IN THE EXETER COUNTY COURT **Case No 3YS07024**

BETWEEN

KATHLEEN JONES

Claimant

and

ROYIAL DEVON & EXETER NHS FOUNDATION TRUST

Defendant

JUDGMENT

Introduction

1 In these proceedings the Claimant, Mrs Jones, claims damages for personal injury suffered as a consequence of an operation carried out by the Defendant, the Royal Devon and Exeter NHS Foundation Trust, on Thursday 29 July 2010.

2 Mrs Jones was born on 1 April 1941. Therefore, she was aged 69 at the date of the operation and is now aged 74.

3 Mrs Jones had experienced back pain for a number of months (for which she was seeing a physiotherapist) when she attended her GP on 23 April 2009, who referred her to a senior physiotherapist, Mr Alan Potts. Mr Potts saw her on 7 July 2009. He considered that a spinal stenosis was the likely diagnosis, and referred her for an MRI scan. This was performed on 31 July 2009 and gave rise to the following report:

> *"significant central canal stenosis at L4/5. Disc bulge with some lateral recess stenosis and displacement of the right S1 root at the L5/S level."*

4 After further physiotherapy Mrs Jones was referred to the Defendant's orthopaedic department on 11 November 2009. She was seen by Mr Patrick Hourigan (Orthopaedic Assistant) on behalf of Mr Daniel Chan (Consultant Orthopaedic Spinal Surgeon) on 7 December 2009. The presenting complaint was one of intermittent low back pain felt

in a band across her back below the level of the iliac crest, in association with bilateral thigh pain. He recommended a caudal epidural injection, which was performed on 28 January 2010.

5 Mrs Jones's case was then reviewed by Mr Chan on 17 March 2010, when she reported that the caudal epidural injection had not relieved her symptoms. Mr Chan therefore discussed the possibility of bilateral decompression surgery, which she opted to undergo. She was put on the waiting list. In a letter written the same day to her G.P., Mr Chan recounted:-

> *"I reviewed Mrs Jones today following her recent cauda epidural which was done about 6 weeks ago. Unfortunately this did not produce any improvement of her symptoms either in the low back or in the lower extremities. She does have a very tight spinal stenosis at L4/5 with relevant lower extremity pain but she has a low back pain to leg pain ratio of 60/40. The back pain does also have a claudicating character with it being worse with standing and walking and relieved by sitting and lying so it remains possible that the back pain could also be related to the severe stenosis. However, it is difficult to completely distinguish between mechanical back pain related to facet joint degeneration versus spinal stenosis. If she could accept that the claudicating leg pain can be relieved by surgery and is happy to cope with some degree of back pain then surgical intervention would still be very justifiable as the spinal canal is really markedly stenotic. Surgery would take the form of a bilateral micro-decompression and I have explained the nature of this kind of intervention at some length outlining its potential risks, rewards and limitations. Mrs Jones does feel that her symptoms would justify surgical intervention. I have therefore put her on my waiting list for bilateral L4/5 micro-decompression. I have provided her with a leaflet for segmental decompression."*

6 The operation was carried out on 29 July 2010, not by Mr Chan, but by another surgeon, Mr Sundaram. Mr Chan enjoyed a very high reputation both locally and nationally. Mr Sundaram was then a Fellow in Trauma and Orthopaedics at the Royal Devon and Exeter Hospital, but he had already been appointed to a consultancy in Gloucestershire, and was waiting to take up that post.

7 Unfortunately, the operation did not go well. It is common ground that during the operation Mrs Jones sustained an injury to her Caudina Equina affecting the right-sided sacral roots, and giving rise to a number of serious and significant ongoing symptoms, including bladder and bowel dysfunctions.

8 Briefly, Mrs Jones has lost much of the mobility which had allowed her to lead a very active life in her later years:

(1) She has numbness in the right perianal area, the buttocks and both legs, extending to the feet, causing her to feel clumsy and affecting her mobility and balance (she had a fall in May 2011 and fractured her left wrist);

(2) She continues to have backache, particularly when carrying out household tasks;

(3) She can only manage about 25 metres walking unaided and uses a wheeled frame or sticks when she is out of the house;

(4) Although, following the operation, she used to be catheterised, she has now learnt to void in a crouching position with the assistance of straining but has to do so every two hours, or so, to avoid accidents. There is some urinary incontinence, so that she uses a pad;

(5) As for her bowel symptoms, she continues to have to use regular laxatives and, as a consequence, voids frequently;

(6) She has developed toe clawing which causes spasms in her feet and is becoming more troublesome, keeping her awake at night;

(7) She also now has a sharp perianal pain which can last as long as 6 hours and which is of such intensity as to cause her to clench her teeth and gasp for air;

(8) She is quite restricted in what she can do around the house and is reliant upon her husband but continues as best she can. She and her husband used to enjoy annual two-month holidays in a caravan in France but she can no longer cope with this and the caravan has been sold.

9 Her condition is not likely further to improve in any respect. She may develop further incontinence of urine in the future and there is a 25% chance that she will require an operation to resolve that stress incontinence problem. There is a small risk that she might develop a vaginal prolapse, known as a cystocoele.

10 Damages have been agreed, subject to liability and causation, and hence this judgment is concerned only with the latter two issues.

Contentions of the Parties

11 In the pleadings:-

(1) Mrs Jones asserted that her injuries were the consequence of the negligence of the Defendant and/or of Mr Sundaram, alleging that:-

(i) she was only told on the day of surgery that the operation would not be performed by Mr Chan, Consultant Spinal Surgeon; and that had she been informed of this in a timely manner she would not have consented to it;

(ii) Mr Sundaram, was inadequately experienced to perform the surgery unsupervised;

(iii) The operation was performed to an inadequate standard, because a tear was caused to the dura resulting in nerve damage.

(2) The Defendant denied that it was negligent, denying the allegations referred to in 11(1) above any causation arising therefrom, and asserting that:-

(i) Mrs Jones gave informed consent for the procedure;

(ii) Mr Sundaram was adequately qualified;

(iii) The surgery was performed competently, and the damage which occurred was a known risk inherent in the procedure: it did not arise from any negligence on the part of Mr Sundaram.

12 Prior to the end of the hearing before me the allegation that Mr Sundaram was not adequately qualified to perform the operation was withdrawn.

