Neutral Citation Number: [2020] EWHC 3333 (QB)

Case No: QB-2018-001352

IN THE HIGH COURT OF JUSTICE
QUEEN'S BENCH DIVISION

Royal Courts of Justice
Strand, London, WC2A 2LL

Date: 04/12/2020

Before:

HIS HONOUR JUDGE COTTER Q.C.

- -

Between:

DANIEL FAILES

Claimant

- and -

OXFORD UNIVERSITY HOSPITALS NHS TRUST

Defendant

- -
- -

GRAHAME ALDOUS QC and STEPHEN GLYNN (instructed by Stewarts) for the Claimant
JOHN DE BONO QC (instructed by Beachcroft DAC) for the Defendant

Hearing dates: 25th, 26th, 27th and 30th November 2020.

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Approved Judgment

I direct that 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 COTTER QC SITTING AS A DEPUTY HIGH COURT JUDGE

His Honour Judge Cotter QC:

Introduction

1. This is the judgment on the liability issues in a clinical negligence action.

2. On 9th June 2015 the Claimant, Mr Failes, underwent an operation at the John Radcliffe hospital, Oxford to remove a tumour from within his spinal cord. The operation was carried out by consultant neurosurgeon, Mr Stewart Griffiths. During the very complex procedure the tumour was successfully "debulked" but it was not possible to suture the sheath that contains the spinal cord (the dura) and a form of patch was applied. Eventually there was a post operatively leak of cerebrospinal fluid through the patch and by the 15th June 2015 the cord had herniated through the back of the spine (part of which had been removed to allow access to the spinal cord; a laminectomy). The herniation resulted in increasing traction on, and distortion of, the spinal cord and/or the stretching of the blood vessels supplying the cord causing an ischaemic myelopathy and eventually permanent damage. The Claimant has been left paralysed from the chest down. It is not the Claimant's case that the operation was performed negligently.

3. It was very important that post operatively the Claimant's neurological condition was carefully monitored in order to detect, assess and treat any post-operative complication. In the five/six days prior to the herniation the Claimant was assessed at a ward round each morning and also had three physiotherapy/ occupational therapy assessments. The very broad overview of the entries in the medical records resulting from these examinations /assessments was that the Claimant was recovering well from the operation; there was "an upwards trajectory" as regards neurological function in his lower limbs.

4. In parallel to these examinations /assessments, and in line with national, if not international practice, the nursing staff commenced neurological observations, recorded about every four hours in the chart entitled "laminectomy observations". In the afternoon of 11th June 2015, the records on the chart showed the deterioration in the claimant's neurological condition; specifically his lower limb function. This deterioration was not brought to the attention of any Doctor. It is the Claimant's case the failure to do so was a breach of the duty of care and that had the treating surgeon Mr Griffiths been made aware of the deterioration he would have immediately re-operated and as a result prevented paralysis.

5. In a step unrelated to the alleged deterioration on 11 June 2015, the Claimant had a routine MRI on 12 June 2015. It is common ground that the MRI was initially misreported. The neuroradiologist described a large ventral (abdominal or anterior) subdural CSF[1] signal collection markedly displacing the thinned cord dorsally (towards the back). It was not in dispute that properly interpreted the MRI did not show an

[1] Cerebrospinal fluid. It is a clear fluid that surrounds the spinal cord cushions it from injury ; it fills the space that normally exist between the arachnoid and the pia mater.

anterior collection of CSF. Rather there was herniation and displacement of the cord into the laminectomy defects i.e. the cord was herniating backwards through the gap left by the removal of part of the bony process without being forced by collection of CSF at the front.

6. Mr Griffiths saw the MRI scan at lunchtime on 12th June 2015 during a multidisciplinary meeting. The incorrect report was not available to him at this time. It was his view that as the scan had been performed with the patient in a supine position the court could be expected to settle in a more dorsal position within the dural sac due to the effects of gravity. It was common ground that this was also not correct interpretation of the scan is gravity could not be an explanation for the abnormal position of the cord.

7. It was common ground between the parties that the MRI findings even if correctly interpreted would not on their own have been enough to indicate the displacement was causing damage. Put simply a thinned cord such as was evident on the MRI could be present in a person with full function or a person with paralysis; it was not a guide to neurological function. As a result, and on its own, the MRI scan did not mandate further/emergency surgery. The important factor in deciding whether to take the claimant back to theatre or not what is clinical status. If the claimant was stable or improving there was no need to re-operate given all the accordant risks.

8. However, if the scan was interpreted against the background of a worsening neurological function, then the position was different. If there was material neurological deterioration and an MRI demonstrating cord herniation revision surgery was needed.

9. It is the Claimant's case that by the 11th June he was symptomatic, as the observations on the laminectomy chart recorded, and that as a result emergency surgery was required. Such surgery would have saved his functioning so he would not now be paralysed

10. It is the Defendant's case that the relevant laminectomy chart entries were wrong and/or their significance overstated as there was no neurological deterioration on 11 June 2015. Rather there was an acute deterioration starting in the evening of 15th June when the claimant lost power in his legs and was unable to get up off the toilet. Reliance is placed on the examinations/assessments recorded in the medical notes and also the fact that the Claimant himself made no complaint of a deterioration in lower limb function power and/or sensation) before the 15th June.

11. Further, it is Defendant's case that Mr Griffiths would still not have re-operated even if he had been made aware of the recorded deterioration on the nursing laminectomy chart,

and the correctly reported MRI, given the results of his examination of the Claimant at a ward round on the morning of 12th June. He would not have re-operated unless a neurological examination had shown deterioration, and no such deterioration was found by him or subsequently, that lunchtime, by a physiotherapist; Mr Lovett.

Issues for the court

12. There is a single factual issue at the heart of the case; when did the Claimant's condition deteriorate. There is a secondary and linked factual issue of what Mr Griffiths would have done had he been made aware of the entries in the laminectomy charts from 15.30 on 11th June 2015 onwards. Mr de Bono QC reduced these issue to a choice between three options;

    a. The laminectomy chart accurately reflected a material change in neurological function. This should have been brought to the attention of Mr Griffiths and a neurological assessment would/ should have led to an MRI (which would have been the same as that actually performed on the morning of 12th) and then to surgery on 11th/ 12th June with a substantially better outcome for the Claimant.

    b. The laminectomy chart recorded a 'step down' but on further assessment Mr Griffiths would probably have concluded that there was in fact no material deterioration. In that case whilst there may have been a breach of duty in not drawing the laminectomy chart to the doctors' attention it was not causative of any injury.

    c. The laminectomy chart did not properly reflect, and was not intended to reflect, a material change in neurological status, notwithstanding its appearance. There was therefore no breach of duty because there was nothing to draw the doctors' attention to. Furthermore, no neurosurgical assessment would have led to a different conclusion.

13. From the outset I struggled with a third option at (c) above. On its face the chart unarguably recorded a deterioration at 15.30 on 11th June 2015 in the Claimant's lower limb function. The record by the nurse either correctly or incorrectly recorded the relevant assessment, which itself was either adequate or inadequate, but the record was created to be seen and interpreted. Subsequent entries also continued to note the reduced power and sensation. I could not, and still cannot, see the point in having a laminectomy observation chart if such a deterioration is not brought to the attention of the clinicians. In my judgment the relevant entries should have led to a neurological review. As a result question the choice framed should have been between (a) or (b) above.

Lay evidence

14. I heard from the Claimant. He has obviously borne the tragic outcome of the surgery with great fortitude. As Mr de Bono QC correctly stated his evidence was given with great dignity and candour. It was also given without the slightest hint of exaggeration or embellishment. There was little (if anything) in his witness statement that could be challenged on behalf of the Defendant. He had no recollection of the deterioration shown on the laminectomy charts on 11th June and, save for terribly debilitating headaches and constipation, insofar as he recollects matters, he remembers a path of gradual improvement in lower limb function up to 15th June. It is clear that he was making the very best efforts to progress his rehabilitation after the operation on the 9th June whilst fighting against some failures in nursing care in relation to the provision of medication. Mr de Bono QC conceded:

> "*Mr Failes did not always get the level of nursing care that he was entitled to. The text messages that he sent to his wife and sister in the immediate post-operative period show that he was in considerable pain and kept waiting for far longer than he should have been for Codeine*[2]*. Mr Griffiths expressed disappointment that this had happened and was right to do so.*"

15. The Claimant had properly been made aware of the risks of paralysis from the primary operation. On the evening of 9th June he texted his wife to report;

> "*Mr Griffiths popped in, the fact that I can feel senses/ cold on right [leg] is good sign that nerve has not been damaged*"

I am quite satisfied that the claimant, an intelligent and articulate man, was well aware of the importance of monitoring neurological function in his lower limbs and very well capable of bringing any concerns he had to the attention of the nursing staff and/or medical staff.

