12
King's Bench Walk

# HEAD TO TOE: The Spine

Charlotte Reynolds
Isaac Hogarth
11 May 2021

# Cauda equina syndrome: the cases

- *Jarman v Brighton & Sussex University Hospitals NHS Trust* [2021] EWHC 323
- *Calderdale & Huddersfield NHS Foundation Trust v Metcalf* [2021] EWHC 611
- *Hewes v West Hertfordshire Acute Hospitals NHS Trust & others* [2020] EWCA Civ 1523
- *Wilcox v KCH NHS Foundation Trust* [2020] EWHC 2555

# CES: Breach issues

- Tension between breach / causation
  - Multiple attendances
  - Primary / secondary care settings
  - Multiple defendants
- GPs
  - Failure to recognise symptoms / signs and refer
  - Urgency of the referral (e.g. *Hewes*)
- Hospitals
  - Failure to undertake proper examination
  - Timing of the MRI (e.g. *Jarman* / *Hewes*)
  - Recognition by courts that resourcing implications (*Jarman* para.35 / 40)

# *Jarman v Brighton & Sussex University Hospitals NHS Trust* [2021] EWHC 323

12 King's Bench Walk

- Facts:
  - 17.02.15 – Injured back in accident at work
  - 17.02.15 / 23.02.15 / 03.03.15 – Attended GP
  - 03.03.15 – Attended A&E – examined and referred for MRI on routine timescale
  - 18.03.15 – MRI showed probable CES
  - 21.03.15 – C underwent spinal decompression
- Issues
  - Were D in breach in not undertaking MRI by 07.03.15?
  - Were D in breach in not operating by 09.03.15?
  - Did the delay in surgery from 09.03.15 to 21.03.15 cause injury / additional damage?

# *Jarman v Brighton & Sussex University Hospitals NHS Trust* [2021] EWHC 323

12
King's Bench Walk

- '35. As I have already noted, CES can only be definitively diagnosed with an MRI scan. Prior to a scan, diagnosis of possible CES is a matter of clinical assessment based on symptoms and signs. However, a number of the symptoms of CES are also typical of other, less serious lower back conditions. **This means that the number of patients presenting with symptoms indicative of CES is far greater than the number of patients who could be scanned given conventional resource constraints.** Even amongst those patients who are sent for scans, on account of symptoms and/or signs of CES, only around 20% are diagnosed with CES. Accordingly, there is a significant element of clinical judgment to be applied when determining whether a patient's presentation contains sufficient evidence of CES as to warrant an immediate scan.'

# *Jarman v Brighton & Sussex University Hospitals NHS Trust* [2021] EWHC 323

- Held:
  - No criticism of examination of C
  - Common ground that no clinical signs
  - No literature to support proposition that patient with symptoms but no clinical signs should be scanned immediately
  - Course adopted by the Trust (e.g. arranging routine MRI + safety netting) was supported by a responsible body of medical opinion in March 2015.
  - In any event, there was no neurological deterioration in the relevant period and so causation was not established.

# CES: Causation issues

- Timing of the neurological deterioration (e.g *Jarman* / *Hewes*)
  - Loss of bladder control
  - Saddle numbness – progression from symptoms to signs

- Evidential issues
  - Often involves subjective interpretation / recording of treating clinicians
  - Or recollection of C as to what occurred when
  - Often complicated by impact of pain on presentation / recollection
  - Rate of deterioration varies between patients so difficult to predict
  - Does not reverse so beware of single episodes

# CES claims: practical considerations

- Careful and precise identification of the breach.
- Realistic evaluation of the facts as they would have appeared at the time and not with the benefit of hindsight.
- Consideration of the breach and causation evidence in conjunction.
- Thorough analysis of the evidence underpinning the expert opinion on the timing of neurological deterioration.

# Are CES cases more susceptible to allegations of FD?

- Many of the symptoms / level of functional impairment beyond objective verification
- Often complicated by psychological factors
- Very wide range of outcomes so difficult to benchmark
- Difficult breach / causation issues can lead to overly invested claimants that naturally want to assist their case
- Court / D trusts will closely scrutinise in light of *Metcalf*
- Perception of fraud on the taxpayer?

