Outer Temple

LEGAL UPDATE on CAUDA EQUINA SYNDROME

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Overview

- Recent liability cases involving CES
  - Breach of duty: delay in diagnosis + treatment
  - Consent + causation

- Delay in diagnosis + treatment
  - ***Shaw v. Stead*** [2019] EWHC 520 (QB)
  - ***Jarman v. Brighton & Sussex University Hospitals NHS Trust*** [2021] EWHC 323 (QB)
  - ***Hewes v. West Hertfordshire Acute Hospitals NHS Trust and others*** [2020] EWCA Civ 1523

Shaw v. Stead

- Facts
  - Thursday: C kicked in back by pupil
  - Friday: sees GP c/o bilateral leg pain
  - Saturday: speaks to OOH service – advised to attend OOH GP
  - Saturday: sees OOH GP – records Hx of severe LBP radiating down left leg but "no red flags" – o/e "sensation normal" – Δ sciatica
  - Monday: sees GP + referred to A&E – MRI scan shows large central disc prolapse at L3/4 → Δ CES – emergency surgery

- Claim against OOH GP
  - Negligent failure to refer to hospital on Saturday

Shaw v. Stead (continued)

- What is GP standard of care in these circumstances?
  - If Hx and examination elicits red flags, GP must refer to hospital
  - If red flags present, would be elicited by reasonably competent GP
  - Red flags
    - Any change in saddle sensation
    - Any change in bladder / bowel function
    - Severe / progressive loss of power in lower limbs
    - Bilateral leg pain and/or sensory disturbance

- Factual issue
  - Key aspects of C's evidence
    - Urinary accident on Saturday morning
    - Weakness in legs when C left home on Saturday afternoon – *"I felt like Bambi"*

Jarman v. Brighton etc

- Facts
  - 17 February: C injures back in accident at work
  - 3 March: attends A&E – seen by orthopaedic team + referred for MRI scan at MDT meeting next day – performed on an "urgent" timescale
  - 18 March: MRI scan – "huge" disc prolapse compressing cauda equina
  - 21 March: surgery

- Medical background to CES at [2]:

  "As the Court of Appeal has recently noted in Hewes … once CES has been diagnosed, it is seen as an emergency, because unless the pressure on the nerves is released quickly, they can be damaged permanently. CES may be suspected following consideration of a patient's symptoms (as subjectively reported) and, following examination, of any physical signs of CES, but a diagnosis of CES can only be confirmed by an MRI scan."

Jarman v. Brighton etc (continued)

- Claim against hospital
  - Negligent delay in performing MRI scan
  - Scan should have been performed within 3 days of referral, i.e. by 7 March
  - If so, CES would have been diagnosed → surgery on 9 March

- What is hospital standard of care in these circumstances?
  - Orthopaedic experts agreed they would have arranged emergency MRI scan by 4 March
  - But applying the *Bolam* test at [37]:

    "… the question is whether, in these circumstances … there is no body of reasonable opinion which would have supported arranging a scan for a patient in the apparent condition of the Claimant on an "urgent" approximately two week timescale, whilst giving the patient "safety netting advice", to return to hospital if there was any deterioration in her condition."

Jarman v. Brighton etc (continued)

- Key factors in relation to *Bolam* test
  - Diagnosis of possible CES is matter of clinical assessment based on symptoms + signs – but number of symptoms of CES are also typical of other less serious back conditions + there are resource constraints on scanning
  - C had several "very worrying" symptoms of CES on 3 March – but no clinical signs of CES o/e
  - No published guidelines / literature to show MRI scan required within this timescale in these circumstances

- Expert evidence
  - Factors for assessment of competing expert evidence: see *C v. North Cumbria University Hospital NHS Trust* [2014] EWHC 61 (QB) at [25]

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Hewes v. West Herts etc

- Facts
  - 06.04: C speaks to OOH GP c/o numbness in saddle area – GP advises C to attend A&E immediately
  - 08.27: C arrives at Watford DGH – referred to orthopaedic team who suspect CES
  - 11.59: MRI scan requested
  - 13.33: MRI scan shows "massive" L5/S1 disc herniation
  - 23.00: surgery (after transfer to London)

- Trial
  - Claim against OOH GP: negligent failure to refer directly to orthopaedic team
  - Claim against hospital: negligent delay in investigating CES

Hewes v. West Herts etc (continued)

- Appeal to CA

- Claim against GP
  - Applying *Bolam*, trial judge would have had to find that only reasonable course was for GP to contact orthopaedic dept directly

- Claim against hospital
  - Trial judge entitled to find that period between orthopaedic assessment and MRI scan was not unreasonably long
    - D's orthopaedic expert *"paid more reasonable attention to the workings of this type of hospital"*
    - No evidence that prioritisation of MRI scan was unreasonable

Hewes v. West Herts etc (continued)

- Test for breach of duty
  - What is reasonable when applying *Bolam* test depends on context – Elisabeth Laing LJ at [70]:

    "The Judge was right to use reasonableness as a touchstone, while making it clear that what was reasonable depended on the context, and that part of the context was that, on his case, the Claimant was an emergency. The other part of the context is the relatively limited resources of a District General Hospital in a busy public health service with many urgent cases competing for attention."

- Test on appeal
  - High hurdle for appeal against finding of fact / negligence – Elisabeth Laing LJ at [64]:

    "The Claimant therefore has significant obstacles to surmount in this case. It is not enough to persuade the court that a different view of the evidence was possible. The Claimant has to persuade the court that the only possible view was that advocated by the Claimant at first instance."