16. There were also witness statements from the claimant's wife Isobel Bates and his mother Anne Failes. They also contained no recollections of a significant deterioration in the power and /or sensation in the Claimant's lower limbs between the 9th and 15th June 2015.

[2] Mr Failes also should not have felt the need to ask his wife to smuggle in suppositories when he felt constipated as he had no confidence that they would be prescribed and administered in a reasonable timeframe .

17. Mr Griffiths gave clear and consistent evidence. I accept Mr de Bono QC 's characterisation of him as a caring and attentive clinician who was understandably very focussed on the progress of a patient on whom he had performed very complex surgery. That focus on his patient's wellbeing and candour was demonstrated by his dismay by the delay in imaging on Tuesday 16th June and the fact that he took immediate steps to have this investigated. I shall return to content of his evidence in due course.

18. I heard from Dr Tomar (a junior doctor in 2015 and now a general practitioner). Not surprisingly he had no independent recollection of his limited involvement with the Claimant and his principal role was as a "scribe" on the ward rounds.

19. I also heard from two physiotherapists; Elizabeth Bellido and Simon Lovett.

20. Ms Bellido has been the Physiotherapy Team Lead for Neurosciences at the John Radcliffe since 2005. Once she had corrected a mistake in her witness statement in setting out the content of the record of her examination of the Claimant her evidence which was not really challenged.

21. Mr Lovett saw the Claimant at about 13.00 on 12th June so after the laminectomy chart recorded a decrease in neurological function. His assessment was curtailed as the Claimant was bleeding and he was only challenged on one issue; the distance the Claimant had covered using a rollator before the assessment was cut short.

22. I also had a witness statement from Mr Andrew Munro[3], a solicitor within the Defendant's legal services department in respect of the lack of evidence from any of the 24 nurses who had made entries within the laminectomy chart or were rostered to care for the claimant during the relevant post-operative period. He was able to identify the nurse with the initials "PM" as Paulina Majewska. She performed routine observations between 21.30 on 11 June 2015 and 6.00 on 13 June and put her initials by her entries. He could not ascertain who made the entry at 15.30 on 11th June 2020, which first recorded stepdown in lower limb function, as it was not initialled. It has not been possible to find a contract address for Ms Majewska despite attempts since the latter part of 2019. As I shall set out the lack of evidence from Ms Majewska was a missing piece in the jigsaw puzzle of what occurred between the 11th and 15th June 2015.

[3] No objection was taken to the request for its late admission.

23. Of the seven registered nurses who had been rostered to care for the claimant between the 9th and 13th June only one remained in Defendant's employment and she (Nurse East) was involved in the care of the claimant in the afternoon of 12 June 2015 and specifically in relation to his skin reactions to dressings.

Expert evidence

24. I heard from Mr Todd (a neurosurgeon instructed on behalf of the Claimant) and Mr Mannion (a neurosurgeon instructed on behalf of the Defendant). Both are hugely experienced clinicians and expert witnesses. There was very little between the respective views and the joint statement was a model of clarity and cooperation. Significantly they agreed as follows;

> "*The experts discussed the evidence. They note that there is variation between objective neurological assessments. They do, however, agree that for pathology and surgery the complexity of the claimant's, it is not unusual to see some fluctuation in objective neurological assessment between different observers at different times, which could be related to the time of day, fatiguability etc. They further agree that the more important observation is the trajectory of the neurological status, whether there is stability/ improvement, allowing continuation of current management, or clear deterioration to mandate a change in management.*"

Also, apart from the laminectomy chart,

> "*….that there is no evidence of neurological deterioration in the records or witness statements from (the) claimant or defendant*"

And

> "*The experts agree that the laminectomy chart is a nurse's screening tool for detecting objective changes in a patient's neurological status. Historically, the charts were always available on a clipboard at the bedside and a very straightforward matter to review them on the ward round. However, nowadays, in many trusts, laminectomy charts are stored digitally in the patient's file and this requires access to a computer, to open the IT system, to then open a patient's chart*

> *and this takes several minutes. Is no longer something which can be easily done alongside the doctors ward round.*
>
> *They agree the final arbiter of concern is the doctors own assessment of the patient. The experts agree that if there was no concern raised by this assessment then there would not be a duty to also review the laminectomy chart. Mr Todd also says that if a nurse noted a deterioration in a patient's neurological status then there would be a duty to raise this with the doctors on the ward round, for them to carry out their own assessment- Mr Mannion agrees with this.*"

25. They were agreed that the MRI alone would not have mandated revision surgery stating:

> "*…Both experts were agreed that the important factor in deciding whether to take the claimant back to theatre or not was his clinical status. They further agree that, if he was stable or improving, there was no duty to do so.*"

And in respect of any assessment had the records been brought to the attention of a clinician

> "*…they also agree that if the impression from this assessment was that the claimant's condition was stable, then no further action was necessary."*

26. In light of the agreement reached by Mr Todd and Mr Mannion if the trajectory at the time of assessment by Mr Griffiths early in the morning on 12th June, and by Mr Lovett around lunchtime, was a continuation of the improvement seen and documented on 10th and 11th June by Ms Bellido and Ms Haddon (an occupational therapist) then no action would, or should, have been taken in relation to the 'step down' recorded within the laminectomy charts on 11th June (notwithstanding the MRI result as properly interpreted). However, if a clinical assessment on the evening of the 11th June on morning of 12 June had revealed material deterioration in the claimant should have been taken back to surgery.

27. I also had the reports and joint statements of Dr Yoong (a radiologist instructed on behalf of the Claimant) and Dr Offiah (a radiologist instructed on behalf of the Defendant). It was not necessary for these experts to give oral evidence. Although they did differ as to whether the interpretation of the scan of 12th June by the Defendant's radiologist was negligent or not, this was not an issue that required determination.

The approach to findings of fact

28. Before setting out my findings of fact, is necessary to make some observations as to the process and principles involved in their determination.

29. I stated in **Busby-v-Berkshire Bed Company Limited**[4] with the regard to the determination of how an accident occurred

> "*In a case such as this the civil "balance of probability" test means that the court has to be satisfied on rational and objective grounds that the case advanced as to the cause of the accident is stronger than the case for not so believing. This requires careful analysis of the arguments for and against the suggested explanations having regard to the totality of evidence including any gaps. At the end of any such systematic analysis, the court has to stand back and consider whether it is satisfied that the suggested explanation was more likely than not to be true*[5]."

and

> "*To approach the exercise of fact finding when faced with stark conflicts in witness evidence as necessarily requiring all the pieces of the jigsaw to be fitted together is often both flawed and an exercise in the impossible. This is because pieces of the jigsaw may be wrong, distorted to a greater or lesser degree or absent. Indeed, it is not possible to make findings if the state of the evidence or other matters mean that it is not proper to do so (see generally* **Rhesa Shipping Co SA v Edmunds (The Popi (M) [1985] 1 W.L.R. 948**). *However, often a sufficient number of pieces may be fitted together to allow the full picture to be seen. This the case here*[6]."

30. I have considered the totality of evidence, witness and documentary, including any gaps, and undertaken a careful and systematic analysis. Taking all the evidence into account I have consider whether or not there was a stepped deterioration which would/should have been detected on clinical assessment on the evening of 11 June or the morning of 12th June.

31. In the present case the Claimant relies, in substantial part, upon records compiled by nurses who have not given evidence as to how the relevant assessments were performed and the conclusions recorded were reached. To that extent some "pieces of the jigsaw" are missing. Mr Aldous QC stated in his written opening

> "*The Defendant has adduced no evidence from any of the nursing staff, even though the issue of the accuracy of the*

[4] [2018] EWHC 2976 (QB)
[5] Paragraph 78
[6] Paragraph 82

> *laminectomy charts is key to their defence. The Defendant has only adduced evidence from four people out of those involved in the Claimant's care, even though they rely on the involvement of others. In those circumstances the court will be able to draw appropriate inferences by the failure of the defendant to adduce evidence (Wisniewski-v-central Manchester Health Authority [1998] PIQR*"

32. This assertion prompted the production of the statement from Mr Munro explaining why no evidence had being produced from the nurses who had made the relevant entries.