The Consent Issue

13 I have summarised above the chronology of relevant events up to and including 17 March 2010.

14 Mrs Jones, in a witness statement dated 14 January 2012, stated:-

> *"4. Following an unsuccessful epidural injection, in April 2010 I had been offered surgery which was to have been undertaken in May. I asked for that surgery to be delayed because we expected to be in France in our caravan between May and June. As a result the operation was put back to July. Unfortunately, we had to come back early from our time in France at the end of May because I was in such pain in my leg because of the back problems. I made tentative enquiries at the Royal Devon & Exeter Hospital to see if there was any possibility of the surgery being brought forward. I was told that Mr Chan was on compassionate leave for a period of 5 weeks and so if the operation came forward, it would be conducted by one of his colleagues. I saw my GP Dr Parker on 1 June. I discussed this with her. Her clear advice was that I should wait and have the operation undertaken by Mr Chan. I followed that advice."*

15 Mrs Jones's husband, in his evidence, stated that he had attended the GP with his wife on, he thought, 1 June 2010, and that Dr Parker, the GP had *"said that she would prefer it if Mr Chan performed the operation but unfortunately he was going to be away on compassionate leave, for possibly five or six weeks: she went on to say that rather than have a more junior surgeon involved it would be preferable to wait for Mr Chan's return"*.

16 Mrs Jones, in the witness statement referred to above, stated:-

> *"3. On 23 July 2010 I met with Mr Sundaram. My husband did not attend that appointment. The appointment lasted about 5 minutes. I signed a Consent Form. My recollection of our meeting is that he advised that this operation should greatly reduce the pain. At no stage during that meeting was I told that Mr Sundaram would be carrying out the surgery. I assumed that he was one of Mr Chan's assistants and that Mr Chan would be doing the surgery. Nothing was ever said to me to the contrary. Had I*

been told that Daniel Chan would not be carrying out the surgery, then I would not have agreed to it. ...

5. *I was not aware that Mr Chan was not going to carry out the surgery until the morning of the procedure on 29 July 2010. My husband had driven me to the hospital. I was put into my surgical gown and I said to the nurse words to the effect of "I haven't seen Mr Chan yet this morning, I assume he is doing the operation?". She said "Oh no, he is in Outpatient today, does it make any difference?" I replied "Yes, it does! I have waited all this time to have my operation undertaken by Mr Chan." By the time this conversation had taken place, my husband had left the hospital. I was in my surgical gown and I felt I was beyond the point of no return. The surgery went ahead.*

6. *Some days later I learnt that it was Mr Sundaram who had actually carried out the surgery. I never saw Mr Sundaram post-surgery as by then he had been transferred to another hospital up country."*

17 In his witness statement, dated 28 July 2014, Mr Sundaram gave the following account of his meeting with Mrs Jones on 23 July 2010:-

"8. *I undertook the consent process with Mrs Jones on 23 July 2010. I explained to her the risks and potential complications of the proposed surgery, which is recorded in my letter to Mrs Jones' GP of the same date. I explained that the risks included pain, infection, nerve root injury/damage, motor weakness, sensory loss, paralysis dural tear, cerebrospinal fluid (CSF) leak, headaches, failure of surgery, blood clots in legs, pulmonary embolism, myocardial infarction, stroke or even death. Mrs Jones confirmed that she understood the risks and she signed the standard NHS consent form (Patient Agreement to Investigation or Treatment (Adults) for the bilateral L4/5 decompression surgery that was planned.*

9. *It was my understanding that Mrs Jones fully understood the risks potential complications of the surgery. If there was any doubt that Mrs*

Jones did not understand these risks, then I would not have proceeded to operate on her.

10. *As I was aware that Mr Chan would be away on compassionate leave when the surgery was listed, I informed Mrs Jones that I would be performing the procedure on 29 July 2010.*

……

11. *On 29 July 2010, prior to the operation, I again explained to Mrs Jones the standard risks associated with spinal surgery (as per paragraph 8 above). I informed Mrs Jones that I would be doing the operation as I would not expect the patient to think that Mr Chan was doing the operation if it was going to be me. Mrs Jones did not raise any concerns that I would be performing the operation in place of Mr Chan. I am fully aware of patients concerns, as in my current practice, when patients want me to specifically perform all of the procedure and not my registrar, I inform my registrar that I will be doing all of the operation."*

18 As can be seen, a fundamental issue is whether or not Mr Sundaram did inform Mrs Jones, when he saw her on 23 July 2010, that it was he who would be performing the operation.

19 Both Mr and Mrs Jones and Mr Sundaram were patently honest witnesses, but the reliability of their recollections was called into question.

20 Mrs Jones's reliability was questioned on the grounds that her recollection generally could be shown to be shaky:-

(1) She repeated in her oral evidence that she never saw Mr Sundaram after her operation, but the medical notes indicate that in fact he attended on her twice.

(2) She also stated that she did not see Mr Sundaram on the morning of her operation - which, it was submitted, was implausible.

(3) The medical notes recorded that on 23 July 2010, when she saw Mr Sundaram, she was x-rayed in a standing position, but she had no recollection of that.

(4) Whilst her evidence was that it was on 1 June 2010 that her GP had advised that she should wait until Mr Chan was available, the GP notes did not record any attendance by Mrs Jones on that date.

21 Mr Jones, it was submitted, was also mistaken when he asserted that the advice referred to in sub-paragraph (4) of the last paragraph as having been given on 1 June 2010.

22 In her oral evidence Mrs Jones accepted that Mr Chan had not told her that he would be performing the operation, and she accepted that her recollection was not good and that it was possible that in the call she made after the end of May, when she had returned from France, she may not have been told that Mr Chan would be performing her operation, but that she had simply assumed that that was the case.

23 Reference was also made to the fact that the consent form which Mrs Jones signed on 23 July 2010 included, in clearly legible print, the following statement:-

> *"I understand that you cannot give me a guarantee that a particular person will perform the procedure. The person will, however, have appropriate experience."*

In her oral evidence, Mrs Jones was unclear whether she had read this, though she said she had read at least some of the form.

24 Mr Sundaram's reliability as a witness was challenged on the basis that he had signed a witness statement which included material now agreed to be incorrect: in the witness statement he asserted that Mr Chan could not carry out the operation because he was on compassionate leave. In fact, on 29 July 2010 Mr Chan was not on compassionate leave, but as a matter of routine he did not operate on Thursdays, but instead held an outpatients' clinic. Mr Sundaram explained that when he signed the witness statement his understanding was that Mr Chan was on compassionate leave, but he later discovered that this was incorrect: Mr Chan had been on compassionate leave earlier in

2010, but was back at work by July. It is to be noted that Mr Chan's witness statement originally included the same mistake.

