IN THE WALSALL COUNTY COURT **1IQ06567**

Before His Honour Judge Mithani QC

B E T W E E N:

BRIDGET KENNEDY

Claimant

and

SOUTH WARWICKSHIRE NHS FOUNDATION TRUST

Defendant

Dr Simon Fox (instructed by **Blythe Liggins**) for the **Claimant**
Mr Andrew Kennedy (instructed by **Browne Jacobson LLP**) for the **Defendant**

Approved Judgment

I direct that pursuant to CPR PD 39A para 6.1 no official shorthand note shall be taken of this Judgment and that copies of this version as handed down may be treated as authentic.

……..

His Honour Judge Mithani QC

20 June 2013

THE CLAIM

1 This is a clinical negligence claim in which the Claimant, Bridget Kennedy, an 87-year old lady, claims damages for personal injury, alleged to have been caused as a result of negligence on the part of the Defendant-Trust, South Warwickshire NHS Foundation Trust, in

the provision of physiotherapy treatment to the Claimant following a right total knee-replacement operation.

2 The personal injury that resulted from the physiotherapy was the rupture of the Claimant's right patella tendon.

3 The manner in which the patella tendon works can be described in simple terms. The patella tendon connects the patella (kneecap) to the tibia (shinbone). The patella tendon works with the muscles in the front of the thigh – the quadriceps – to straighten the leg. The patella is attached to the quadriceps by the quadriceps tendon. Working together, the quadriceps, quadriceps tendon and patella tendon allow the knee to flex and extend. When a rupture occurs, the patella loses support from the tibia. It moves upwards when the quadriceps contract, thus impeding the ability of the leg to extend. This means that when a person attempts to stand, he is unable to do so as his knee buckles and gives way.

4 My short and simple summary of how the patella tendon works is sufficient for the purpose of this judgment. However, I am extremely grateful to Professor John Fairclough, the orthopaedic expert instructed by the Claimant, for providing me, when he gave evidence, with a more detailed account of the manner in which it operates by reference to an anatomical model of the knee.

THE FACTS

5 The background leading to the carrying out of the knee-replacement surgery need only be mentioned briefly. I understand the substance of it to be agreed by the parties, although some of the finer details may be disputed.

6 The Claimant was born on 8 January 1926. On 1 February 1994, she had a right hip replacement at Walsgrave Hospital, Coventry.

On 6 June 2000, she had a left hip replacement at Walsgrave Hospital. On 29 April 2002, she had a left total knee-replacement at Walsgrave Hospital. On 15th November 2007, she was listed for right total knee-replacement. However, that procedure was not carried out on that day. Instead, it took place 17 January 2008 at the Defendant hospital in Warwick. The Claimant was 82 years of age when the procedure was carried out.

7 The procedure was successful. From 18 to 22 January 2008, the Claimant remained an in-patient at the Defendant's hospital.

8 On 18 January 2008, the Claimant was reviewed by a physiotherapist, who went through the following exercises with the Claimant, which the document at page 81 of Bundle 'MR' shows that the Claimant had achieved satisfactorily: (a) static quadriceps extension; (b) straight leg raised; (c) active knee flexion; and (d) inner range quadriceps. That document also records that the Claimant had achieved full knee extension and partial flexion with minimal assistance being needed, but that she needed some assistance with independent straight leg-raising. It is, at this stage, important to record that no suggestion was made, let alone any indication given, by the team of consultants and doctors responsible for treating or looking after her that it was not appropriate for her to receive physiotherapy treatment following her operation.

9 The Claimant was reviewed again by a physiotherapist on 19 January 2008, and the exercises described at paragraph 8 above were repeated. The Claimant's range of movement in her right knee was 0 to 60 degrees (full extension and partial but greater flexion), and she was noted to be mobilising with a frame. She was also noted to require minimal help with independent straight leg-raising.

10 On 20 January 2008, the Claimant was noted to be mobilising with two walking sticks, albeit with reluctance.

11 On 21 January 2008, a physiotherapy assessment of the Claimant took place, and it was noted that she had already mobilised with a frame and had mobilised 10 metres to the bathroom. However, as she felt dizzy in the bathroom, she was taken back to her bed in a wheelchair. She also appears on that day to have undertaken the exercises referred to in paragraph 8 above satisfactorily – see page 89 of Bundle 'MR'

12 On 22 January, 2008, the Claimant was able to mobilise independently with two sticks and managed a step.

13 The Claimant was discharged from hospital on 22nd January 2008. Upon her discharge, she was provided with a Physiotherapy Department booklet entitled 'Knee Replacement Surgery'. The booklet contained the following advice:

> "A physiotherapist will see you on the day after your operation to start exercises and mobility. It is vital that you are fully committed to rehabilitation from this early stage to ensure a good long-term result. It is important that you get your knee bending as soon as possible; otherwise, you will develop stiffness which may be permanent. You must also make sure that your knee goes out straight. **Do not** be tempted to rest with a pillow under your knees, as this will stop them from going straight. Once you are discharged from the ward and SWATT you will often be referred for outpatients physiotherapy. This is so that we can continue to monitor you and progress your exercises." (Emphasis in bold included in the original text).