# *Calderdale & Huddersfield NHS Foundation Trust v Metcalf* [2021] EWHC 611

- Facts:
  - Committal for contempt of court
  - 4 attendances at hospital
  - On 4th attendance diagnosed and treated for cauda equina syndrome
  - Breach of duty admitted in relation to the 3rd attendance
  - Pleaded at £5.7m / true value agreed to be around £350k
- Dishonesty
  - Exaggeration of her physical disabilities and infirmities
  - Claimed she could not walk unaided, took relatively few holidays
  - Discovered that in a 7 month period trips to Fuerteventura, France, Spain, Tenerife, Thailand without any mobility difficulties
  - Lied to a total of 13 different experts on 19 different occasions

# *Calderdale & Huddersfield NHS Foundation Trust v Metcalf* [2021] EWHC 611

- Griffiths J:
  - C was acting not only deliberately but systematically (e.g. use of wheelchair / sticks when in or near the premises of experts)
  - Not a temporary loss of judgment but a course of conduct sustained relentlessly over a period of years
  - Sentenced to 6-month custodial term

# *Hewes v West Hertfordshire Acute Hospitals NHS Trust & others* [2020] EWCA Civ 1523

- Facts (all on 12.03.13):
  - 0500 – C awoke in pain – groin had become numb
  - 0543 – C's wife called UCC, then ambulance
  - 0604 – C spoke to out of hours GP for about 5 minutes – reported numbness 'in bum and leg' down his L leg and pins and needles in foot – no bladder / bowel issues – GP recommended immediate attendance to hospital for urgent scan
  - 0632 – C's wife spoke to ambulance service, ambulance arrived at 0721, left at 0738, arriving at hospital at 0819
  - 0920 – Seen in A&E and referred to Orthopaedics
  - 1040 – Orthopaedic assessment

# *Hewes v West Hertfordshire Acute Hospitals NHS Trust & others* [2020] EWCA Civ 1523

- Facts continued:
  - 1123 – Spinal x-ray
  - 1159 – Form completed asking for an MRI
  - 1203 – Bladder scan – following which he could not urinate when asked to try
  - 1333 – 1350 – MRI
  - 1500 – Orthopaedic review and discussion with QSH for transfer for surgery
  - 1835 – Ambulance arrived for transfer, left at 1935 and arrived at QSH at 2009
  - 2034 – Admitted to QSH
  - 2230 – Surgery started

# *Hewes v West Hertfordshire Acute Hospitals NHS Trust & others* [2020] EWCA Civ 1523

- Issues
  - Should GP have called the Orthopaedic department directly?
  - Should FY1 have first consulted the Consultant instead of the Registrar and would this have led to a quicker scan?
  - Should referral form have noted that this was suspected CES / urgent and would this have led to a quicker scan?
  - Should the MRI scan have been given higher prioritisation?
  - Factual causation – reasonable period between orthopaedic acceptance and decompression
  - Legal causation – time at which bladder function salvageable – CESI to CESR

# *Hewes v West Hertfordshire Acute Hospitals NHS Trust & others* [2020] EWCA Civ 1523

- Held: found against C on all issues
- CA: upheld decision on all grounds
  - Interesting discussion on legal causation in CES and the medical literature (para.81-92)
  - Davis LJ: "96. We were told that, so far as is known, this was the first case directly relating to the treatment of CES which has come before the Court of Appeal. But that does not mean that it raises issues of principle of general application. In fact an appellate court, a court of law, often may need to be careful to avoid making generalised pronouncements on the obligations of doctors in medical situations. What is ordinarily required, in each case, is consideration of whether the responses and procedures actually undertaken in a given medical situation fall outwith the range of reasonable and logically justifiable responses and procedures, applying the *Bolam* / *Bolitho* principles, on the facts of the individual case."