33. In his closing submissions Mr Aldous QC did not press the court to draw an adverse inference from their absence. Although I did not, after considering matters in the round, draw any adverse inference, I did not approach the relevant entries in the laminectomy chart as I may other entries in documents in different contexts. Rather I took as a starting point a presumption that they accurately recorded the belief of the relevant nurse after some form of investigation or assessment. In **Synclair v East Lancashire Hospitals NHS Trust**[7], Tomlinson LJ held that:

> "*Clinical records are made pursuant to a clear professional duty, serious failure in which could put at risk a practitioner's registration. Moreover, they are not compiled simply as a historical record, they fulfil an essential and ongoing purpose in informing the care and treatment of a patient. Contemporaneous records are for these reasons alone inherently likely to be accurate.*"

34. In **HXC-v-Hind & Craze**[8], faced with a dispute about the accuracy of medical records I stated;

> "*Mr Jones QC made reference to a rule/statement often used within training for medical professionals to encourage the making of full and accurate entries within medical records; "if it is not there; it did not happen". Indeed, the case against the First and Second Defendants is a paradigm of the disputes which can arise if a full note is not made. It is the Claimant's case that the records of 19th and 27th May do not set out the Claimant's recollection of the onset of her headaches, because she was not asked about their onset. If the Claimant had been asked then the answer would have been recorded. However Mr Jones QC did not refer to the logical corollary of the teaching rule ; "if it is there ; it did happen", because the note of 29th May does set out the Claimant's recollection of the onset of her headaches and it is a record which, as it refers to gradual onset, is not helpful to her case. In this regard Mr Jones QC was to a degree seeking to run with the hare and the hounds. In my judgment a court can*

[7] [2015] EWCA Civ 1283, [2016] Med LR 1
[8] [2020] EWHC (QB) ; 5th October 2020

> *and often will taking a starting point, but no more than a starting point, that a contemporaneous entry made by a medical professional is likely to be a correct and accurate record of what was said and done at a consultation/examination.*"

35. I now turn to my findings of fact which I shall set out in chronological order.

Chronology

36. I shall now set out my findings of fact.

37. Following some unusual findings by a physiotherapist the Claimant underwent imaging of his brain and spinal cord with the results referred to Mr Griffiths. On 22nd April 2015 Mr Griffiths telephoned the Claimant and confirmed that the images showed that he had a cervico thoracic intramedullary spinal cord tumour. In his letter the same date Mr Griffiths noted that walking for 10 minutes led to an increase in heaviness in the Claimant's legs worse in his right than his left leg.

38. On 28th April 2015 tumour biopsy was performed (a significant operation in itself) which confirmed there was a grade 2 intradural ependymoma at C6-T1.

39. On 8th June 2015 the Claimant was admitted to the John Radcliffe Hospital and consented for the operation to remove the tumour. A pre-operative scan confirmed the intramedullary mass centre on the C7/T1/T2 levels with an associated cervicothoracic syrinx. At a ward round on a neurological assessment confirmed that the claimant had 5/5 power in all his limbs say that the left hip flexion was noted as 4+/5

9th June 2015 (Tuesday)

40. The operation commenced at 11.40am. It was technically very complex. The previous incision from the biopsy was reopened and deepened and a further laminectomy performed. The dural opening was found and extended and a very large tumour identified. It was removed piecemeal under a microscope leaving only a small tail. Significantly, the dura was not sutured closed as would ordinarily be the case, but coated with Duraseal then a layer of surgicel and more Duraseal. The operation ended at 19.25.

41. As Mr Mannion explained an ependymoma is extremely rare (Mr Todd accepted an incidence of about 1.2 per million), and it is even rarer not to be able to close the dura post-operatively. Therefore Mr Failes in having the tumour at all, and then in having his dura left open (but patched) following surgery, belonged to an extremely small sub-set of patients. Mr Todd suggested that this case was probably unique.

42. The recovery room observation notes record at 19.50

> "*Legs-normal movement and sensation L, severe weakness with minimal movement and dull sensation to R*".

43. By 20.30 the notes record

> "*Arterial line removed. Movement returning R leg*"

44. The Claimant was also noted to have a large bruise to his forehead from his position (face down) on the operating table.

10th June 2015 (Wednesday)

45. The Claimant awoke after "a terrible night's sleep". He had pain in his neck so asked the nurses for some more pain relief medication as

"*Up until then they had only given me Paracetamol and it was not really relieving the pain. I asked for Codeine but the nurses told me that they could only give me Paracetamol or Oramorph and so they gave me Oramorph*"

46. Mr Griffith reviewed the Claimant during his ward round at 9.00am. Dr Tomar acted as "scribe" and recorded matters within the notes. The extract within the record is as follows;

Day 1 post op, obs stable
Pain at wound site when moving arms
To take it easy
Sensation in both legs
Can lift left leg; moves decreased[9] *right leg*
Incomplete sensory level at T
Proprioception intact bilateral arms
Proprioception intact right foot

Right leg
4+/5 hip flex extension
4+/5 knee flex extension
4+/5 ankle flex extension

Left leg
3/5 hip flex
3/5 hip extension
3/5 knee flex
1/5 ankle flex extension +F[10]
Toe movement intact

Slight reduction in light touch sensation ankle left leg
Wound looks good
Drain empty
Plan: Dexamethasone
Drain in till Saturday
Sit up only
Help with all movement
Catheter in till able to sit up

[9] Confirmed by Dr Tomar during oral evidence
[10] Flexion

Start Dalteparin
Drain removal only 12 hours pre and post Dalteparin
OT + PT

47. Dr Tomar accepted that he had made a mistake in that what was recorded in relation to the left leg should have been recorded as the right leg (and vice versa). It is of significance that the Claimant's pain was in the region of the wound site. It was noted that the claimant required neurological observations every two hours and that he was complaining of pain in his head and neck and was given morphine.

48. At 14.47 Liz Bellido undertook a physiotherapy assessment, accompanied by Zoe Haddon). She stated in her statement:

> "*On day one post operatively, in my assessment the Claimant had demonstrated significantly impaired mobility in his right lower limbs, principally in the power and control of his thigh, knee and ankle. My findings on his stepping abilities and gait demonstrate how far from normal he was on his right side and his poor gait showed an inefficient, unstable pattern of walking, with a right sided foot drop, his right leg crossing the midline, and a potential for the right knee to give way. He was not able to properly control where he was placing his right foot and was not able to walk without the support of a Zimmer Frame and the assistance of two Healthcare assistants.*"

49. Her contemporaneous record set out

> "*History of leg weakness, seen for ortho surgery meniscus repair then referred to outpt physio who raised concern and referred onto neurologists.*
>
> *Current symptoms are lower limb weakness*[11] *and possible bladder and bowel symptoms.*"

And in respect of the left lower leg

> "*full passive ROM*
>
> *muscle testing 5/5 throughout all muscle groups*"

[11] she corrected her witness statement which stated left leg weakness as opposed to lower limb.

In contrast to the right lower leg which had reduced activity and flexion. The note continues

> "*reduced orientation to right lower limb, reduced weight bearing weakness noted right hip and knee… Able to step right lower limb forward, recruit extension through stance through weakness noted as hip and knee flexes. Right lower leg crossing midline during gait. Able to clear thought with some DF sliding foot along at times…. Young man presenting as a spinal patient with recovering neurology in the lower limbs, no upper limit involvement, right lower limb worse than left in terms of weakness and unable to stand and walk with WZF with assistance.*"

50. Mr Aldous QC submitted that the fact that the left leg was at this stage reported on detailed assessment as essentially normal, was of considerable significance given later reports of deterioration.

51. The Claimant recollected that

> "*In the afternoon of 10th June I had some physiotherapy but by then the Oramorph had worn off and the pain made it very difficult to mobilise. I texted Isobel to say that I couldn't get back into bed after the physiotherapy and I was in a lot of pain*"

52. This was pain at/about the wound site and not the legs. The Claimant's text messages to his family are annexed to the witness statement. Those on the 10th include the following;

> "*Only got it*[12] *an hour ago, properly knackered, did some physio but can't get back into bed as morphine worn off and too much pain, not a good experience this time*" (15.59)"

> "*It has been 18 hours since I asked for codine to getting it feel really let down*" (16.02)

[12] A reference to proper pain relief

> "*Kaela is here now and sorting them out! So no need to come in*" (16.47)
>
> "*... my folks have just left, have requested some morphine and will call you in a bit*" (20.16)
>
> "*Finally been given morphine, night nurse really defensive, denies that I had a poor night yesterday..*" (22.05)

53. The Claimant stated that during the 11th June 2015 he had begun to lose confidence in the nurses to give him the correct medication at the correct time. He recalled

> "*I started recording the times I was being given medication in my Filofax. I am not a naturally suspicious person but I became concerned that nurses did not seem to know what they were doing and I felt the need to keep track of what drugs I was being given and when.*"

54. I unreservedly accept what the Claimant has recorded as accurate. He had justified concerns about delays in receiving pain relief medication and was not experiencing the care he was entitled to expect. Of course, it would be quite possible for errors to have occurred in relation to medication and the same nurses to have been meticulous about entries in the laminectomy chart. However, whatever the accuracy of the chart entries (something I shall return to in due course) they had actually been recorded and the stepped change should have been brought to the attention of a clinician by the nurse who first made it or nurse who made the next entry. The overall picture is, on any view, not one of exemplary nursing care.