14 The Claimant was also shown various exercises that she was told to do every two hours throughout the day. Those exercises are described at paragraphs 1 to 5 under the heading 'Exercises' in the booklet. Those paragraphs do not just provide clear instructions on how the exercises should be performed, but are accompanied by pictorial illustrations of the exercises.

15 Between 22 and 23 January 2008, the Claimant had follow-up assessments at home by the physiotherapy staff of the South Warwickshire Accelerated Transfer Team – or 'SWATT', as that team is known. SWATT is a multi-disciplinary team made up of

physiotherapists, occupational therapists and nurses based at the Defendant-Trust, but with a remit of assisting patients in the community with their physiotherapy and general health needs following joint-replacement surgery.

16 At 4.30 pm on 22 January 2008, the Claimant received a ‘settle’ visit from a member of the SWAT Team. It was noted that her knee was quite swollen. She was advised to apply regular ice therapy.

17 On 23 January 2008, the Claimant received a visit from a member of the SWAT Team. It was noted that the Claimant was well with ‘no problems to report’. She was managing the exercises well, although she was only able to manage three independent straight leg-raises, and was feeling sick when she was doing them. Her range of movement was shown to be 0 to 85 degrees – full knee extension and increasing knee flexion.

18 On 24, 25 and 26 (or 27) January 2008, the Claimant had follow-up visits at home by the SWATT nursing staff. However, these visits dealt mainly with concerns which the Claimant had with her bowels. In the record of the visit on 26 January 2008 – or possibly 27 January 2008 as the document at page 94 of my Bundle ‘TB’ is not entirely clear – the Claimant was noted to have ‘no further problems’.

19 Once a patient reaches a certain level of function after a procedure such as the one the Claimant had, he is normally referred by the SWAT Team for physiotherapy as an out-patient. The referral is principally one of two types – either a referral for ‘one to one’ physiotherapy or a ‘physiotherapy class’.

20 The Claimant was referred by the SWAT Team to a physiotherapy class for patients who had total knee-replacements at the Physiotherapy Department of the Defendant hospital at Warwick as an out-patient. She was asked to attend a class that was being run

on 13 February 2008. However, she was unable to attend that class because she had a cold. She was given a date for another class. That date was 20 February 2008.

21 The Claimant was able to attend that class. It was being run by Ms Lisa Fitter, a qualified physiotherapist, a member of the Chartered Society of Physiotherapy, and a Registered Health Professional. Ms Fitter was being assisted by a second-year physiotherapist student, Ms Georgina Wilkinson, and a physiotherapy assistant, Ms Sue Sharp.

22 The class consisted of a circuit of exercises. The Claimant undertook a series of 'sit to stand' exercises. She completed those exercises successfully and moved on to the 'mini-squat' exercise[1]. The circumstances in which she came to do that exercise are in dispute between the parties. However, it was in the course of carrying out that exercise that the Claimant suffered a rupture of her right patella tendon. The immediate aftermath of that incident does not require any mention by me. It is set out in detail in the written statement of both the Claimant and Ms Wilkinson, and is not material to the issues that I have to determine.

23 On 25th February 2008, the Claimant had a tendon repair and reconstruction operation. In spite of that operation, the Claimant has significant reduced mobility. She requires the use of crutches or walking sticks. As the Claimant states at paragraph 51 of her witness statement, she has been told that she is unlikely to be able to walk without the use of sticks.

THE ISSUES

[1] There is some issue as to whether the expression 'mini-squat' is appropriate to describe this exercise – see, for example, Ms Zena Schofield's response to Question 8 of the 'Claimant's Agenda' in the joint statement prepared by her in conjunction with Mr Paul Errington in which she describes the exercise as a 'wall-squat'. For the sake of convenience, I will describe this exercise in this judgment as 'the mini-squat'.

24 Liability is in dispute. However, quantum has been agreed between the parties, subject to liability, in the sum of £30,000. That amount includes both general and special damages.

25 The basis upon which it is alleged by the Claimant that the Defendant is liable to the Claimant for the injury which the Claimant suffered is set out at paragraph 8 of the Particulars of Claim. Although there is some criticism by the Claimant of the assessment of the physiotherapy requirements of the Claimant prior to the physiotherapy class on 20 February 2008, the Claimant's claim is focussed primarily on the physiotherapy class on 20 February 2008. The allegations of negligence against the Defendant may be summarised as follows: (a) the Claimant asserts that the Defendant should have carried out a full assessment of the suitability of the exercises that the Claimant was invited to perform at the class (which included the mini-squat) before she started the class. The Claimant states that such an assessment should have been carried out by the physiotherapy staff at the class. So far as the Defendant asserts that such an assessment of the Claimant was carried out, the Claimant asserts that it was inadequate. She maintains that if a proper assessment of her condition and needs had been carried out, it would or should have resulted in the mini-squat exercise (and, therefore, the injury) being avoided; (b) the Claimant's asserts that the mini-squat was a 'completely inappropriate' exercise for someone in the Claimant's position to be invited to undertake, taking into account the risk associated with it when compared with the benefit that the Claimant would derive from it; and (c) the risk to the Claimant would or should have been apparent given the following matters, which the physiotherapy staff failed to take into account: (i) the effect of eccentric contraction involved in the mini-squat; (ii) the fact that the Claimant had weakened quadriceps; (iii) the fact that the knee-replacement operation would have the effect of compromising the Claimant's proprioception – that is her sense of body orientation, balance and movement; (iv) the effect of her