25 It was pointed out that when Mr Sundaram wrote to Mrs Jones's GP following her attendance upon him on 23 July 2010, he gave a fairly detailed resume of his review but made no reference to his having informed her that he would be carrying out her operation. Reference was also made to the fact that there is no record in the medical notes of his having seen her on the morning before her operation.

26 The correspondence prior to the issue of the proceedings is, I consider, significant:-

(1) Mrs Jones in a letter to the Defendant's Managing Director, dated 13 October 2010, did complain that the operation was intended to be performed by Mr Chan, and that she was informed much too late that Mr Chan would not be carrying out the operation:-

> ... *I had an operation for Lumbar Spine Segmental Decompression at your hospital on Thursday 29 July 2010. Although this operation was originally intended to be performed by Mr Chan, I was informed, just as I was being prepared for theatre, that he was unfortunately unavailable. I accordingly had little opportunity of refusing the operation, as this would have meant a considerable delay, to the accompaniment of considerable pain, and for an unknown length of time.*"

(2) The belated response to that letter from the Defendant's Chief Executive, dated 25 January 2011, did not suggest that Mr Sundaram had told Mrs Jones either on 23 or 29 July 2010 that he would be carrying out the operation: this may be explained by the fact that at that date the Defendant asserted, bizzarely, that because Mr Sundaram had already left the Trust it had not been possible to speak directly to him. However, a subsequent letter, dated 27 April 2011, again did not suggest that Mrs Jones had been told on 23 July 2010 that Mr Sundaram would be carrying out the operation.

27 Also of particular significance are the GP's notes for 1 and 9 June 2010:-

(1) The note dated 1 June is in the following terms:-

"tel – had to come back from france early as back flared up, awaiting back op, seen in emerg dept in hosp, then dr visited at home, given pain-killer and cortisone, been onto mr chan's sec but he is off for 5w so unlikely to get earlier slot with him, poss with colleague would like further supply of french emerg meds as did settle things enough to get her home, hb will bring in details."

(2) The note of Mrs Jones's attendance on the GP on 9 June records amongst other things:-

> *"definite op fdate end july with mr chan so just needs to manage her life gently until then."*

28 These notes provide corroboration for at least some of Mrs Jones's evidence, and support the submission of her counsel, Mr Counsell, that they point to a conclusion that, on the balance of probabilities, Mrs Jones was given to understand by the Defendant's personnel that her operation was scheduled to be performed by Mr Chan. I accept that submission.

29 It also follows, in my judgment, that it is more probable than not that Mrs Jones, probably over the telephone on 1 June 2010, did seek her GP's advice as to whether or not she should wait until Mr Chan was available, and that the GP did, as Mr and Mrs Jones asserted, state that it would be preferable to wait for Mr Chan. It also follows that both Mr and Mrs Jones were wrong in stating that this advice was given when they attended the GP's surgery, but such a flaw in their recollections is not such as to entirely undermine their evidence in relation to the GP's advice: Mr Jones's understanding might be explained on the basis either that he had overheard the telephone call, or else had been told of its contents by Mrs Jones.

30 The finding made in paragraph 28 also supports Mr Jones's case that she was not told by Mr Sundaram when she saw him on 23 July 2010 that he would be carrying out the operation scheduled for the following week: had he told her that, it is likely that she would have questioned why, and it is likely that both she and Mr Sundaram would have recalled the exchange.

31 The background is reflected in a passage in the Defendant's Chief Executive's letter to Mrs Jones dated 25 January 2011:-

> *"It is clear that there was a breakdown in communication regarding who would be undertaking your surgery. Mr Chan has explained that, at no point, was it planned for him to perform your surgery, and he has asked me to pass on his apologies for the misunderstanding. Mr Chan confirms that he was in an outpatient clinic throughout that day. I should explain that, even though you were admitted under the care of Mr Chan, this does not mean he will be performing the operation. However, please be reassured that, if Mr Chan does not undertake the surgery, it will be done by an appropriately qualified member of his team."*

32 It is not suggested that Mr Sundaram had any reason to suppose that Mrs Jones had been lead to believe that the operation would be carried out by Mr Chan or any other named surgeon. Mrs Jones confirmed the statement referred to in paragraph 23 above, by signing the consent form. Accordingly, he would not have regarded it as of critical importance for him to explain to Mrs Jones, when he saw her on 23 July 2010, that he himself would be performing the operation. Against that background, and in the light of the terms of his letter to the GP referred to in paragraph 25 above and of the matters referred to in paragraph 26 above, I consider it more likely than not, and find as a fact, that he did not inform her that it was he who would be carrying out the operation.

33 As already stated, Mrs Jones's evidence was that she did not see Mr Sundaram on the morning of the operation. Mr Myhill, on behalf of the Defendant, submitted that this evidence is not credible – it is the invariable practice for operating surgeons to see their patients on the morning of an operation if only to satisfy himself that there have been no relevant changes in the patient's condition or to the patient's willingness to undergo the operation since the patient had last been assessed: the fact that there was no note was made of Mr Sundaram's review on the morning of the operation is not particularly significant, because, as the expert witnesses explained, there was nothing unusual about this.

34 I accept the submission referred to in the last paragraph, but I reject Mr Sundaram's evidence that at that stage he informed Mrs Jones that it was he who would be

performing the operation – on the basis of the findings made above, there would have been no need for Mr Sundaram to do this; it is more probable than not that he had no appreciation of the fact that Mrs Jones was concerned as to the identity of the surgeon who would be performing the operation. Further, it is more likely than not that if he had told her on 23 July 2010 that it was he who would be carrying out the operation, she would have questioned why.