11th June 2015 (Thursday)

55. The nursing records set out that at 04.25 the Claimant complained of pain and was given Oramorph and that there were "no new issues".

56. At 9.00 am Mr Pancharatnam conducted the ward round. He was accompanied by Dr Tomar who again acted as scribe. The relevant entry is

> *GCS 15/15, some eyelid swelling- likely positional*
> *Seen by PT*

Pain sometimes limits exercises
Keep sat upright
Plan
Add morphine to encourage exercising
Walks with frame and support
Keep catheter in for now
Keep drain in

57. The nursing records record

> "*At 10.45 patient request morphine before work with PT and OT. Check his obs after laminectomy he has weakness and numb on the left leg-GCS 15/15"*[13]
>
> Given prior and subsequent entries the reference to the left leg is likely to be a mistake i.e. it should have referred to the right leg.

58. At 11.30 am Zoe Haddon, an occupational therapist, conducted an occupational therapy assessment. She recorded the claimant was

> *"concerned that he was not feeling as good as yesterday" and that he was "feeling a little stiff and sore"*

59. The record reveals that the Claimant was now able to sit on the edge of the bed and stand with assistance. He was able to lift each foot off the ground and was managing to walk to the door of the room and back using a walking Zimmer frame with one assistant, but right leg weakness remained;

> "*Reduced power at hip, required prompts to extend right knee and widened base of support.*"

Her analysis was

> *"very motivated young man experiencing plus main (sic), weakness in RLL. Walking with wzf and AO1"*

60. In his statement Mr Griffiths stated that

[13] Record made at 12.20

> "*Both of the medical and therapy assessments on Thursday, 11 June 2015 reflect a gradual improvement compared with his condition on the previous day.*"

61. The Claimant had the following recollection of 11 June

> "*...I was still on bed rest, but mobilising and walking with a walking frame, I was able to go to the toilet independently, but I was a bit constipated. I began to have problems with the drain around the operation site in my neck. It was blocking up and leaking. By this time the bruise on my forehead had swelled up, and I also had swelling around my ear and eyelids. I was pleased to see the nurse called Paulina*[14]*, who had been on duty when I had my biopsy, was on my ward again. I had more faith in her to ensure I was given appropriate pain relief and she made sure I was feeling more comfortable*."

62. It seems clear from the Claimant's recollection and the records set out above that Claimant was feeling stiff and sore and that he had weakness in the right leg, but was able to mobilise using a Zimmer frame and the support of one other person.

63. The entries in the laminectomy observations chart which are at the heart of the case commenced at 15.20 on 11th June. To put the "stepped" change in perspective;

    (a) The preceding 18 entries in relation to limb movement recorded normal power in the left leg.
    (b) The first five preoperative entries had recorded severe weakness in the right leg, and the next 15 entries mild weakness[15].

64. At 1520 an entry for normal power for the left leg is crossed out and replaced with mild weakness in the left leg i.e. a deterioration. Also the right leg is recorded as having severe weakness; again a deterioration. As for limb sensation the left leg is marked as having deteriorated from normal, which it had been for the preceding seven entries, to dull. Further, and on the only occasion on the chart, there is an entry of a painful right leg.

65. The entry in the records is unsigned. However the next entry at 21.30, which has the same assessments as regards limb movement and limb sensation (but no record of a

[14] Paulina Majewska
[15] one entry at 1900 on 10 June has the left leg with normal power and mild weakness.

painful right leg), was initialled by Paulina Majewska. She was the nurse in whom the Claimant had some confidence.

66. If accurate, the entry recorded a significant stepped deterioration in both legs. It is common ground that the entries and/or any concern about deterioration in neurological function in his lower limbs were not brought to the attention of Mr Griffiths (or any other clinician). In my judgment they should have been. Mr Griffiths stated during cross-examination

> *Q. But you do say in your evidence that you would have expected the nursing staff to have drawn these observations to your attention?*
>
> *A. Yes, I think the nurses are using a number of assessment tools, and if they have concerns based on a deterioration on the chart, or even just maybe the feeling that the patient is not quite so well, I would expect them to flag that up and we would then reassess the situation and see whether we agreed or not as the medical staff.*

There is little point in keeping an observation chart if significant changes are not brought to the attention of clinicians.

67. I will return to the accuracy and reliability the observation chart entries in due course.

12th June 2015 (Friday)

68. Mr Griffiths reviewed the Claimant during a ward round at 8.30. The record in the nursing notes states

> *"Swelling around right eye down*
> *better movement of right leg.*
> *? Allergy to mepore - change dressing.*
> *Drain out today at 2 PM.*
> *PT and PT to continue please*
> *Dex halved every three days."*

69. In my view this review at the ward round is of central importance. Mr Aldous QC referred to the lack of a record of a full neurological examination of the lower limbs

such as was recorded as having been performed on 10th June. He submitted that the reference to "better movement of the right leg" was a broad comparison with the immediate post-operative position and failed to take into account that initial improvement had been to a significant degree negated by deterioration during the previous day, as noted on the laminectomy chart. He suggested to Mr Griffiths that the reason that there was no record of a neurological examination is that one did not take place and received a firm rebuff.

Q. There was no neurological assessment by the clinical staff after 10 June, was there?
A. No, there was a neurological assessment. The documentation of the follow-up assessments may not be going through every single muscle group in quite the same way. It would almost certainly be scribed as positives or negatives features compared with the baseline immediately post op.
Q. Are you then saying that on 12 June, you undertook a neurological assessment of both legs?
A. Indeed. That would be my normal practice and that's what I've done and that's what's been noted.
Q. It hasn't been noted, though, has it, for 12 June on page 210? There is no reference to the right leg, is there?
A. On 12 June, it says "better movement of the right leg".
Q. My question was: there's no reference to the left leg?
A. No, but as I say, we'd have put positives and negatives into that depending on whether it's a change from previously.
Q. So if there was weakness in both legs, then it should have been noted, shouldn't it?
A. Well, there was weakness in both legs, as I say, from April.
Q. But if there was weakness in both legs by comparison with the day before, then it should have been noted?
A. Yes, if there indeed had been increasing weakness, then that would have been noted.

And

Q. So really it can't have been a detailed neurological assessment undertaken by you or anybody else on that ward round at 8.30 on 12 June, can it?
A. We would regularly do the detailed medical assessment, as I've said to you, and we would note the important positive or negative findings. The positive finding there was that we found better right leg movement than

we had previously.

70. If Mr Griffiths is correct in his recollection, then even if he had been aware of the recorded deterioration on the laminectomy chart it is unlikely that he would have re-operated as he found no evidence on his assessment of material deterioration in lower limb function. However, if it was a cursory assessment during a busy, or as Mr Aldous QC described it "sweeping", ward round (as is not uncommon with ward rounds if there is no significant concern raised by patient or nursing staff) then it does not provide anything like the same support for an overview of a trajectory of improvement. However, as I shall point out in due course, it is significant to note that what it does not record is any suggestion from the Claimant that he had experienced a deterioration in function.

71. Between 10.01 and 10.35 a routine post-operative cervical spine MRI with contrast was performed to determine the extent of tumour resection and to act as a baseline for future comparative purposes. It was initially incorrectly reported as showing a large ventral subdural CSF signal collection extending from C7 to T2 markedly displacing the thinned cord dorsally.