age; (v) the lack of any or any proper support being provided to the Claimant to perform the mini-squat (although this appears no longer to be relied upon by the Claimant); and (vi) the fact that the total knee-replacement operation involves the patella being moved over, which stretches the tendon and makes it more vulnerable to a rupture.

26 The position of the Defendant may be summarised as follows: (a) the Claimant's orthopaedic surgeon had not suggested that the Claimant should not attend a knee-rehabilitation class following the operation. On the contrary, he had stated that the Claimant should 'mobilise FWB [i.e. full weight bearing]'. It followed that it was appropriate for the Claimant to participate in the knee-rehabilitation exercise; (b) the mini-squat is a recognised exercise for those undertaking knee rehabilitation-classes following a total knee-replacement; (c) the assessment of the Claimant by the Defendant – specifically by Ms Fitter on 20 February 2008 – was both appropriate and adequate; (d) there was nothing about the Claimant's condition on 20 February 2008 arising from the assessment conducted by Ms Fitter that meant that the mini-squat should have been avoided; (e) even if Ms Fitter had conducted a 'full' assessment of the Claimant – as the Claimant contends she should have done – Ms Fitter's conclusion about the ability of the Claimant to perform the mini-squat was likely to have been the same; and (f) there is no proper basis upon which it can be contended by the Claimant that the mini-squat was not an appropriate exercise for the Claimant to be invited to undertake on 20 February 2008 – or, in other words, there is no basis upon which it can be asserted by the Claimant that the mini-squat was inappropriate, let alone 'completely inappropriate'.

THE LAW

27 The law is relatively uncontroversial. The Defendant is vicariously liable for the negligent acts and omissions of its staff, which include the members of the SWAT Team and those individuals who were running or assisting in the running of the physiotherapy class on 20 February 2008.

28 The classical exposition of the test for breach of duty in clinical negligence is that set out by McNair J in *Bolam v Friern Hospital Management Committee [1957] 1 WLR 582 at 587*:

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

29 The decision in *Bolam* makes clear that medical opinion on a particular issue may differ, and that a person is not negligent merely because he acts in accordance with a body of opinion which does not represent the most popular body of opinion. In determining whether a defendant has fallen below the required standard of care, the court must take into account responsible medical opinion, and the fact that reasonable professionals skilled in a particular art may differ. As McNair J put it, a professional who acts in conformity with an accepted current practice is not negligent 'merely because there is a body of opinion which would take a contrary view.'

30 In resolving any difference or dispute arising between experts, it is important to note the warning given by Lord Browne-Wilkinson in *Bolitho v City and Hackney Health Authority [1998] A.C. 232 at 238*:

> "Having made his findings of fact, the judge directed himself as to the law by reference to the speech of Lord Scarman in *Maynard v. West Midlands Regional Health Authority [1984] 1 W.L.R. 634* , 639:
> '. . . I have to say that a judge's 'preference' for one body of distinguished professional opinion to another also professionally distinguished is not sufficient to establish negligence in a practitioner

> whose actions have received the seal of approval of those whose opinions, truthfully expressed, honestly held, were not preferred. If this was the real reason for the judge's finding, he erred in law even though elsewhere in his judgment he stated the law correctly. For in the realm of diagnosis and treatment negligence is not established by preferring one *respectable* body of professional opinion to another. Failure to exercise the ordinary skill of a doctor (in the appropriate speciality, if he be a specialist) is necessary.' (Emphasis added)."