35 The scope and rationale of a doctor's so-called *"duty to warn"*, was articulated by Lord Hope (with whom Lord Walker and Lord Steyn agreed) in a passage in his opinion in **Chester v Afshar** [2004] UKHZ 41:-

> *"86. I start with the proposition that the law which imposed the duty to warn on the doctor has at its heart the right of the patient to make an informed choice as to whether, and if so which and by whom, to be operated on. Patients may have, and are entitled to have, different views about these matters. All sorts of factors may be at work here – the patient's hopes and fears and personal circumstances, the nature of the condition that has to be treated and, above all, the patient's own views about whether the risk is worth running for the benefits that may come if the operation is carried out. For some the choice may be easy – simply to agree to or to decline the operation. But for many the choice will be a difficult one, requiring time to think, to take advice and to weigh up the alternatives. The duty is owed as much to the patient who, if warned, would find the decision difficult as to the patient who would find it simple and could give a clear answer to the doctor one way or the other immediately.*

36 The Department of Health publishes guidance in relation to the process of obtaining a patient's consent to physical examination or treatment. The current edition of this publication, which is entitled "Reference guide to consent for examination or treatment" is the Second edition. The following material in that guidance is of particular relevance in the present context:-

> *"15. Although informing people of the nature and purpose of procedures enables valid consent to be given as far as any claim of battery is concerned, this is **not** sufficient to fulfil the legal duty of care to the*

person. Failure to provide other relevant information may render the practitioner liable to an action for negligence if a person subsequently suffers harm as a result of the treatment received. ...

18. *In considering what information to provide, the health practitioner should try to ensure that the person is able to make an informed judgment on whether to give or withhold consent. Case law on this issue is evolving. ...*

19. *The GMC provides guidance on the type of information that patients may need to know before making a decision, and recommends that doctors should do their best to find out about patients' individual needs and priorities when providing information about treatment options. It advises that discussions should focus on the patient's 'individual situation and risk to them' and sets out the importance of providing the information about the procedure and associated risks in a balanced way and checking the patients have understood the information given. ...*

31. *The seeking and giving of consent is usually a process, rather than a one-off event. For major interventions, it is good practice where possible to seek the person's consent to the proposed procedure well in advance, when there is time to respond to the person's questions and provide adequate information. ... Clinicians should then check, before the procedure starts, that the person still consents. If a person is not asked to signify their consent until just before the procedure is due to start, at a time when they may be feeling particularly vulnerable, there may be real doubt as to its validity. In no circumstances should a person be given routine pre-operative medication before being asked for their consent to proceed with the treatment.*

...

> 32. *The validity of consent does not depend on the form in which it is given. Written consent merely serves as evidence of consent: if the elements of voluntariness, appropriate information and capacity have not been satisfied, a signature on a form will not make the consent valid."*

37 Mrs Jones's evidence, which I accept, is that she only learned that Mr Chan would not be performing her operation when, effectively, she was about to go into theatre. Realistically, in the light of the guidance referred to above, Mr Myhill did not challenge the proposition that if Mrs Jones's evidence in relation to this were accepted, then the Defendant was in breach of its duty of care to her. That this was too late a stage at which to provide her with this information was accepted by both the medical experts who gave evidence before me: a decision taken *"so far down the line"* is unlikely to be taken freely: apart from anything else, the patient would be aware that if he or she declined, at that stage, to undergo the operation, he or she would lose his or her place in *"the queue"*, a number of people would necessarily be inconvenienced by it, the *"slot"* for the operation would be unlikely to be filled by anyone else, and time which would be precious, not only to the NHS and its personnel but also to other patients waiting for operations, would be wasted.

38 I accept the account given by Mrs Jones as to why she allowed the operation to go ahead – see paragraph 5 of her witness statement, quoted at paragraph 16 above. In the circumstances I consider that her decision to allow the operation to go ahead (and thus her consent to it) was not freely taken, and I find that the Defendant was in breach of its duty of care to her.

The Operation

39 As stated above, the diagnosis of the cause of Mrs Jones's symptoms and MRI the scans showed that she was suffering from a significant central canal stenosis at L4/5. The term *"stenosis"* comes from the Greek for *"choking"*. Spinal stenosis in the lumbar spine is commonly associated with degenerative changes in the bony and/or ligamentous structures surrounding the spinal cord. A central canal stenosis occurs when the spinal cord is choked by such changes, resulting in compression of the bundle of roots (the cauda equina – *"horse's tail"*) which branch off at the bottom of the spinal cord, typically giving rise to the kind of symptoms experienced by Mrs Jones.

40 Two eminent spinal surgeons were called to give expert evidence. Mrs Jones called Mr P Kirkpatrick F.Med.Sci FRCS (SR), a Consultant Neurosurgeon. The Defendant called Mr N. Chiverton FRCS ED (TR & Ortho), a Consultant Orthopaedic Spinal Surgeon. Both have very substantial experience operating on the lumbar spine, although possibly Mr Chiverton has more experience than Mr Kirkpatrick of operations on that level of the spine, whilst Mr Kirkpatrick's main specializations are head and neck injuries.

41 In a report dated 11 October 2014, Mr Chiverton commented, in relation to the relevant MRI scan of Mrs Jones's lumbar spine:-

> *"Degenerative changes are seen from the L2/3 to the L4/5 disc levels. At the L4/5 level a combination of a moderate posterior annular disc bulge and severe degenerative changes affecting the facet joints bilaterally are causing severe central and bilateral lateral recess stenosis. Significant degenerative changes are also seen to be affecting the facet joints bilaterally at the L5/S1 level and osteophytic spurs arising from the medial aspect of the left L5/S1 facet joint are seen to be causing some stenosis of the transiting left S1 nerve root. There is no evidence of any significant forminal stenosis at either the L4/5 or L5/S1 levels. Other than the stenosis at the L4/5 level the appearances of the lower cord, conus and cauda equine are normal."*

42 The degree of the stenosis and the involvement of both the facet joint and the ligamentum flavum was confirmed in the review of the MRI scan recorded in a report from Mr Kirkpatrick dated 22 January 2013:-

> "i) *I have reviewed the pre-operative MRI scan on Kathleen Jones dated 31.07.09.*
>
> ii) *The T2-weighted images in saggital form declare multi-level degenerative disease throughout the lumbar spine.*
>
> iii) *This is most apparent at the L4/5 level where there is a significant degree of spinal canal stenosis.*
>
> iv) *The tranverse T2-weighted images indicate that the CSF spaces at this level are completely effaced and the degree of stenosis is severe. It is*

due to a combination of facet joint hypertrophy and ligamentum flavum hypertrophy. ..."

43 As stated above, the procedure proposed for her by Mr Chan, and carried out by Mr Sundaram, was a bilateral L4/5 decompression. Mr Kirkpatrick and Mr Chiverton agreed that this procedure was entirely appropriate. The principal objective of the procedure was to remove the thickened ligaments which were indenting and compressing the spinal cord, having first removed sufficient of the lamina (i.e. bone) to gain access to the ligaments.