72. An important nursing entry was made at 13.00 and recorded

> "*Patient alert, orientated GCS 15/15, observations stable. Swelling on forehead-patient states that is better than previous day-ongoing issue-doctor aware. Appears to have good bed rest. Medications given as prescribed. Laminectomy obs – (illegible) -<u>legs weakness, more in the right side. Dull and numbness in both lower limbs</u>. Catheter patent, training well. Eating drinking well dressing on back checked clean and drain in situ, no suction to be removed tomorrow (?).*" (underling added)

73. The entry was made by Paulina Majewska and matches an entry at 12.45 in the laminectomy chart (although not initialled by her). Mr Aldous QC highlighted the fact that the entry referred to weakness, dullness and numbness in both legs, and not just the right leg. He submitted that this meant a significant deterioration occurred in the left leg since the physiotherapy assessment by Ms Bellido and was consistent with the stepped deterioration noted on the laminectomy chart. He submitted that this detailed entry was a more reliable record of the trajectory than the ward round assessment earlier that morning. However, the record does not stand to be considered in isolation as at approximately the same time as this entry Mr Lovett (Clinical Specialist Therapist for the Neurosciences and Stroke Rehabilitation Department) assessed the Claimant.

74. Mr Lovett noted significant progress since the assessments of Ms Bellido on 10 June and Ms Haddon on 11 June. He stated;

> "*I recall the claimant and my assessment of his physiotherapy needs in a side room on the ward at the time of the review. This is because I remember the blood dripping onto the floor just outside the door to the room and it was quite odd to see this. The bleeding was found to be attributed to a wound on his testicle*."

and

> *"In accordance with my usual practise, at the start of the review, I would have gone into the room and introduced myself. I don't recall there being anyone else present. I recall that he was sitting in his chair. I would have asked him how he was progressing and whether he would like to have a therapy and mobility review. I recorded that he reported his "power improving'. This indicated that his legs were functioning and right leg strength had improved over the previous two days. I would have also asked how he was now getting on with walking. My note records that he had told me that he was able to perform the manoeuvre of "sit to stand independent". This response suggested that he was finding it easier to move and do things on his own, such as standing up from a sitting position (a bed or perhaps a chair), which is a good and positive indication of an improvement in his lower limb function, control and right lower leg power from the day before, when he was assessed by Zoe and was noted to require the assistance of one other person to perform sitting up and standing.*
>
> *If he had reported that he felt his leg power and abilities was not improving, I would have recorded this in my entry on EPR face therapy review and I would have performed a physical examination of his trunk and lower limbs to reassess his strength, specifically testing each muscle group is listed in her initial assessment two days earlier."*
>
> *"Given Liz's note which had identified a weakness in the right leg and an altered gait with a right foot drop, in the course of my assessment, when I was observing him mobilising along the ward corridor over a distance of 10 metres with the use of only a Zimmer Frame the support and the supervision of myself (i.e. he did not require physical support of a person to mobilise) I would have been watching the claimant to see how he transferred his weight on sitting to standing, how much he relied upon his arms*

> *during the transfer, if he was keeping his weight on the left leg when standing and walking (which Liz had identified and indicates a loss of power and stability in the right leg) and how much weight he was taking to his arms when standing and walking.* "

And

> *"I have outlined above why my assessment was curtailed. My assessment of the Claimant identified a clear trend of a positive and good recovery from his operation, being evidenced by the above, which was in contrast with his assessment by my colleagues the two previous days in which they had both identified that he required physical personal assistance will all of these activities.*"

75. The contemporaneous EPR note recorded as follows

> *"patient agreed to treatment, reports power improving.*
> *Observations stable on room air*
> *sit to stand independently.*
> *Mobilised 10m with R/F with supervision only. Blood spots noted on floor, return to chair and seated, checked patient for wound to find swollen testicles with blood dripping from them. Treatment ceased nursing staff informed."*

76. Mr Aldous QC submitted that the assessment was cut short without an ability for proper evaluation. Further it is unlikely that Mr Lovett had seen the claimant move over a distance of 10m in the corridor as his statement claimed as elsewhere in the statement he recalled

> "*I recall you managed to get past the threshold of the room door because this is when I noticed the dripping blood on the corridor floor, about half a metre outside the room. At this point I would have decided that we need to go back to the room and sit down.*."

77. The reference in the statement to progressing 10m down the ward corridor is inconsistent with the reference to only reaching about half a metre outside the door. However as Mr Lovett explained given the width of the room it is likely that he did observe the claimant over a distance of 8 to 10m. In my judgement it is likely the contemporaneous record, made at a time when the Claimant was stating that he was

improving and there would be no need to exaggerate, is likely to have been an accurate and best assessment of the distance travelled by the claimant under his own steam. Significantly, him been able to move such a distance, albeit with a rollator, was consistent with an improvement; which Mr Lovett described as

> "*a progressive and sustained improvement in truncal and lower limb neurological function and mobility in the immediate (day1-3) post-operative period.*"

78. There is an obvious degree of contradiction between the assessment in the nursing and laminectomy charts and the assessments of Mr Griffiths and Mr Lovett on the same morning/lunchtime, particularly in relation to the left leg. It is a conflict which I have had to resolve through analysis of all of the relevant the history before and after the 12th June; so I shall continue with the chronology before returning to it.

79. A note made in the medical records at 14.00 recorded

> *"catheter and drain out now*
> *Dalteparin at 6.00pm.*
> *MRI reviewed at MDT -post op OK"*

The last time is the only record of the Multi-disciplinary meeting which considered the Claimant's case.

80. Mr Griffiths stated in respect of the Friday neurosurgery/neuroradiology MDT meeting

> "*This investigation (the MRI) was discussed in the Friday lunchtime neurosurgery/neuroradiology MDT which is attended by a number of senior consultant neurosurgeons and neuro-radiologists. The MRI scan confirmed there had been an excellent resection of the tumour with reduction of the syrinx size. There were a number of expected post op changes including thinning of the cord in the region where the tumour had been resected and some dorsal displacement of the cord towards the dural repair. The decompressed spinal cord in the post op phase is now very thin and lacking in structure in comparison with the pre-op MRI performed on 8 June 2015… With an increase in compliance compared to when the tumour was present and, as the scan was performed with the patient in a supine position, the court may be expected to settle in a more dorsal/dependent position within the dural sac due to the effects of gravity. My view was that there was no significant large pseudo-meningocoele (no large fluid collection outside the dural repair)*

> *to suggest significant CSF leak or a failure of the dural repair at this time*."

81. The scan would have been available at the MDT meeting "hot off the press" but without the radiology report. Mr Griffiths recalls

> "*none of the attendees raised any concerns regarding the continued conservative management plan in the light of the clinical progress and imaging*"

82. By way of overview Mr Griffiths stated

> "*with a clearly demonstrated improving clinical status from the 10th to 12 June 2015, especially regarding leg power, control and function and sphincter control, and a scan that showed the expected post operative changes, I had no reason to taking the claimant back to theatre at this time. Such an approach on the background of clear positive sustained improvement could not be reasonably justified as being in the claimant's best interests (and will carry all the attendant risks a spinal operation including neurological deterioration*"

83. A further record at 15.30 records

> "*SHO Tomar.*
> *C the SF leak post drain removal-called by nurses*
> *2x3.0 interrupted inserted aseptically*
> *leak stopped, dressing applied. Remove sutures in 14 days*
> *return to bed as now has low pressure headache*"

84. In my view the Claimant's recollection of 12 June has very great significance in resolution of the conflict between the records. He stated

> "*On 12th of June I was sent for an MRI scan of my cervical spine to review the effects of the surgery. That afternoon, the drain from the surgery site was removed. I could feel the power in my right leg gradually increasing. That evening, however, I developed an intense headache. Isabel called me and I explained that my head was extremely painful. We actually ended up arguing*

> *about this she thought it was not a big deal and probably just similar to when I came of codeine in May 2015, but I could tell the pain was much worse now.*" (underlining added)

85. The reference to the power in the right leg gradually increasing is inconsistent with a downward trajectory in sensation and function within that limb and consistent with what was recorded by Mr Griffiths and the assessment of Mr Lovett.

86. As for the headache Dr Tomar had identified it as likely to be a low pressure headache due to the loss of CSF. I have no doubt that it was little short of a crippling headache and the otherwise remarkably stoic Claimant was suffering real distress which was not relieved by medication to the extent that it should have been. He was failed by the nursing staff in this regard.

13th June 2015 (Saturday)

87. An entry in the nursing records, again by Paulina Majewska, at 4.00 am records

> "*Daniel has been settled in bed. Able to use call bell when needs assistance to go to the toilet. Walking with Rollator frame at the moment to help with weakness of legs. Numbness still on both legs.*" (underlining added).