31 Since even a relatively small body of supportive medical opinion may be effective to satisfy the *Bolam* test, the practical application of the test means that the Claimant effectively has to show that no body of respectable and responsible medical (more precisely physiotherapy) opinion would have supported what Ms Fitter did on 20 February 2008. However, as Lord Browne-Wilkinson stated in *Bolitho at p 242-3*, that does not mean:

> "… that a defendant doctor escapes liability for negligent treatment or diagnosis just because he leads evidence from a number of medical experts who are genuinely of opinion that the defendant's treatment or diagnosis accorded with sound medical practice. In the *Bolam* case itself, McNair J. [1957] 1 W.L.R. 583, 587 stated that the defendant had to have acted in accordance with the practice accepted as proper by a '*responsible* body of medical men.' Later, at p. 588, he referred to 'a standard of practice recognised as proper by a competent *reasonable* body of opinion.' Again, in the passage which I have cited from *Maynard's case [1984] 1 W.L.R. 634* , 639, Lord Scarman refers to a 'respectable' body of professional opinion. The use of these adjectives - responsible, reasonable and respectable - all show that the court has to be satisfied that the exponents of the body of opinion relied upon can demonstrate that such opinion has a logical basis. In particular in cases involving, as they so often do, the weighing of risks against benefits, the judge before accepting a body of opinion as being responsible, reasonable or respectable, will need to be satisfied that, in forming their views, the experts have directed their minds to the question of comparative risks and benefits and have reached a defensible conclusion on the matter."

As McNair J himself put it in *Bolam* at p 587:

> "A medical man [may not] obstinately and pig-headedly carry on with some old technique if it has been proved to be contrary to what is really substantially the whole of informed medical opinion. Otherwise you might get men today saying: 'I do not believe in anaesthetics. I do not believe in antiseptics. I am going to continue to do my surgery in

the way it was done in the eighteenth century.' That clearly would be wrong."

32 In the circumstances that obtain in the present case, what the application of this test requires is for the court to determine whether the mini-squat would be accepted as proper by a reasonable and responsible body of physiotherapists. But, as Lord Brown-Wilkinson observed, what that test also requires is for the court to be satisfied that the experts purporting to express the opinion of a reasonable and responsible body of opinion have directed their minds to the question of comparative risks and benefits, and have reached a defensible conclusion on the matter. However, in that context, the following observations of Lord Browne-Wilkinson in *Boitho* at p 243 are instructive:

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

33 The burden of proof is on the Claimant. The standard of proof is the usual civil standard of proof – the balance of probabilities. Breach of duty and causation have to be established by the Claimant to that standard of proof if she is to establish liability against the Defendant, and recover the amount of the agreed damages.

34 As a general rule, the ordinary principles of causation apply in clinical negligence. It remains for the Claimant to establish that the defendant's negligence caused, or at the very least materially contributed to, her injury. However, in the context of clinical negligence, a further principle of causation arises, which is set out in *Bolitho* at pp 239-240:

> "Where as in the present case, a breach of a duty of care is proved or admitted, the burden still lies on the plaintiff to prove that such breach caused the injury suffered: *Bonnington Castings Ltd. v. Wardlaw [1956] A.C. 613*; *Wilsher v. Essex Area Health Authority [1988] A.C. 1074* . In all cases the primary question is one of fact: did the wrongful act cause the injury? But in cases where the breach of duty consists of an omission to do an act which ought to be done (e.g. the failure by a doctor to attend) that factual inquiry is, by definition, in the realms of hypothesis. The question is what would have happened if an event which by definition did not occur had occurred. In a case of non-attendance by a doctor, there may be cases in which there is a doubt as to which doctor would have attended if the duty had been fulfilled. But in this case there was no doubt: if the duty had been carried out it would have either been Dr. Horn or Dr. Rodger, the only two doctors at St. Bartholomew's who had responsibility for Patrick and were on duty. Therefore in the present case, the first relevant question is 'What would Dr. Horn or Dr. Rodger have done if they had attended?' As to Dr. Horn, the judge accepted her evidence that she would not have intubated. By inference, although not expressly, the judge must have accepted that Dr. Rodger also would not have intubated: as a senior house officer she would not have intubated without the approval of her senior registrar, Dr. Horn… Therefore the *Bolam* test had no part to play in determining the first question, viz. what would have happened? Nor can I see any circumstances in which the *Bolam* test could be relevant to such a question…However in the present case the answer to the question 'What would have happened?' is not determinative of the issue of causation. At the trial the defendants accepted that if the professional standard of care required any doctor who attended to intubate Patrick, Patrick's claim must succeed. Dr. Horn could not escape liability by proving that she would have failed to take the

> course which any competent doctor would have adopted. A defendant cannot escape liability by saying that the damage would have occurred in any event because he would have committed some other breach of duty thereafter. I have no doubt that this concession was rightly made by the defendants. But there is some difficulty in analysing why it was correct. I adopt the analysis of Hobhouse L.J. in *Joyce v. Merton, Sutton and Wandsworth Health Authority [1996] 7 Med.L.R. 1* . In commenting on the decision of the Court of Appeal in the present case, he said, at p. 20: 'Thus a plaintiff can discharge the burden of proof on causation by satisfying the court *either* that the relevant person would in fact have taken the requisite action (although she would not have been at fault if she had not) *or* that the proper discharge of the relevant person's duty towards the plaintiff required that she take that action. The former alternative calls for no explanation since it is simply the factual proof of the causative effect of the original fault. The latter is slightly more sophisticated: it involves the factual situation that the original fault did not itself cause the injury but that this was because there would have been some further fault on the part of the defendants; the plaintiff proves his case by proving that his injuries would have been avoided if proper care had continued to be taken. In the Bolitho case the plaintiff had to prove that the continuing exercise of proper care would have resulted in his being intubated.' There were, therefore, two questions for the judge to decide on causation. (1) What would Dr. Horn have done, or authorised to be done, if she had attended Patrick? and (2) if she would not have intubated, would that have been negligent? The *Bolam* test has no relevance to the first of those questions but is central to the second."