# *Wilcox v KCH NHS Foundation Trust* [2020] EWHC 2555

- Facts:
  - Appeal from a case management decision refusing D permission to rely upon surveillance evidence at trial
  - Admitted delay in diagnosis and treatment of cauda equina
  - Causation in issue as to extent of recovery C would have made with timely surgery
- Pleaded case:
  - In consequence of the delay C had sustained a permanent disability in the form of an incomplete paraplegia at L3 with reduced lower limb strength and sensation and neuropathic pain affecting both lower limbs.
  - C needed to use walking sticks for mobility which was limited to around about 250m.
  - C needed help with many ADLs and his care requirements would increase with advancing age.
  - Mr Gawronski forecast a need for a commercial care regime in the future.
  - Claim included loss of earnings, adapted accommodation, commercial care

# *Wilcox v KCH NHS Foundation Trust* [2020] EWHC 2555

- Surveillance
  - Driving on motorway in heavy traffic
  - Shopping in crowded supermarket mobilising up and down stairs
  - Negotiating steps on a bus

- Deputy Master Bard:
  - Refused permission
  - Of marginal relevance to issues of condition and prognosis
  - Unlikely to impact materially on substantial care claim
  - Likely impact on trial length and associated costs not justified

# *Wilcox v KCH NHS Foundation Trust* [2020] EWHC 2555

12 King's Bench Walk

- Appealed:
  - On the basis that it was wrong to refuse permission on grounds of proportionality without evidence of the likely value of the care claim
- Lambert J:
  - Dismissed the appeal
  - The finding that the evidence was of marginal relevance was unchallenged.
  - There were no significant inconsistencies between what C was shown to be doing on the footage and what he had said concerning his disabilities, and the impact of his disabilities upon his everyday function, in his witness statement.

# Non-CES Cases

- Spinal epidural abscess
  - *Newman v (1) Maurice and (2) Surrey & Sussex Healthcare NHS Trust* [2010] EWHC 171 (QB)
- Spinal surgery
  - *Lesforis v Tolias* [2019] EWCA Civ 487
  - *Failes v Oxford University Hospitals NHS Trust* [2020] EWHC 3333 (QB)

# Introduction to non-CES cases

- There are very few of them
- Facts tend to be extremely detailed and every decision is fact-specific
- Useful to see how judges approach the evidence, given how few fight:
  - SPOILER: depends on the judge, and depends on the facts

- Rider: cases involve solicitors and experts who are present
  - Will attempt to be neutral
  - When looking at points arising, obv with benefit of hindsight

# Newman v (1) Maurice (2) Surrey & Sussex Healthcare NHS Trust [2010] EWHC 171

- Facts:
  - C was (in early 60s) began suffering worsening back pain and rectal discharge. Went to see GP
  - GP referred him to undergo colonoscopy
  - In the meantime, was referred to D1 (spinal surgeon) privately for back pain
  - Saw D1, who advised steroid injection and MUA, which he underwent on 11/2/05
  - Shortly thereafter, C began to feel unwell with flu-like sx
  - After several days, started to complain of numbness in torso
  - Was able to get through to D1, and saw him privately that pm (2/3/05)
  - Hx: unwell for 48 hours with increased temp and rigors, some difficulty urinating and numbness in perineum. Also had stiff neck

# Newman (cont)

- Facts (cont):
  - D1 recorded impression of either meningism or epidural abscess following injection. He noted the need for urgent MRI, bloods and cultures
  - C immediately admitted. Bloods showed low platelets
  - MRI showed epidural abscess at L2, with epidural gas at L3, with possible small abscess behind sacro-coccygeal junction
  - D1 accepted clinical signs and scan indicated extensive and serious spinal infection, but did not consider the scan showed evidence of significant neural compression
  - Plan was for high dose abx and to obtain biopsy of infected area
  - On evening of 2/3/05, aspiration of sacrococcygeal abscess carried out and sent for analysis

# Newman (cont)

- Facts (cont):
  - 3/3/05, D1 saw C at 0700, and recorded that he was felling better, he had passed urine and had better perineal sensation and his neurology in his legs was ok
    - D1 ordered a further MRI and CXR
    - D1 told court (and judge accepted) that he gave instructions for C to be monitored
    - MRI came back showing extension of the epidural abscess and some enhancement of the meninges. The CXR confirmed severe infection
    - On the basis of the appearances in the scans, D1 arranged for C to be transferred to D2's hospital for drainage of the abscesses at the sacrococcygeal region
    - Transfer took place around 1840 on 3/3/05
    - C underwent excision and drainage of the post-sacral abscess – appearances according to D1 were suggestive of necrotising fasciitis