88. The reference to weakness and numbness in both legs is inconsistent with the physiotherapy assessment of Mr Lovett the previous day as regards the left leg. So the divergence between the nursing records and laminectomy chart on the one hand and the clinical records and physiotherapy assessments continued.

89. Further entry timed as "early" states

> "*Care taken over this a.m. observations stable.. Miles neck pain- required Codeine PRN and regular paracetamol tablet at lunchtime. Mobilising with Zimmer frame to toilet. Had is washing the toilet independently just needing assistance in cleaning his back and applying cream at affected area on his back…* "

90. A note by Dr Imran Haq (a neurosurgery junior doctor) in respect of the weekend ward round is brief only recording

> *"A C6-T1pendymoma (day 3 post op[16])*
> *Obs stable, apyrexial*
> *Plan review Monday"*

91. At this stage (the weekend) the Claimant was able to walk with a rollator/Zimmer frame. He was experiencing constipation and it was noted had not opened his bowels of four days. He was still complaining of neck pain.

92. Mr Griffiths recalls within his witness statement;

> "*I was the on-call neurosurgery consultant over the weekend of the 13th-14th June 2015. I recall visiting the claimant on the neurosciences Ward outside the ward round, and were both very pleased with the dramatic recovery in his lower limb, bladder and bowel sphincter function so soon after such a major spinal cord operation and I remember expressing the hope that he may be fit enough to be discharged during the following week. There is no formal entry in the medical notes recording that I saw the claimant over the weekend because it was my normal practice not to make such an entry when I was in effect "popping in" to check on my patients over the weekend. I would have made an entry had I performed a formal assessment or had been a particular issue of concern.*"

93. Even if this was only a very short visit to the claimant it did provide the claimant with an opportunity to raise any particular concern about his post-operative recovery. I accept that the overall theme of the brief meeting was happiness with the progress so far. This is not consistent with a material deterioration on 11th June, which the Claimant would surely have been aware of given that he was making brave efforts to progress his recovery.

94. The Claimant recalled

[16] In fact it was day 4 post-operation and not day 3

> "*By 13 June 2015 I was still experiencing a headache and I become very constipated. I asked Isobel to bring me in some suppositories and fruit to help with my bowel movements as I did not have faith in the nurses to provide me with the tablets without a long delay. There was an emergency admission in the hospital on the night of 12 June and lots of the nursing staff were tied up with that so there were not many of them around to come and help me.*
>
> *Before Isobel and Flossy came in to see me I managed to get up and use the walking frame to walk to the washroom, and I was able to stand in shower unaided. I had been given some painkillers which relieved my headache slightly. I got dressed into clean pyjamas and sat into a wheelchair to go down to the cafeteria to meet them. I wanted to be upbeat when they came to see me. I was anticipating that states that I would be discharged home in a few days time following a review from Mr Griffiths*."

95. The fact that the Claimant was able to get up without assistance and use the walking frame to get to the washroom, and then stand in the shower unaided, is not consistent with a significant deterioration in his lower limb sensation and function. Rather it is broadly consistent with an upward trajectory of improvement in the lower limbs since the operation; as is the optimism about discharge. It is clear at this stage the claimant was not worried about the function his lower limbs. This was the fourth day post-operation and he would have been able to assess for himself whether his lower limb function was generally improving or deteriorating. What he was able to do on the 13th was consistent with his own recollection of improving power on 12th June and inconsistent with a significant step deterioration on 11th June.

14th June 2015 (Sunday)

96. At the ward round at 10.15 am the claimant was seen by Mr Wright; neurosurgery specialist registrar. The entry in the medical records states

> *"obs stable*
> *feels well*
> *no acute concerns*
> *feels progressing well.*
> *Wound dry*
> *Plan- OT/PT*

97. The Claimant recollected

> "*I've also seen that at 10.15 there is a note… saying that I felt "progressively well". I remember that my headache was not as severe that morning but it was still there and the problems with my bowels were ongoing. My sisters and my parents came to visit at around 15.15 and stayed with me until 20.00. I try to make an effort when they came in but I initially had to wait for the pain relief to kick in before I sat up. After about 45 minutes I was able to get out of bed. My dad had brought a wheelchair up from the hospital reception and I was able to go downstairs and have a copy with them. As the hours passed I was becoming more and more uncomfortable as the headache worsened and ended up being quite tetchy as I was in so much pain. My mum and dad were worried to see me in pain and out of sorts, but they thought they'd simply stayed too long and they should leave me to rest. After they all left a try to get to sleep but Isobel rang me at 21.00 to see how I was doing. I found it very difficult to hold the phone and speak to her due to the severity of my headache…*"

98. The clear area of concern for the claimant was his severe headache which was due to low pressure arising from loss of CSF. He was able to get out of bed and would have had an opportunity to assess his lower limb function and sensation against previous days. Again it is of considerable significance that he had no concern about lower limb function.

15th June 2015 (Monday)

99. Mr Griffiths did the ward round at 9.00. He noted

> *"headaches this am*
> *progress with walking good over the weekend*
> *wound looks okay*
> *Obs stable*
> *Apyrexical*
> *CGS15/15*
> *feels hungry*
> *gets wind O/E (diagram of abdomen) distended."*

The plan was for a CT scan of the brain and flat rest for the day. The reference to progress with walking over the weekend is not consistent with a deterioration or downward trajectory in the Claimant's lower limb function.

100. At 12.00 the nursing records note

> "*patient complained of pain since beginning of the shift PRN Codiene and Oromorph given which took effect after a while. Complained of abdominal discomfort and headaches. Discussed on ward round and patient for CT scan chest and abdominal x-ray and bloods? bowel obstruction? wind. Patient feeling slightly more comfortable late morning all obs stable to rest today*"

101. A CT head scan was performed. The imaging showed only shallow collections of fluid between the inside of the skull and the surface of the brain and some air in the fluid school cavity. These findings were not unexpected after a laminectomy and dural opening. There was no sign of hydrocephalus or hind brain descent.

102. An entry in the nursing records at 19.30 states

> "*Patient's obs.. he been (sic) in pain for all of the afternoon. CT head is ready to be check by the doctor. Medications given as prescription. Pain killers given regularly"*
>
> *BG6.6. He stayed into toilet for 40 minutes and didn't call none. When I discovered the patient he couldn't stand up. We used to chair to move the patient from toilet to bed.*"

103. The claimant's recollection of the day is as follows;

> "*On the morning of the 15th June my headache was getting worse and I remember groaning in pain and felt quite tearful thinking to myself "I've got to get across to these nurses how bad this pain is". I kept saying to them how bad it was, that it wasn't normal to me and I was also very constipated. I got the impression they thought I was just a bit of a wimp and a nuisance. I note that my records show that Mr Griffiths did a ward round at 9.00 on 15 June 2015 and noted that I had a headache. I do not recall any detail about this ward round the descent if a CT scan of my head which took place at midday.*"

He stated that his headache became unbearable during the afternoon and he was now finding it difficult to breathe and that

> "*At around 19.00, I got out of bed to go to the toilet. I remember having enough power in my legs to walk to the toilet with a frame, but after five minutes sat on the seat. I was not able to get up again as my legs had become too weak. It was a struggle for me to stand so I would try once, then rest, then try again. The nurses eventually found me in the toilet and had to help me up. I had some movement in my legs but there was a marked reduction in power. I think they may have put me in a wheelchair to bring me back to my bed."*
>
> And
>
> "*My parents and Mikaela arrived at the JRH about 20.30. I told my mum that never had a headache like this in my life and I was losing feeling in my legs, as well as having a badly bloated stomach. Mikaela asked what the nurses to call the doctor to review my CT scan, which the nurse advised she would do. My family left about 22.00 as they thought the doctor would be with me soon, and I was getting more and more agitated. As I lay in bed between 22.00 and midnight I began to groaning pain due to the severity of my headache. I told one of the nurses that I could not feel my legs and she simply said I did not need to feel my legs as I should be asleep. With hindsight looking at my medical records I think the nurse was trying not to worry me but at the same time she began to bleat for a doctor to come."*

104. The Claimant then sent a message to his wife asking her to come and see him in the morning and remembers little from this point onwards.