35 I accept the substance of paragraphs 7 to 9 of the closing written submissions[2] prepared by Mr Kennedy that: (a) in determining the appropriateness of the assessment carried out by the Defendant, the court has to apply the *Bolam* test. Likewise in determining whether inviting the Claimant to undertake a mini-squat was 'completely inappropriate', the court will apply the *Bolam* test: that is, whether no responsible physiotherapist would have asked the Claimant to undertake a mini-squat; (b) where – as in the present case – an allegation of breach of duty consists of an omission to act, the court must, when addressing the issue of causation, pose two questions: first, what would an adequate assessment have revealed, and would this have resulted in the mini-squat being avoided and, second, what should an adequate assessment have

[2] It should be noted that both counsel agreed to deal with closing submissions by way of written submissions only.

revealed and should this have resulted in the mini-squat being avoided. The first question involves a factual enquiry. The second is an issue for expert evidence; and (c) when considering competing expert evidence, the court should consider whether an expert's opinion can be logically supported. It is only if an expert's evidence cannot be logically supported, that such opinion 'will not provide the benchmark by reference to which the defendant's conduct falls to be assessed.'

36 As regards expert evidence, the Claimant relies upon the expert evidence of Professor Fairclough, Consultant Orthopaedic Surgeon, and Ms Zena Schofield, Chartered Physiotherapist, to support her case. The Defendant relies upon the expert evidence of Mr Philip Radford, Consultant Orthopaedic Surgeon, and Mr Paul Errington, Chartered Physiotherapist in support of its defence to the claim.

UNDISPUTED OR UNCONTROVERSIAL MATTERS AND THE ACTION PLAN

37 It is appropriate that I record the following matters, which although they may have been in issue before the commencement of the trial, can no longer be regarded as disputed or controversial:

(a) The system operated by the Defendant for providing physiotherapy treatment to patients who have had knee-replacement surgery is not unique to the Defendant. As Mr Errington stated, it is operated by a number of NHS Trusts throughout the country – a statement expressly agreed by Mrs Schofield. In her evidence, which was unchallenged on this point, Ms Lisa Fitter indicated that a similar system was in place in a different Trust in which she had worked prior to working for the Defendant-Trust;

(b) The mini-squat is widely used in physiotherapy classes following knee-replacement surgery. Mrs Schofield found that of the four units she contacted for the purpose of preparing her written evidence in these proceedings, two units used them. Mr Errington stated that its use was common in physiotherapy classes, following a knee-replacement operation, throughout the country, stating expressly in his response to Question 9 of the Claimant's Agenda that 'the Mini Squat is an accepted and standard exercise for knee-rehabilitation classes and as such is standard practice and an accepted method by a reasonable and responsible body of physiotherapists.' The orthopaedic experts had also some experience of its use in knee-rehabilitation classes. Professor Fairclough indicated that it was used in the Trust in which he used to work, and Mr Radford stated that he too was familiar with its use in such classes; and

(c) The Claimant no longer criticises the adequacy of her assessment while she was an in-patient.

38 It is also appropriate that I deal with the significance of the 'Action Plan' (included at Document 64 of Bundle 'TB') which was produced following the injury to the Claimant as a result of doing the mini-squat. Following the incident on 20 February 2008, Mrs Jan Fereday-Smith, the general manager of the Physiotherapy Team at the Defendant-Trust, asked for critical incident statements from Ms Fitter and Ms Wilkinson about the incident. She also asked the Physiotherapy Team to develop an action plan to review the physiotherapy programme which the Defendant was providing to its patients. She did so because – as she says in paragraph 7 of her

witness statement – she wanted to ensure that her Trust was 'delivering the best programme.'

39 The Action Plan was produced by the Physiotherapy Team and submitted to Mrs Fereday-Smith. She wrote on it 'avoid this exercise, redesign programme'. Dr Fox appeared to suggest in the course of his questioning of Mrs Fereday-Smith that those comments amounted to an indication that the Defendant accepted that the mini-squat was an inappropriate exercise for patients such as the Claimant who attended a physiotherapy class following a total-knee replacement operation. I do not know whether the Claimant continues to maintain that position. There is no indication in Dr Fox's written submissions that she does. So far as she does, I wholly disagree with her for the following reasons:

(a) At paragraphs 7 and 9 of her witness statement, Mrs Fereday-Smith stated why she made the above comments on the Action Plan:

> "… My role involves risk management, so the comments were my way of engaging the team in discussion about our current practices, and to ensure that the evidence base for this exercise had been fully reviewed or whether a different exercise could be used to achieve the same outcome."
>
> "My comments were designed to engage the team in discussion about the exercise Mrs Kennedy performed, and was purely about managing risk."