# Newman (cont)

- Facts (cont):
  - C deteriorated post-surgically, and was admitted to ITU on 6/3/05. By 7/3/05 he required intubation and ventilation
  - On 8/3/05, D1 decided to carry out further surgery to drain infection from the remainder of the spine
  - C remained in ITU for 8 weeks
  - Left with permanent deficit
- The issue
  - Essentially a question of whether it was reasonable to initially manage conservatively with abx
  - Alternative was spinal surgery to drain abscess

# Newman (cont)

- The judgment
  - Judge listed many risks of spinal surgery, several of them agreed, and several of them agreed between experts for D1 and D2 and D1 himself, but not by C's expert
  - Judge suggested the advantages of draining abscess as simple as (1) having a sample to culture (which he dismissed as unnecessary due to aspiration which had taken place), (2) relieving pressure on the cord (which he dismissed as unnecessary as there was minimal evidence of neurological loss) and (3) to remove infected and potentially toxic tissue
  - Judge was critical of C's expert, effectively for being overly supportive and refusing to make concessions –
    - an example was the very thin evidence of neurological compromise on 2/3/05, which was a cornerstone of C's case, and another was the evidence of clinical improvement on the morning of 3/3/05
  - Judge noted the literature suggested that urgent drainage was the primary treatment for spinal epidural abscess
  - The fact that there was ongoing deterioration on 3/3/05 despite aspiration and abx did not necessitate surgery, as it was a matter of clinical judgment

# Newman (cont)

- Points arising
  - Two D experts, plus D1 against C's expert – 'weight of opinion' effect
  - Slightly unusual facts in that there was relatively little by way of neurological deficit, and as such, literature noted possibility of conservative management
  - More often be the case, as in spinal epidural haematoma cases, that there is a delay in MRI and surgery
  - [With hindsight:] don't allow expert to ignore parts of other side's case that are unhelpful

# Lesforis v Tolias [2019] EWCA Civ 487

12
King's Bench Walk

- Facts:
  - Mrs L suffered back pain and sciatica in 2007, and was diagnosed with spondylolisthesis, a condition where intravertebral disc slips and overlaps with an adjacent disc, narrowing spinal canal
    - Referred to Mr T at KCH
  - L decided to undergo decompression on 20/2/13
  - Due to NHS delays, T ultimately performed privately at Harley Street on 27/6/13
  - After surgery, taken to ITU
  - 3 hrs post-surgery, started LMWH, given as chemo-prophylaxis against formation of DVT
  - Around midday on 29/6/13, L tried to move and found she was unable to feel her legs or wiggle her toes and had difficulty weight bearing

# Lesforis v Tolias (cont.)

- Facts (cont):
  - T arranged for L to have CT (no MRI being available at the weekends)
    - Reported as showing no compressive haematoma
  - Steroids started. Made no difference, so operation shortly before midnight on 29/6/13, which did not relieve the neurological deficit
  - L left with denervated bladder and bowel, severely restricted mobility, and largely wheelchair bound
  - C's case that early use of LMWH contributed to formation of compressive haematoma

# Lesforis v Tolias (cont.)

- First instance:
  - Judge concluded it was negligent for T to arrange administration of chemo-prophylaxis within 6 hrs of the operation, and that causation was made out
  - T's evidence had been that it was his invariable practice to prescribe CP after this sort of operation
  - Experts were in agreement that CP is administered 12-24 hours post-operatively
  - D expert said his practice was to do so at 24 hours, and did not say in terms that there was a reasonable body of spinal surgeons who would administer CP as early as T did
  - At experts' meeting stage, D expert noted a range of practices, and C expert was critical

# Lesforis v Tolias (cont.)

- First instance (cont.):
  - In oral evidence, in re-examination, D expert suggested based on all relevant risk factors, that giving CP early post-surgically was reasonable
  - Ratio of judgment: "*I accept Mr Leach's evidence that no reasonable body of spinal surgeons in 2013 would have given chemo-prophylaxis routinely within six hours of spinal surgery in 2013. To give such early chemo-prophylaxis required specific justification in the specific circumstances of the case having weighed the risks and benefits of so doing.*"
  - Agreed risk factors were:
    - 1. She was overweight
    - 2. She was expected to be immobile for 48 hrs post-operatively
    - 3. Surgery / anaesthetic time had exceeded 90 mins