16th June 2015 (Tuesday)

105. The records show that the Claimant's condition deteriorated quickly;

a) At 02.05; pyrexia of 38.1C

b) At 02.20; neurological observations noted the left leg deteriorated from mild weakness to severe weakness and the right leg continued to have severe weakness.

c) At 02.30; the Claimant was reviewed by Mr Martin who noted that he had not moved his legs and this had been the case since he went to sleep. The impression was new paraplegia second to potential cord infection. There was a large volume of faecal incontinence, but the Claimant did not feel the sensation.

d) At 03.40; the claimant was catheterised due to urinary retention.

e) At 04.25 the claimant was reviewed by the neurosurgical registrar and the plan was for an urgent MRI scan. The request was refused.

f) At around 7.45 the Claimant had an MRI scan.

g) 08.00; Mr Griffiths noted that the claimant was in the MRI scanner and that initial images revealed called herniation. The Claimant was reviewed outside the scanner and taken straight to the theatre for re-exploration. Subsequent report refers to a large subdural CSF signal collection which had increased since 12 June.

106. The re-operation commenced at 08.45 and Mr Griffiths performed re-exploration and the debridement of the laminectomy wound and insertion of a drain. In his operation note Mr Griffiths states the wound when opened revealed a large quantity of fluid suggestive of infection. Sadly the operation did not improve the claimant's condition and he recalls Mr Griffiths coming in to see him after the operation and telling him that he was devastated at the deterioration in his condition. Thereafter the claimant remained paralysed with a sensory level from the chest downwards. He retained some upper limb function but is wheelchair-bound.

26th June 2015

107. Mr Griffiths was very upset by the deterioration and the result after the second operation and was concerned about the delay in obtaining the MRI. He raised his concerns formally and showed professionalism and the best interests of his patients in doing so. He told the Claimant that he had asked the trust to carry out an investigation into his deterioration. The report which was eventually produced in September; "The Root Cause Analysis Investigation Report" recorded;

> "*the trigger for this investigation was that the on-call neurosurgical registrar doctor contacted the on call consultant neuro-radiologist for an urgent MRI (at 04.32) which was declined as an emergency scan but agreed to be done at 07.00. The scan was undertaken at 07.45 to 08.16 and the patient was transferred directly from neuroradiology to theatre for urgent spinal surgery. The neurosurgical opinion is that earlier intervention would not have reversed the patient's cord damag*e"

108. On 2 July 2015 the lead investigator wrote to the claimant to inform him that an investigation was underway which included an apology she received a response to the letter from the family on 21 July with information to support the investigation

The Root Cause Analysis Investigation Report

109. The report was dated 28 September 2015. In the "brief incident description" it is stated

> "*The 38-year-old patient had an operation to remove a low grade intramedullary spinal tumour on 9 June; post operatively he had mild right leg weakness and was mobile and continent. There was fluctuating post-operative recovery with some initial improvement in his motor and sensory feeling, but with severe weakness in his right leg from 11 June. At seven days following excision he developed acute changes with severe weakness in both legs. Paralysis and sphincter loss (urinary and faecal incontinence) at approximately T4/5 sensory level in the early hours of 16 June 2015.*"

110. The report stated under "involvement and support provided for staff involved" that

> "*the consultant neurosurgeon has been supported by his clinical lead and has also had the opportunity of reviewing the entire case with one of his consultant colleagues who reviewed this as part of the investigation*."

111. Mr Aldous QC pointed out that despite his involvement in the report and ability to review it Mr Griffiths had not sought to correct the overview of facts and specifically that the claimant had

> *"severe weakness in his right leg from 11 June"*

although he now states that this is incorrect.

112. Mr de Bono QC pointed out that under the rubric "the following is the family's recollection of events in response to the duty of candour letter". It is noted

> "*In the family's opinion there was an overall deterioration of his condition over 36 hours and it appears to them that the delayed intervention of appropriate clinical investigations during that time and the lack of escalation by the nursing staff to a doctor consultant during the day on Monday, may have contributed to the final outcome.*"

113. He submitted that the suggestion that the deterioration had been over 36 hours prior to the 16th June, and in particular on the Monday, was inconsistent with the belief that there had been a stepped deterioration as early as 11th June.

114. The RCA itself was, on the Defendant's case, poorly written and inaccurate. Mr de Bono QC suggested that part of the problem may have been that it strayed beyond its original remit and did not have the required input from clinical staff. Also the report was prepared by a non-clinician (the lead investigator was a Consultant Neuroradiologist).

115. The only available record of neurosurgical input comes from Mr Cadoux-Hudson, late in the day on 17 September 2015. He stated that

> "*the post-operative course of these rare intra-medullary cervical ependymoma patients are marked by fluctuating neurology as occurred with this patient. There was a "step down" in neurology on 12th June (6 days after op) and a cervical MRI was done at 09.43 excluding compressive haematoma. There was a further dramatic change in neurology in the early hours of Tuesday, 16 June, after a "stormy" previous 36 hours and an experienced registrar phone consultant neuroradiologist for an out of hours scan*"

116. It is difficult to reconcile this overview with the records. Six days post-operation was 15 June and not 12th. There was certainly a step down on 15th June, but on the claimant's case the laminectomy observation chart shows a step down on 11th June which was two days post -operation.

117. When cross-examining Mr Griffiths Mr Aldous QC, not surprisingly in my view, was somewhat nonplussed, by the answer revealing that although he was the instigator of the report Mr Griffiths did not receive a copy of it and had not read it before he compiled his witness statement. Of greater significance is that even when he did see it, he had not seen the laminectomy chart. His evidence was as follows;

> *Q. When did you in fact first see the laminectomy chart?*
> *A. I didn't actually see the laminectomy chart until this case reached the legal department.*
> *Q. Right. So you didn't look at the laminectomy chart at*

all when the root cause analysis investigation took place?

A. No, I didn't have a huge amount to do with the root cause analysis in the September, I think was the final draft of it, was my understanding.

118. Although at first blush the report provides significant support the existence of a deterioration on 11th June, on careful analysis of the report as a whole I do not find that it adds significant support to the Claimant's case as to a deterioration. I am quite satisfied that Mr Griffiths has at no stage believed there was a step deterioration on 11th June. He was and is very firmly of the view that there was an upward trajectory of improvement in lower limb function (power and sensation) from 9th June to 15th June when there was an acute deterioration. He had not seen the laminectomy chart entries at the time of the preparation of the root cause analysis so had no reason to raise their inaccuracy with the investigator. Remarkably, despite being the clinician who raised the concern which promoted it, he did not see the report until long after its production. To say the very least neither the history of the production nor the distribution of the report shines a favourable light upon the Defendant's internal investigatory process.

Was there a deterioration in lower limb function on 11th June 2015

119. Having set out the chronology I now return to the central issues; was the recorded deterioration in the laminectomy charts accurate and what would Mr Griffiths have found on an assessment had they been brought to his attention as they should have been?

120. The neurosurgeons agreed that apart from the laminectomy chart the clinical picture set out in the Claimant's clinical notes, in the Defendant's witness statements and the Claimant's witness statements is consistent with a patient who was making reasonable progress following the major surgery on 9th June before an acute deterioration on the 15th June. As set out within the joint statement there can be variation between individual objective neurological assessments and it is not unusual to see some fluctuation in objective neurological assessment between different observers at different times, which could be related to the time of day and /or "fatiguability". The more important observation is the trajectory of neurological status, whether there is stability/ improvement, allowing continuation of current management, or clear deterioration to mandate a change in management

121. Mr Griffiths was satisfied that there was no deterioration on the 12th June. He was sufficiently happy with the Claimant's progress to reduce the steroids and allow removal of the catheter. In my judgment he would have taken neither of these steps if he had significant concerns about neurological function. His view was supported by the subsequent assessment of Mr Lovett albeit that it was curtailed. I am also satisfied,

having heard his evidence that Mr Griffiths assessment at the ward round would not have been a cursory one. He was clearly very interested in the progress of the Claimant as this complex and relatively rarer procedure as proved by him "popping in" over the weekend when he was under no obligation to do so. I find that he did undertake a neurological assessment of the lower limbs but did not dictate the scores as he had done previously as he did not feel it was necessary. In his view the trajectory was of gradual improvement. Importantly he had the direct information form the Claimant that leg function was improving.

122. In my judgment the evidence of the Claimant is crucial to constructing the overall picture despite missing pieces of the jigsaw; such as evidence from Paulina Majewska. So often over 35 years of involvement in clinical negligence work I have seen complaints from Claimants that the nursing or clinical staff did not take sufficient notice of what they were saying about issues with their bodies ; that judgments were made or not made without adequate weight being attached to the history or issues raised by the person actually experiencing the relevant symptoms. A paradigm is the failure in the present case to adequately deal with the Claimant's crippling headaches; so severe they even caused him to be short with his own family. What a person says about what they think of pain, discomfort etc is vitally important as they can usually put it into a context or normality or relevant recent history whereas a clinician (absent objective testing) cannot do so. Indeed even with objective testing it will often still be the case that what a patient says, and/or can actually do, that should usually have primacy within a clinical assessment. By way of example the neurosurgeons agree that the scan on 12th June could not be used to predict the Claimant's degree of function. A thinned cord could result in paralysis or the retention of normal lower limb function. In the present case the Claimant's recollection is that he was not ignored as regards concerns about a deterioration in lower leg function; he recalls no such concerns.