(b) The exercise and the incident on 20 February 2008 were discussed at a team meeting. Mrs Fereday-Smith states at paragraph 9 of her witness statement that the aim of the meeting was to 'challenge our views and practices, and to look at incidents in order to see whether we can learn from them and whether we should adjust our physiotherapy programmes.' I entirely understand and endorse that approach. I would

consider it to be wholly inappropriate – and indeed to amount to a serious dereliction of duty – for a responsible provider of physiotherapy treatment to press on with a programme which it knows has or may have resulted in an injury being occasioned to a patient without reviewing it in order to consider whether its continued used is appropriate or whether it might, at the very least, be modified. In asking for an action plan and suggesting that the mini-squat should be withdrawn from the knee-rehabilitation class until a full review of the exercises offered at the class was undertaken, the Defendant was doing what any reasonable provider should have done – conduct a proper, and fully open and transparent, evaluation of the exercise programme in order to determine whether it should be modified and, in the meantime, give consideration to the suspension of that part of the programme that was or might have been responsible for the injury to the Claimant being caused. As Ms Fitter observed in the course of giving her evidence, if a physiotherapist continued with a programme which had resulted in an injury being occasioned to a patient, the physiotherapist might be in breach of Standard 20 of the Core Standards of Physiotherapy Practice (2005 Edition), which were in force at the time of the incident on 20 February 2008.

(c) Mrs Fereday-Smith was not challenged on the above points by Dr Fox. I can see no basis, therefore, upon which it can be said that the manuscript comments made by her on the Action Plan amounted to an acceptance on the part of the Defendant that the mini-squat was inappropriate. As Mrs Fereday-Smith stated, far from abandoning the use of the exercise or even modifying it, the Physiotherapy Team decided that it

should continue to be offered to patients because it was safe, appropriate and beneficial for them. It continues, therefore, to be part of the programme of exercises which is offered to physiotherapy patients attending knee-rehabilitation classes at the Defendant-Trust.

40 Before I deal specifically with the issues that I need to determine, it is appropriate that I deal with the evidence of the Claimant and Ms Georgina Wilkinson. Although that evidence is not dealt with at any length in the written submissions of the parties, it is relevant to the issues I need to determine.

THE EVIDENCE OF THE CLAIMANT AND MS WILKINSON

41 There is a factual dispute between the parties about whether the Claimant was provided with proper instructions on how to carry out the mini-squat and the precise circumstances in which the Claimant's right patella tendon came to be ruptured.

42 At paragraphs 39 to 43 of her witness statement, the Claimant says this:

> "39. One of the physiotherapists said that they did not know what to put me on. All the exercises that were left were a chair to get up and down from and a wall.
>
> 40. I was thus given the chair to get up from once or twice on a sitting to standing exercise which was tough but I managed it.
>
> 41. After the chair exercises I walked to get my stick as I did not wish to lose it. I then stood the stick upright against the wall about three feet from me. The physiotherapist then asked me to stand with my back against the wall and my heels touching the wall. She told me to put my hands straight down by my side and then to bend my knees. I went down quickly but not very far and then up and she then said 'Do it slowly'.
>
> 42. I then did a further squat more slowly. I did not go down very far, may be up to a foot. My right knee gave way and I fell over

onto my right side against the wall. My right arm caught my stick which was nearby, in the upper arm and the stick bent. My right hand was twisted on the floor with my little finger and that next to it bent sideways. My little finger on my right hand still gets sore as a result as does my knuckle. I definitely did not slip.

43. It appeared that the tendon in my knee had gone…"

43 In her oral evidence, the Claimant said this. First, she indicated that she could not recall whether the student physiotherapist who was looking after her had in fact demonstrated the mini-squat to her. She did not think that the student physiotherapist had but, at any rate, the rupture took place after she had done what she had been asked to do on some four occasions[3]. When on the fifth occasion, she was asked to lower herself gently down the wall and asked to do so slowly and further down than she had on the previous occasions, her knee gave way.

44 Ms Wilkinson, who was the student physiotherapist to whom the Claimant was referring, gives a slightly different account. At paragraph 11 to 18 of her witness statement, she says this:

"11. The circuit of physiotherapy exercises entails asking the patient to perform as many of the relevant exercises as they can do so comfortably within two minutes. The first exercise which Mrs Kennedy undertook was the repeated 'sit to stand'. The sit and stand exercise involves sitting the patient on a height adjustable plinth. The height is adjusted to ensure that the patient's feet are flat on the floor and their knees at 90 degrees. The patient then slowly stands, using their hands and knees if necessary to push themselves up.

