seems to me on the central issue of whether Mr Sudhakar was negligent for choosing ACDF over vertebrectomy there is nothing in the particular facts of this case which distinguishes it from the cohort of multilevel CSM discussed in the literature, there being no substance in Mr Choksey's argument that the Claimant was somehow in a different position having regard to the inclusion criteria by reference to JOA scores in the Wang paper.

79. Equally, the decision to operate on 26 October was reasonable. It is supported by Mr Mannion and by literature; there is nothing in the point about the failure to request a CT scan, for the reasons articulated by Mr Mannion to which I have referred above.

80. In the circumstances, there is no need for me to go on to consider the various arguments put forward as to causation. Had it been necessary I would have accepted the force of the arguments put forward on the Defendant's behalf in connection with the 2008 allegations on the basis that as a matter of fact if Mr Fewings would have offered surgery it would have been limited to ACDF at the C6/7 level, accepting as I do Mr Fewings's evidence on the point, and that as a matter of fact the Claimant did not deteriorate clinically between May 2008 and October 2012.

81. So far as the 2012 allegations are concerned, even if there had been a delay of two to three weeks, Mr Sudhakar would not in fact have ordered a CT scan; reasonably would not have performed a vertebrectomy and even if he had done so, it would have necessitated the removal of discs above and below the section of vertebral body in a manner identical to that used in carrying out the ACDF procedure as explained by Mr Mannion, with the same risks of injury; and, reasonably would not have been converted to a vertebrectomy following any CSF leak.

Disposal

82. It follows in my judgment that this claim should be dismissed.

83. I trust that the parties will be able to agree the form of an order to reflect the substance of the judgment.

84. Finally, I would like to acknowledge the very considerable assistance of all counsel in this case.