123. Specifically, the Claimant did not recall a deterioration in function in his lower limbs on the 11th June. On the 12th June he recalled that he could feel the power in his right leg gradually increasing. Whilst the absence of comment about deterioration could be potentially explained away by an inability to remember events in detail; the positive assertion that he could recall improvement on the 12th June is another matter, and produced an obvious forensic issue for Mr Aldous QC. It undermined the Claimant's own case.

124. The Claimant's recollection had corroboration from the note of Mr Griffiths that there was better movement of the right leg. Also, significantly, there was no note of any compliant by the Claimant of deterioration. I am sure that if he had reported this concern it would have been recorded. The note of the assessment by Mr Lovett provides even stronger corroboration as he contemporaneously recorded the Claimant as reporting power improving. In my judgment it is highly unlikely that the Claimant would have reported this unless that is what he felt. He had the experience of three days of recovery to fall back on and it was his body and he knew whether he was improving or not

125. A trajectory of gradual improvement in lower limb function is also consistent with the messages and exchanges/meetings the Claimant had with his family. He mentioned no concerns about his legs; unlike the issue with his headaches and constipation, until the 15th June. This is why there was a reference to a deterioration over 36 hours within the input to the root analysis investigation.

126. Also the Claimant was able to shower independently on Saturday 13th June and Mr Griffiths recalls further improvement over the weekend and discussing (probably on 13th) with Mr Failes the arrangements for discharge the following week. The Claimant's recollection of optimism that this would come to pass is only consistent with an overall trajectory of improvement.

127. Absent the laminectomy chart and the entries in the nursing records the picture would be plain and clear; an improving trajectory up to an acute and devastating deterioration on the 15th June 2015. However the nursing assessments paint a very different of a material deterioration on 11th June 2015 continuing thereafter. Taking the starting point that they accurately record the assessment of the relevant nurses the issue is how such assessments can have been made?

128. The first entry recording a deterioration is on the laminectomy chart at 15.30 on 11th June by an unidentified nurse. There is no accompanying entry in the nursing notes; the most proximate being at 12.20 when it was recorded that the Claimant had been seen by a doctor and said that he was able to sit up on the chair and "*mobilise with PT and OT*" and was requesting morphine before work with the PT and OT. The note then records that "*he has weakness and numb the left leg"*. As I have set out this is a mistake and should have stated right leg. So no marked deterioration was recorded at that time (or reference to the left leg). It is clear from the subsequent assessment by Zoe Haddon, and his own recollection, that Claimant was feeling stiff and sore and that he had weakness in the right leg, but was able to mobilise using a Zimmer frame and the support of one other person.

129. The 15.30 entry was after Zoe Haddon's assessment and recorded pain; the only recording of pain on the chart. Unlike weakness and loss of sensation, pain would not ordinarily be a feature of loss of neurological function. The conclusion that I have reached is that the Claimant was tired after trying his best during the OT assessment and was in general pain. He was a determined man who was pushing himself. As he had told nurses he did not feel as good as he had the day before. I think it likely that pain and "fatiguability" led to exactly the type of variation in reported function which the neurologists stated could occur. However, it was a temporary dip, linked to his

general pain and discomfort which the Claimant has now forgotten. He could see what he had achieved during the assessment and was pleased with the general trajectory. By the next morning he was felling less fatigued and was able to report his progress to Mr Griffiths. Nevertheless this "dip" should have been brought to the attention of Mr Griffiths otherwise the chart lacked utility.

130. As Mr Bono QC pointed out it is also necessary to have regard to the limitations of this particular laminectomy chart and specifically that

i. There is no scoring system, only the categories of normal power, mild weakness and severe weakness. This inevitably increases the possibility of different assessment by different observers.
ii. The legs and arms are each treated as a whole. This would pose difficulty for a nurse if the leg were normal apart from one joint.
iii. As Mr Mannion explained, limb movement is not the same as limb power.

In my view much more weight must be attached to the targeted neurological and physiotherapy assessments.

131. It is also significant to note when assessing the reliability of the laminectomy chart that

(a) the entries recorded an assessment of the right leg on 10th June which appears inconsistent with the detailed testing of Ms Bellido. She found what would usually amount to severe weakness in the right leg (as accepted by Mr Todd) but the chart recorded only mild weakness. This assessment continued until 15.30 on 11th June. Also, and of more concern;

(b) The entries completely failed to pick up on the very serious deterioration on the evening of 15th June when Mr Failes could not stand up in the toilet. It was what Mr de Bono QC referred to as a 'barn door' change in neurological function yet it is not noted on the chart.

132. I think it likely that the entries on the chart after 15.30 on 11th June simply followed the "marking" without detailed further analysis of whether function had changed or not. It was clear that the Claimant still had residual weakness and reduced power in the right leg; so the record was continued without too much regard to the detailed scoring of function as his mobility continued to be impaired. Given the limitations of the form, the assessments lacked nuance. They must also be seen in the context that the nurses knew that more detailed assessments were being made by clinicians and others.

133. The entries in the nursing records by Paulina Majewska on 12th June 2015 and 13th June[17] (and also her entries in the laminectomy chart), also conflict with the pattern of an upward trajectory (as the left leg was recorded by Ms Bellido as having 5/5 power and a full range of movement on 10th June this would be a deterioration). They are not in line with the assessments of Mr Griffiths and Mr Lovett on 12th in relation to the left leg, the Claimant's recollection and the Claimant being able to get up without assistance and use the walking frame to get to the washroom and then stand in shower unaided. Having considered the totality of the evidence available to me it is my view that the entries of Ms Majweska must contain an historical overhang as regards the left leg. What she recorded was influenced by a general post-operative overview. I arrive at that view in part because I simply do not accept that if there had been either a deterioration in the left leg function and/or continuing, significant weakness and numbness in that limb that it would not have been picked up on the clinical/physiotherapy assessments on 12th June and the Claimant would not have noticed the issue and mentioned it. It is also difficult to see how he could have mobilised independently as he did on 13th June 2015.

134. I find as a fact that the Claimant's left leg had not deteriorated by 11th June. What was recorded by Ms Majewska did not accurately reflect the detailed and up to date picture on 12th or 13th June 2015. I cannot properly go further to consider why this was so without speculation. A piece of the jigsaw (the evidence of Ms Majewska) is missing but I started with a presumption of accuracy. Ultimately the weight of contrary evidence has displaced this presumption.

135. So the answer to the question of whether there was a deterioration in lower limb function on 11th June is in the negative. There was an upward trajectory of improvement in the lower limbs until the 15th June 2015.

Conclusion

136. For the reasons set out in detail above, had the entries made in the laminectomy chart from 15.30 on 11th June 2015 onwards been brought to the attention of Mr Griffiths, as they should have been, subsequent detailed neurological examination would not have found any material deterioration in the lower limbs and the Claimant would not have been returned to surgery so as to have avoided the catastrophic deterioration that befell him. In my judgment he suffered an acute deterioration on 15th June 2015 and up to that point there had been an upwards trajectory, in no small part due to his determination

[17] Which was at 4.00am

and drive to progress his rehabilitation. I find option (b) in paragraph 12 above to be correct. As a result the claim fails.

137. I should add that in my view the Defendant attracted fire upon itself, and did little to engender the confidence in the Claimant or his family, in that;

(a) Nursing care fell below an acceptable standard as regards;

(i) the attention to the Claimants post-operative headaches and the timely provision of medication, and
(ii) the failure to draw the content of the laminectomy observation chart to the attention of Mr Griffiths.

(b) As the Root Cause Analysis Report identified, there was a delay in obtaining the MRI on the16th June (due to a request for an immediate MRI being refused by the on- call neurologist).

(c) The Root Cause Analysis contained mistakes and was not properly distributed to Mr Griffiths (who would then have had the opportunity to correct errors).

138. I have very considerable admiration for the way the Claimant dealt with the post-operative period and the devastating deterioration and the frank and also for the honest and straightforward evidence which he gave. I wish him the very best in coping with his disability.

139. I leave it to Counsel to try to agree the content of a final order.