44 Plainly an operation in such close proximity to the outer sheath (the dura) of the spinal cord involves a risk of injury to it and to the nerve roots which, to adopt the description provided by Mr Kirkpatrick, run within like "*strings of spaghetti*".

45 Mr Kirkpatrick's report dated 6 November 2014 included a statement, with which Mr Chiverton concurred:-

> "*Inadvertent dural tears do occur during operation(s) of this type, even in the most experienced hands.*"

In his oral evidence, Mr Kirkpatrick stated that every surgeon operating on the spine has caused dural tears, and:

> "*Experience matters ... in my early days I caused more dural tears than I do now.*"

Paragraph 12 of Mr Chan's witness statement is in the following terms:-

> "*12. I understand that a dural tear did occur during the surgery on 29 July 2010. This is a recognised risk of this type of surgery, which Mrs Jones was made fully aware of when I saw her in my clinic on 17 March 2010. However, such a complication may have occurred even if I was the surgeon who undertook this procedure.*"

46 The two expert witnesses were agreed that the proposed operation

(1) Had an 85%-95% prospect of improving Mrs Jones's back pain and neurological symptoms without complications.

(2) Carried on approximately 0.5-1% risk of an isolated nerve root injury.

(3) Had a 1:1000 chance that a spinal calamity would occur.

(4) Had an approximately 55% chance of a dural tear with a Cerebral Spinal Fluid ("CSF") leak and an inherent risk of associated nerve root damage, occurring in approximately 1% of patients.

47 Mr Sundaram's Operation Note records the actual procedure as follows:

> *"Midline incision, bilateral paraspinal muscle dissection, L4/L5 interspace identified. Kocher applied to L4 Lamina, Image Intensifier confirmed level check. Left side laminotomy proceeded 1st flavum free proximally, dural tear occurred with nerve roots visible. 2 inch of nerve rootlet avulsed. Therefore midline spinous process removed left right side decompression proceeded with laminotomy. Dural tear 5*4mm in size therefore Mr Clarke and Mr Hutton called to assist. Dural tear protected with patties. Bilateral decompression occurred at the L4/L5 level both L5 nerve roots decompressed in lateral recess and foramen. Both L5 nerve roots intact. Left L5 nerve root adherent to vertebral body difficult to mobilise.*
>
> *Dural tear addressed. Nerve roots carefully re-inserted into dura. Dura closed with 6.0 prolene. Good closure. Small dural tear 2mm over sleeve of left L5 nerve root present and left of dural repair. This risks or repairing these tears were thought to be too great to do safely. Washout normal saline, tissue dura applied, tisseal applied. Tight closed with vicryl. Subderman drain. Monocryl to skin."*

48 His witness statement expanded to some extent upon the Operation Note:-

> *13. After making a midline incision, I performed a bilateral paraspinal dissection to identify the L4/5 interspace. I then applied the Kocher to the L4 Lamina. The image intensifier confirmed the level check.*
>
> *14. The dural tear was caused by the Kerrison rongeurs instrument which is the standard instrument used in spinal decompressive surgery. I noted that 2 inches of one nerve rootlet was avulsed. Once the dural*

tear occurred, I protected the dura and proceeded with the decompression to see the extent of the tear and to allow room to repair it. Once I noticed that it was a large tear (4 to 5mm in size), I asked for the assistance of Mr Andrew Clarke, Consultant Spinal Surgeon who was operating in the next theatre along with Mr Mike Hutton, Consultant Spinal Surgeon, Mr Clarke came immediately to assist in the repair of the dural tear. It is standard practice in Royal Devon & Exeter Hospital that if there is a complication during surgery, such as a large dural tear, then the operating surgeon would summon the help of their consultant colleague. We then both proceeded to complete the operation.

15. *The dural tear was protected with patties. Bilateral decompression occurred at the L4/5 level. Both L5 nerve roots were decompressed in lateral recess and foramen. I saw that both L5 nerve roots were intact, however, the left L5 nerve root was adherent to the vertebral body and was difficult to mobilise. We then proceeded to address the dural tear and the nerve roots were carefully re-inserted to the dura. We then proceeded to close the dura with 6.0 prolene, obtaining good closure.*

16. *During the operation, there was another small dural tear of 2mm in size which occurred over the left L5 nerve root sleeve. This occurred when Mr Clarke and I were repairing the dura. During the procedure, the dura and nerve roots have to be manipulated to allow adequate decompression. This second dural tear occurred with the manipulation of the dura. This is an extremely rare, but recognised, complication of spinal decompression surgery. The dura of Mrs Jones was clearly very friable as it was damaged easily with manipulation. As a result, Mr Clarke and I decided that the risks of repairing the second dural tear were too great to do safely. We therefore proceeded to perform a washout with normal saline and applied tissue dura and tisseal to the dura prior to closing the wound.*

> 17. *Although I have seen nerve rootlets being avulsed by experienced surgeons a few times (not by myself), these have not led to any neurological consequence ..."*

49 The Kerrison rongeur is an instrument with a *"bite"* which is controlled by spring-loaded handles, as illustrated in the first photograph included in Annex 1 to this judgment. The second photograph is a close-up of the *"bite"*. The upper jaw has a sharp cutting edge: the lower jaw (or footplate) is blunt. The jaw closes when the handles are squeezed. The footplate, being blunt, can rest on the dura without damaging it – Mr Kirkpatrick explained that the dura is durable, the skin being thicker than a sausage skin and thinner than a bicycle tyre. It is common ground that this was an appropriate instrument for Mr Sundaram to have been using.

50 Based on Mr Sundaram's Operating Note and Mrs Jones's continuing disabilities Mr Kirkpatrick's view is that seven of the twelve nerve roots at the L5/5 level had been avulsed or damaged. Mr Chiverton did not disagree with this.

51 Based on the number of nerve roots involved, the severity of the injury to them, and the early stage in the operation when the injury occurred Mr Kirkpatrick is of the opinion that the operation was not performed with the requisite degree of skill and care:

> *"Inadvertent dural tears do occur during operation of this type, even in the most experienced hands. The usual dural tear rate is described at between 2 and 4%. However, this is usually a very small or limited tear, and does not involve underlying nerve rootlets. To cause a dural tear and avulsion of a nerve root would mean that the instrument has been placed to a dangerously deep level, indenting the spinal dura, offering the opportunity of capturing a nerve root, or indeed multiple nerve roots in this way. I am also mindful of the fact that this happened very early in the operative proceedings. My overwhelming feeling is that the operation was carried out with inexpert hands. ...*
>
> *In Mrs Jones' case, multiple nerve roots have been damaged during the operation representing, in my view, a highly substandard level of surgical are."*

- see his report dated 6 November 2014.