# Lesforis v Tolias (cont.)

- The appeal:
  - The only ground on which permission was granted to appeal was that the judge failed to address the case that the relevant question was not whether T's practice of routinely giving antithrombotic medication to all his cranial and spinal patients within 6 hrs of surgery was a breach, but whether giving such medication to this patient within 3 hrs of surgery was a breach, given the accepted risk factors in her case
  - On the key issue, CA's judgment:
    - "*On the judge's findings the three risk factors did not justify any departure from what he found to be the routine safe practice. It was therefore understandable that he should make findings by reference to what was "routine". Equally, when the judge referred to the fact that there might be specific justification in the specific circumstances of a case for giving CP within six hours of surgery, he was clearly referring to circumstances other than the three risk factors. He did not address the specific question he there posed because, in the light of the findings he made, it did not arise in this case.*"

# Lesforis v Tolias (cont.)

- Points arising:
  - Try to anticipate battleground points and ensure they are fully addressed in expert reports, to avoid suggestion that evidence is changing, or points being made too late
  - Listen to your experts – if they are unable to make the point you want them to make in Bolam / Bolitho terms, you are likely to have a problem

# Failes v Oxford University Hospitals NHS Trust [2020] EWHC 3333 (QB)

12 King's Bench Walk

- Facts:
  - 9/6/15, Mr F underwent op at JRH to remove a tumour from within his spinal cord
  - Tumour successfully debulked but not possible to suture the sheath containing the spinal cord (dura) and a form of patch was applied
  - Post-operative leak of CSF through the patch and by 15/6/15, cord had herniated through the back of the spine
  - Herniation resulted in increasing traction on, and distortion of, the spinal cord and/or the stretching of the blood vessels supplying the spinal cord causing an ischaemic myelopathy and permanent damage
  - C left paralysed from chest down
  - No issue in respect of operation itself

# Failes v Oxford (cont.)

- Facts (cont.):
  - C was subject to post-operative monitoring
  - In pm of 11/6/15, nurse recorded deterioration in F's neurological condition; specifically lower limb function
    - Not brought to the attention of any doctor
  - C's case was that this was a BOD, and that had treating surgeon been made aware of deterioration he would have reoperated, and this would have prevented paralysis
  - C underwent MRI on 11/6/15 (not related to deterioration)
    - Was misreported
    - What it showed was herniation and displacement of the cord into the laminectomy
    - Surgeon did not correctly interpret scan
  - Had the scan been interpreted against the background of worsening neurological function, revision surgery would have been required

# Failes v Oxford (cont.)

- Facts (cont.):
  - C case: he was symptomatic, as obs on laminectomy chart showed, and emergency surgery was required, which would have avoided paralysis
  - D case: the relevant laminectomy chart entries were wrong / their significance was overstated as there was no neurological deterioration on 11/6/15. Rather, there was acute deterioration on 15/6/15 when C lost power in his legs
  - When surgeon examined on 12/6/15, did not notice any particular deterioration
  - In his evidence, C did not recall a deterioration on 11/6/15, and could positively recall feeling the power in his right leg increasing on 12/6/15

# Failes v Oxford (cont.)

- Judgment:
  - As judge put it, there was a single issue at the heart of the case: when did C's condition deteriorate?
  - Secondary linked issue as to what surgeon would have done had he been made aware of laminectomy chart on pm of 11/6/15
  - In very detailed judgment, judge found (contrary to D's own RCA) that there was no neurological deterioration on 11/6/15, and as such, there was no breach of duty
  - Both the laminectomy chart and the RCA were wrong
  - Much greater reliance placed on surgeon's assessment on 12/6/15 and fact that C did not in his own evidence recall a deterioration on 11/6/15, and could positively recall feeling the power in his right leg increasing on 12/6/15

# Failes v Oxford (cont.)

- Points arising:
  - Factual determinations carry risk
    - Until witnesses of fact give oral evidence, outcome is speculative
  - The Root Cause Analysis accepted the premise of that there was severe weakness in the right leg from 11/6, which was not what the judge ultimately found (essentially because it was inconsistent with surgeon's evidence, and indeed, C's own recollection)
  - Need to carefully test own client's recollection in conference and at early stage

12
King's Bench Walk

# Thank you