12. Mrs Kennedy completed this successfully and without difficulties. She could in fact stand without using her hands to push through, or to push herself up. This was a very good sign that she was recovering her strength well…

[3] In the course of his questioning of various witnesses, Dr Fox suggested that the rupture took place on the third squat. My note of Ms Wilkinson's evidence is that it took place on the fourth or fifth squat. However, no point of substance arises from this.

13. The fact that Mrs Kennedy could do this exercise without using her hands to push herself suggested she was more advanced in her recovery.

14. After completing the sit to stand exercise successfully, Mrs Kennedy moved to the 'mini squat' exercise. This involves the patient standing with their shoulders against the wall, with their heels a few inches away from the wall and feet shoulder width apart. The patient then slides their back gently and slowly down the wall. One is looking for the patient to slide down to around a 45 degree bend in the knee, after which the patient slides their back up the wall, again to a standing position.

15. Mrs Kennedy was a short distance away from the corner of the room. Mrs Kennedy felt that she did not need her walking stick so leaned it up against the wall beside her. I demonstrated a squat to Mrs Kennedy, emphasising that she must keep her back and shoulder blades in contact with the wall. I also advised her to slowly execute the squat to achieve control.

16. Mrs Kennedy successfully carried out four to five squats…

17. Whenever I supervise a patient on a one to one basis, I talk to them throughout the exercise. I remember advising Mrs Kennedy that she did not need to squat too low whist she was doing these exercises. In doing so, I was trying to describe to her how she should be doing it and how it should be feeling. I was not saying this because I felt that she was in fact squatting too low. After performing around four or five squats, on the consequent squat, Mrs Kennedy's body weight was distributed unevenly over her right (operated) knee. This resulted in her inability to stand up and she lost her balance and began to slip on the wall.

18. Mrs Kennedy fell on to her right side on her walking stick…"

45 In the course of giving her evidence, Ms Wilkinson demonstrated both the 'sit to stand' and mini-squat exercises. She also indicated that she had demonstrated to the Claimant how those exercises needed to be undertaken, and had asked the Claimant to undertake the squat slowly in order to achieve control.

46 I accept the substance of the account given by Ms Wilkinson. Of course, it is not because I believe that the Claimant was being untruthful. Far from it. I do not believe the Claimant to be capable of

being untruthful. In fact, I found her a very pleasant, polite and delightful lady. Even though she is 87 years of age, she was both articulate and, to borrow the words of Ms Julia Gibson, the occupational therapist instructed by her, for a person of her age, remarkably 'cognitively intact'. I find that she was simply mistaken about some of the matters she said in her witness statement and in her oral evidence.

47 There are many reasons for my preferring Ms Wilkinson's evidence over the evidence of the Claimant. It suffices for me to mention just a few.

48 It was plain to me – and cannot be surprising given the Claimant's age – that the Claimant's recollection of what happened some five years ago was not good. She said as much in her response to a number of the questions that she was asked both about the incident on 20 February 2008 and about the events which preceded it.

49 In contrast, at paragraph 6 of her witness statement, Ms Wilkinson states why she has a clear recollection of matters:

> "Because Mrs Kennedy unfortunately suffered a rupture to her patella tendon, I in fact remember this particular class and Mrs Kennedy well. I can remember that Mrs Kennedy was using one stick to mobilise. Given she was around five weeks after a total knee replacement, this is fairly normal and suggests that she was progressing well. I remember that Mrs Kennedy was talking about how she was getting on. She indicated that all was fine and that whilst she was experiencing some swelling in her knee, she said she was fine with the post-operative exercises"

50 Ms Wilkinson's written and oral evidence also reflects the substance of a 'critical incident' statement which she prepared more or less immediately after the incident on 20 February 2008. That statement is included at page 65 of Bundle 'TB'.

51 There were matters about which the recollection of the Claimant was plainly mistaken. For example, in para 4.2.4 of her report dated 8 August 2012, Ms Schofield said:

> "Mrs Kennedy stated to me that she was not shown the exercises specified in the booklet. She cannot recall the physiotherapist any time to show her or emphasise the important of regaining full knee extension."

52 In contrast, in her evidence, the Claimant said that she knew exactly what exercises she needed to do not just from the SWATT booklet but also from information she received at the hospital, particularly at a 'nurses and physiotherapist class' that took place on 21 November 2007.

53 In the information she gave Mrs Schofield, the Claimant referred to having done two mini-squats. In her evidence to me, she accepted, as Ms Wilkinson had asserted, that she had done four. Plainly, she was mistaken about the information she had given to Mrs Schofield.

54 I find the substance of the account given by Ms Wilkinson in her written and oral evidence to be correct. Specifically:

(a) I reject the evidence of the Claimant that 'one of the physiotherapists said that they did not know what to put me on. All the exercises that were left were a chair to get up and down from and a wall.' I accept the evidence of both Ms Wilkinson and Ms Fitter that this was not the case. Specifically, I accept the evidence of Ms Fitter at paragraphs 17 and 18 of her witness statement that: (i) as the Claimant was a new patient, she asked Ms Wilkinson to assist the Claimant by demonstrating each exercise for her and then supervising her as she did them. Ms Wilkinson had assisted Ms Fitter before, and Ms Fitter was confident in Ms Wilkinson's ability to assist the Claimant; and (ii) she asked the Claimant to pick an exercise to begin with, and the Claimant chose the 'sit to stand' exercise, and thereafter

moved to the mini-squat, and – as she states at paragraph 20 of her witness statement – she observed Ms Wilkinson standing in front of the Claimant, and the Claimant complete a mini-squat with the correct technique.