52 In his oral evidence Mr Kirkpatrick stated that as Mr Sundaram was in the early stage of the operation *"doing bony work"* and not having commenced any decompression the rongeur should not have been near the dura.

53 The experts' Joint Statement records:-

> *"Mr Kirkpatrick believes that although it is recognised as standard operation that a dural tear can occur, and on occasions this can damage a given nerve root, the extent of the dural tear and the multiplicity of the nerve root injuries indicate to him that the operation was carried out to a substandard level, and represented inappropriate use of the surgical instruments.*
>
> *Mr Chiverton wishes the Court to recognise that dural tears are a recognised and often non-negligent complication of spinal surgery and whilst he accepts Mr Kirkpatrick's view that the dural tear and the nerve root damages were extensive this alone does not reflect substandard surgical practice. He has not been presented with any evidence which has led him to believe that the complication in this case occurred as a result of any negligence, rather than being at the severe end of a spectrum of similar non-negligent complications."*

54 It was apparent from Mr Kirkpatrick's oral evidence that he considered that:-

(1) it was the number of nerve roots which had been damaged rather than the size of the tear which was more significant, and that in order for so many to have been damaged the end of the rongeur must have been pressed on or into the dura to a deep level;

(2) on his reading of Mr Sundaram's Operating Note this had occurred at an early stage of the operation where he was still *"doing bony work"* (i.e. on the lamina) and decompression of the ligamentum flavum had not yet commenced, so that the rongeur should not have been near to the dura.

55 Mr Kirkpatrick also asserted that Mr Sundaram should have been, but was not, aware of the proximity of the end of the rongeur to the dura, making the point that Mr

Sundaram did not have sight of the dura: Mr Sundaram *"was slightly lost"* as to where the dura was and *"got deeply into the dural sac"*: *"he did not know where the dura was and the dura found him"*.

56 Mr Kirkpatrick, describing, as I understand it, his own technique, said that one has to remove bones before tackling the ligament, and that at this stage one can try to get to a normal part of the dura so that you can see it before moving on. It seems to me that whether or not this is possible will depend upon the extent of the stenosed ligament, but in any event Mr Kirkpatrick and Mr Chiverton agreed that there is no single approach which can be regarded as *"correct"*, and that different surgeons will adopt different approaches.

57 Whilst the degree of injury to the nerve roots was not in dispute, there was no consensus as to the precise mechanism by which this was effected. Both expert witnesses agreed that it might have been effected as a result of the dural sac being pierced by the rongeur and the nerve roots then being damaged by the operation of its bite, but they also agreed that the dural sac may have been depressed (rather than pierced) by the end of the longueur, causing the dura to become folded, and then *"bitten"* by the operation of the longueur. Mr Kirkpatrick initially considered that the former explanation was more likely, but accepted that the latter explanation was a possibility, though, as I understand it, he remained of the view that the number of nerve roots damaged was an indication that any depression of the dural sac could not have been superficial.

58 Mr Sundaram's evidence was that the dura can *"fold"* when depressed, even slightly: he did not think that he had pierced the dura: he thought that it had folded and then been *"caught"*: he had felt no pressure or resistance: the instrument had felt *"right"*. He thought that the dura was very *"friable"* as a result of the stenosis. Mr Kirkpatrick rejected the reference to friability, saying that he had never seen this on a dura which had not been subject to any previous operative procedure. Mr Chiverton did not dissent from Mr Kirkpatrick's evidence on the issue of friability; and it seems to me that if the dura were friable it was more likely to be pierced then to fold. No evidence was adduced from Mr Clarke or Mr Hutton, the surgeons who assisted Mr Sundaram, and in all the circumstances I do not consider that the thesis of *"friability"* is established.

59 Mr Chiverton did not agree that the number of nerve roots damaged was indicative that the rongeur had pierced or depressed the dural sac to a significant depth: he explained that the nerve roots which had been damaged are not spread evenly within the dural sac but are clustered towards the area where, in this case, the tear in the dura occurred and that this positioning would not have been significantly altered by the presence of stenosis, so that the damage which occurred was not necessarily indicative of the depth of invasion or depression of the sac envisaged by Mr Kirkpatrick. This explanation was only given in Mr Chiverton's oral evidence and was not put to Mr Kirkpatrick in cross-examination, but no application was made to re-call Mr Kirkpatrick, and hence I infer that he did not disagree with the evidence as to the location of the nerve roots within the sac, even though he did not agree with Mr Chiverton's conclusion.

60 It has to be remembered that the dimensions with which this case is concerned are very small – Mr Kirkpatrick's evidence was that the dural sac is just over 1cm in diameter, and the bite of the rongeur being used at the material time is 1cm. The technique followed by Mr Sundaram was agreed by Mr Kirkpatrick to be acceptable, and was described by Mr Chiverton as the technique which he taught. Mr Sundaram's evidence is that he was applying only the normal amount of force. I do not consider that the evidence justifies a finding that the dural sac was pierced by or depressed by the rongeur to a significant depth, and I do not consider that the evidence justifies a finding that Mr Sundaram *"lost control"* over the rongeur or was heavy handed. I consider it more likely than not that the injury was a result of the dura folding over in circumstances which could not have been avoided or foreseen, and in other words was a fortuitous and non-negligent complication.

61 Accordingly, the claim based on the allegation that the operation was performed negligently must be dismissed.

62 In his oral evidence, as I understand it, Mr Sundaram explained (as depicted in the sketch included in Annex 2 to this judgment) he had nibbled away at the lamina with the rongeur, removing several pieces of bone: having thus gained access he placed the lower jaw beneath the lamina and took an initial bite of the ligament: when he withdrew the rongeur he saw that he had effected a tear in the dura. This evidence

might suggest that the operation had proceeded a little further than Mr Kirkpatrick and Mr Chiverton inferred from the Operation Note. If there is an inconsistency between the Operation Note and the oral evidence given by Mr Sundaram some five years later, it seems to me that the Operation Note, being a contemporaneous document, should be preferred, but, in any event, it appears to me that if the tear occurred at the stage of commencing decompression of the dura then Mr Kirkpatrick's criticism that the tear occurred at an early stage would be a little more w..........