Overview

- Consent + causation
  - ***Pomphrey v. (1) SSH (2) North Bristol NHS Trust*** [2019] Med LR 424
  - ***Malik v. St George's University Hospital NHS FT*** [2021] EWHC 1913 (QB)

Chester v Afshar

- Facts:
  - C suffered from low back pain. Neurosurgeon advised her to undergo an elective lumbar surgical procedure (microdiscectomy on three levels).
  - 3 days later operation took place. No negligence in way it was carried out.
  - Procedure entailed 1-2% chance of serious neurological damage arising from operation.
  - This risk eventuated (*cauda equina* contusion leading to motor and sensory impairment on left side below L2).
  - C was *not* informed of this fact pre-op (this *was* negligent).
  - If C had been warned of this, she would not have agreed to operation *on that day*. She would have taken further advice. Undetermined whether or when she would have undergone the surgery. But this surgery, whenever carried out, would have carried this same risk.

Chester (continued)

- Had the breach caused her loss? 3-2 split:
  - Minority: no. Had not increased C's exposure to the risk. She had not established that she would *never* have had operation. The injury would have been as liable to occur whenever the surgery was performed and whoever performed it.
  - Majority: yes – policy and "but for".
    - Causation to be addressed by reference to scope of doctor's duty: to advise patient of disadvantages or dangers of treatment proposed. Duty was closely connected with need for patient's consent. Since injury was within the scope of D's duty to warn and was result of risk of which she was entitled to be warned when he obtained her consent to the operation in which it occurred, the injury was to be regarded as having been caused by D's breach of that duty. Justice required narrow modification of traditional causation principles.
    - Also "but for" causation made out – if she had had agreed to surgery at a subsequent date, the risk attendant upon it would have been the same, i.e. 1-2 per cent, therefore improbable she would gave sustained neurological damage.

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Chester (continued)

- Much debated ever since.

- Confined to clinical negligence cases (*White v Davidson & Taylor* [2004] EWCA Civ 1511, *Beary* [2005] EWCA Civ 415 – exceptional and justified by particular policy considerations involved in patients giving informed consent to medical treatment).

Pomphrey

- Facts:
  - C had constitutional degenerative disorder of the spine.
  - He was operated on on 24 January 2012 (not negligently). He sustained a dural tear.
  - This led to revision surgery, infection and the pain condition arachnoiditis. Left with pain, double incontinence, and mobility issues.

- C's case:
  - C had compression of *cauda equina* nerve roots for 9 months or so before operation. D should have been referred and operated on sooner. Without this delay, he would have had a better outcome.
  - Had the surgery been performed on any other day, he would have avoided what happened on 24 January 2012 (*Chester v Afshar* point).

Pomphrey (continued)

- D's case:
  - C did not have compression of cauda equina nerve roots before the operation. His symptoms were due to spinal claudication arising from spinal stenosis. There was no delay and he was treated appropriately.
  - He suffered a dural tear in the operation and *this* caused CES.

- The court found, on the first strand:
  - Pre-operation scans did not demonstrate compression of the nerves.
  - C did not suffer from saddle anaesthesia pre-operation.
  - There had therefore been no negligent delay (apart from in one respect – 10 days between 14 January and 24 January).
  - Ongoing symptoms were attributable to the dural tear, not pre-existing CES.

Pomphrey (continued)

- On the second strand, C's case was that:
  - D should have been operated on 10 days sooner.
  - Had that happened, 5-10% chance of dural tear was unlikely to come to pass.
  - The hypothetical surgery would not have been identical because it cannot be by definition.
  - Essentially, an application of "but for" case in *Chester*.

Pomphrey (continued)

- The court said no:
  - On the "but for" argument: no reason why things would have been different on earlier occasion:

    "same surgeon, physiology, same difficulty with depth technique and use of punch in the same spot.. Analysis of likelihood of the same dural tear having occurred on an earlier occasion logically must start with the cause of the tear… Mr Patel explained the difficulty with the procedure was its depth and exactly how he undertook it. He explained how the tear occurred. It was, it appears the function of this procedure working at the necessary depth and the raising of the punch where the bone is. This step, the raising of the punch, is something that he would have undertaken the same way on another occasion."
  - On the policy argument: *Chester* was distinguishable. There, the injury was within the scope of the duty to warn. Here, the scope of the duty (to avoid unreasonable delay) did not extend to avoiding a risk inherent in the surgery.

Malik

- Facts:
  - C attended A&E in 2014 with pain and weakness in his legs.
  - He underwent an operation in 2014 decompression at T10/11 and L3/L4. Slow and incomplete recovery.
  - Underwent second operation in August 2015: revision thoracic decompression of the exiting nerve root on the left hand side at T10/11 + a lumbar decompression.
  - Surgery not negligent in itself. But C was render significantly worse off, now incomplete paraparesis, confined to wheelchair.

- C's case:
  - Not consented to second surgery. Not given indication of any potential adverse outcome. Ought to have been offered alternative *e.*"

Malik (continued)

- The court found:
  - Consent had been properly obtained.
  - He *was* warned of risks. C's evidence about this unreliable.
  - C did complain of terrible intercostal pain. This justified diagnosis of compression of left sided T10 nerve root and recommendation for procedure.
  - Not negligent not to offer alternative of injections in this case. Long waiting list and would only have provided short term relief.

- On causation:
  - The *Chester* point failed on the facts. Given all the information and options C would still have gone ahead on same date in August 2015. He would not have sought another opinion or delayed making his decision. Therefore, no room for Chester analysis at all.

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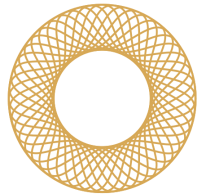
- *Chester* criticised by Leggatt LJ in *Duce* [2018] PIQR 348:

> "These are all matters which may be thought ripe for further consideration by the Supreme Court when the opportunity arises…"



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