Causation

63 It is the Defendant's case that the breach of duty on its part which I have found in relation to obtaining Mrs Jones's consent was not causative of the damage which she sustained. This is based on two contentions:-

(1) if she had been informed in good time of the unavailability of Mr Chan, it is more probable than not that she would have consented to it being performed by another one of the Defendant's surgeons, including Mr Sundaram; and

(2) in any event, it is likely that she would have sustained the injury which she did sustain even if she had waited and the operation had been performed by Mr Chan.

64 The first contention is without any substance - the fact that Mrs Jones originally wanted her operation to be carried out by Mr Chan is corroborated by the reference to Mr Chan in the GP's Note of the attendance on 9 June 2010: Mr Chan had and has a high reputation locally and nationally: Mrs Jones's evidence, which I accept, was that several people whom she knew had been operated on by him, and that when she raised with her GP the fact that there would be a delay if she wanted him to carry out the operation, the GP advised that it would be preferable to wait: in spite of the severity of her symptoms, she did decide to wait until Mr Chan was available. I therefore reject this contention.

65 So far as the Defendant's second contention is concerned:-

(1) the risks of injury to a nerve root occurring during the operation would be small, regardless of by whom the operation were to be performed – see paragraph 46 above;

(2) Mr Kirkpatrick's evidence was that *"experience counts"*, and that he now occasioned fewer dural tears when carrying out the procedure in question than he had done in his earlier years.

(3) I have rejected the thesis of *"friability"* i.e. that there was a condition of the dura which contributed to the injury in this case. I do not consider that it can be argued that there was a condition which necessarily would have lead to the same result if the operation had been carried out at a later date by Mr Chan.

(4) Mr Chan is a surgeon of considerable seniority with a national reputation which implies a degree of pre-eminence in his field of surgery;

(5) The statistical material agreed by the two experts is, I assume, based on published research of the results of the relevant operations carried out by surgeons with a range of experience i.e. they are of general application. Based on the evidence of Mr Kirkpatrick referred to in (2) above, therefore, it seems to me that, statistically, the risks of a dural tear occurring and of a nerve root injury in the case of an operation carried out by Mr Chan would be less than those reflected in the statistics which are of general application.

(6) Accordingly, I consider that it is more likely than not that Mrs Jones would not have suffered the injury which she did suffer had her operation been performed by Mr Chan, and hence I consider and find that causation is established.

66 I am conscious that similar issues arose in the decision of the House of Lords in **Chester v Afshar** (above). In that case the claimant suffered from low back pain. A neuro-surgeon advised her to undergo an elective lumbar surgical procedure. The procedure entailed a 1%-2% chance of serious neurological damage arising from the operation. The claimant was entitled to be informed of this fact. In breach of the common law duty of care the surgeon failed to inform the claimant of the risk. The claimant reluctantly agreed to the operation. The claimant underwent the surgery. The claimant sustained serious neurological damage. In the result the very injury about which she should have been warned occurred. The surgeon had not been negligent in

performing the operation: he did not increase the risks inherent in the surgery. On the other hand, if the claimant had been warned she would not have agreed to the operation. Instead she would have sought further advice on alternatives. The judge found that if the claimant had been properly warned the operation would not have taken place when it did, if at all. The judge was unable to find whether if the claimant had been duly warned she would with the benefit of further medical advice have given or refused consent to surgery. The majority of their lordships considered that it was clear that if she had agreed to surgery at a subsequent date, the risk attendant upon it would have been the same, i.e. 1%-2% and that it was therefore improbable that she would have sustained neurological damage. The majority of the judicial committee, therefore, concluded that the claimant could not establish causation or conventional principles.

67 It is clear from paragraph 6 of the opinion of Lord Bingham that causation would have been established on conventional principles:-

> *"if the evidence had entitled the judge to conclude, and if he had concluded, that Miss Chester, if properly warned as she should have been, could and would have minimised the risk of surgery by entrusting herself to a different surgeon, or undergoing a different form of surgery, or (in another kind of case) losing weight or giving up smoking."*

68 The present case, in my judgment, is one in which the evidence does indicate that an operation carried out by Mr Chan would have involved a lesser risk than an operation carried out by any less experienced surgeon, and hence is distinguishable from the facts in **Chester v Asfar**.

69 If I am wrong in concluding that causation is established on conventional principles, I would nevertheless consider that it is established on the basis of the principle upon which it was found, by the majority of the committee in **Chester v Asfar**, which, I think, is encapsulated in paragraphs 86 and 88 of the opinion of Lord Hope, with which Lord Steyn and Lord Walker concurred, in which he stated:-

> "86. *I start with the proposition that the law which imposed the duty to warn on the doctor has at its heart the right of the p0atient to make an informed choice as to whether, and if so when and by whom to be operated on. Patients may have, and are entitled to have, different*

views about these matters. All sorts of factors may be at work here – the patient's own views about whether the risk is worth running for the benefits that may come if the operation is carried out. ...

87. *... The function of the law is to enable rights to be vindicated and to provide remedies when duties have been breached. Unless this is done the duty is a hollow one, stripped of all practical force and devoid of all content. It will have lost its ability to protect the patient and thus to fulfil the only purpose which brought it into existence. On policy grounds therefore I would hold that the test of causation is satisfied in this case. The injury was intimately involved with the duty to warn. The duty was owed by the doctor who performed the surgery that Miss Chester consented to. It was the product of the very risk that she should have been warned about when she gave her consent. So I would hold that it can be regarded as having been caused, in the legal sense, by the breach of that duty.*

88. *The reasoning of Kirby J in Chappel v Hart, 195 CLR 232, para 95, which I would respectfully endorse, supports this approach. I am encouraged too by the answer which Professor Howard gave to the question which he posed for himself in his case note on that case at p.8: "is this a case where courts are entitled to see to it that justice is done despite the absence of causal connection?" I would hold that justice requires that Miss Chester be afforded the remedy which she seeks, as the injury which she suffered at the hands of Mr Afshar was within the scope of the very risk which he should have warned her about when he was obtaining her consent to the operation which resulted in that injury."*

70 Although in the present case there was no breach of the duty to warn Mrs Jones of the risks of the operation it was an infringement of her right *"to make an informed choice as to whether, and if so when, and by whom to be operated on"*. Unless a remedy is provided in the present case that right would be a hollow one. There is venerable

authority that, under the common law, *"where there is a right there is a remedy"* – see **Ashby v White** (1703) 2 Ld. Raym. 938.

71 Further, as Lord Steyn pointed out (at paragraph 18):-

> *"18. ... in the context of attributing legal responsibility, it is necessary to identify precisely the protected legal interests at stake. A rule requiring a doctor to abstain from performing an operation without the informed consent of a patient serves two purposes. It tends to avoid the occurrence of the particular physical injury the risk of which a patient is not prepared to accept. It also ensures that due respect is given to the autonomy and dignity of each patient".*

72 The provision of a remedy in the present case supports the objective, recognized in the opinions of the majority of the judicial committee in **Chester v Asfar**, of ensuring that respect is given to the autonomy and dignity of patients.

Conclusion

73 For the reasons given above, therefore, I consider that Mrs Jones is entitled to recover the damages to which it was agreed she was entitled subject to the issues of liability and causation – which, in the event, whilst rejecting the claim that her operation was performed negligently, I have found in her favour.

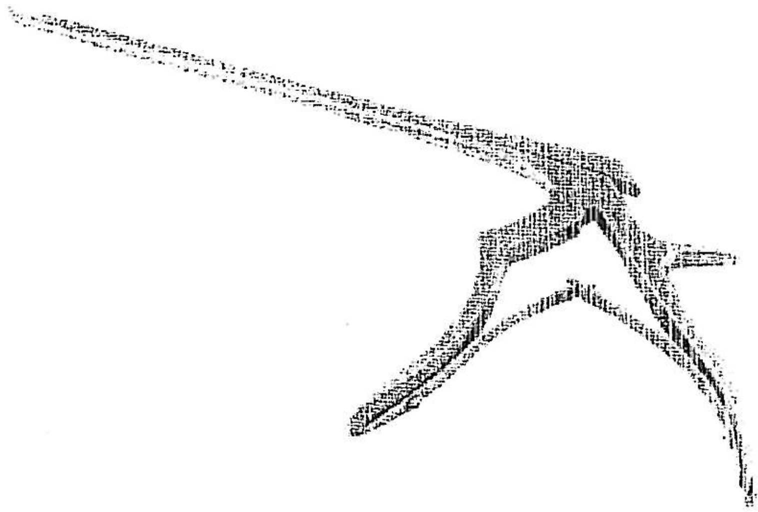
David Blunt QC

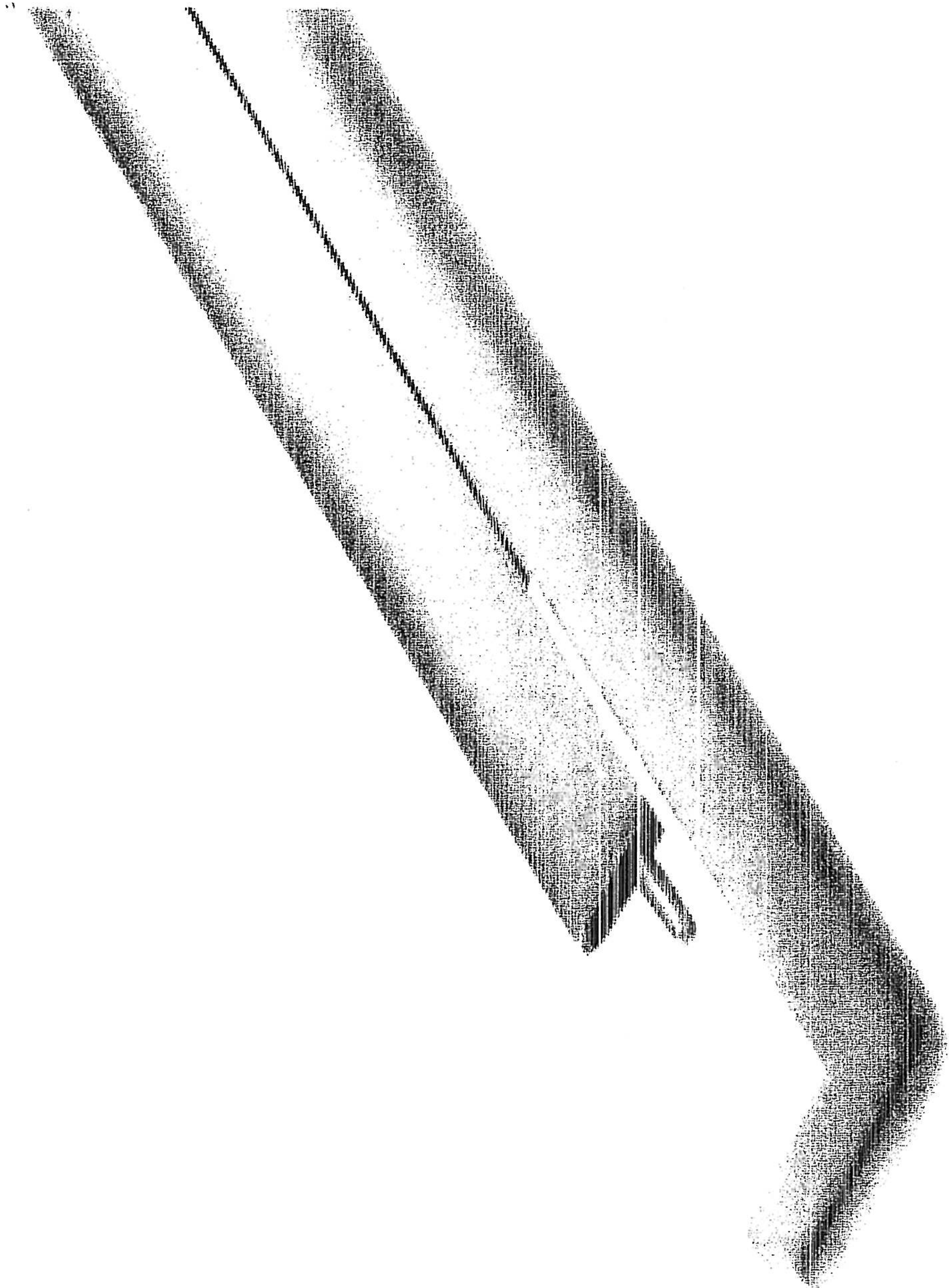
[Recorder]

Draft judgment issued 4 September 2015

Judgment handed down 22 September 2015.

Annex 1





Annex 2