(b) I am unable to accept the Claimant's evidence that she only did one or two 'sit to stand' exercises, which she found tough. I accept the evidence of Ms Wilkinson that she did those exercises for some two minutes and completed them successfully and without any difficulty – a fact reflected by the record that was made on the form included at page 432 of Bundle 'MR'. I also accept Ms Wilkinson's evidence that the Claimant could stand without using her hands to push herself up.

(c) I am unable to accept the Claimant's evidence that she was simply told to do the mini-squat exercise. I accept Ms Wilkinson's evidence that she saw the Claimant successfully complete the sit to stand exercises. She then asked the Claimant whether she was ready and able to undertake the mini-squat, and whether she would like to move on to it. The Claimant said she was ready and able to undertake it and decided to move on to it.

(d) I am unable to accept the suggestion made by the Claimant that Ms Wilkinson did not explain to her precisely how the exercise needed to be carried out. I accept Ms Wilkinson's evidence that she did. I also accept Ms Wilkinson's evidence that she talked to the Claimant throughout the exercise and, specifically, that she told the Claimant that she did not need to squat too low whist she was doing the exercise.

55 I am unable to accept that there can be any criticism of Ms Wilkinson. She fully complied with the instructions and directions

that she was given by Ms Fitter to assist in the running of the physiotherapy class on 20 February 2008, and discharged the responsibilities that she was given properly and efficiently. She was not involved in making any assessment of the overall physiotherapy requirements of the Claimant. She expressly stated in the course of giving her evidence, in response to Dr Fox's questions, that her role in relation to the physiotherapy exercise on 20 February 2008, was simply to ascertain whether, and how well, the patients (specifically, the Claimant, with whom she was working on a one to one basis) were able to undertake the exercises which had been designated as being appropriate for that class. She was not challenged when she said that the only autonomy she had from Ms Fitter was to decide whether a patient had completed an exercise before he moved on to the next exercise (and whether he was willing to proceed to the next exercise), and that she had received sufficient training for that purpose – a point that is expressly acknowledged in paragraph 17 of Ms Fitter's witness statement. Ms Wilkinson rightly observed both in paragraph 9 of her witness statement, and in her oral evidence, that the formal assessment of the Claimant's level of function had already taken place in which she, of course, had no part.

THE ADEQUACY OF THE ASSESSMENT OF THE CLAIMANT BY THE DEFENDANT

56 The Claimant asserts that the Defendant should have undertaken a proper assessment of the suitability of the exercises (which included the mini-squat) that the Claimant was invited to perform at the class before she started the class. She states that if a proper assessment of her condition and needs had been carried out, it would or should have resulted in the mini-squat (and, therefore, the injury) being avoided. She maintains that mini-squat exercise was a 'completely inappropriate' exercise for someone in the Claimant's

position to be invited to undertake, and that this would or should have been apparent to the physiotherapy staff at the time.

57 As I have indicated above, the Claimant relies upon the expert evidence of Professor Fairclough, Consultant Orthopaedic Surgeon, and Ms Zena Schofield, Chartered Physiotherapist, to support her case. The Defendant relies upon the expert evidence of Mr Philip Radford, Consultant Orthopaedic Surgeon, and Mr Paul Errington, Chartered Physiotherapist, in support of its defence to the claim. Both sets of experts have provided reports, and all the experts gave oral evidence.

58 As regards the orthopaedic evidence on the issue of the adequacy of the assessment of the Claimant, the orthopaedic experts were in broad agreement on the main points on which they could give evidence. They largely deferred to the physiotherapist experts on that issue.

59 I have already referred to the fact that Mrs Schofield no longer criticises the monitoring of the Claimant while she was an in-patient between 18 and 22 January 2008. I can see no basis upon which there can be any criticisms of the monitoring of the Claimant by the members of the SWAT Team between 22 and 26 January 2008. Ms Carol Gray, the Physiotherapy Team Leader at Warwick Hospital, was painstakingly taken through the documents at pages 80 to 95 of Bundle 'MR' which provided a summary of the monitoring of the Claimant during the period from 18 January to 26 January 2008. She gave a full explanation of each of the entries that had been made in those pages.

60 The physiotherapy entries in the hospital records are entered on the red sections of each page. It would appear that when these were provided to the Claimant's solicitors, they were copied in black and white only, resulting in all of the red physiotherapy sections

appearing blank, such that the Claimant's legal team understood that the Claimant had hardly been seen by physiotherapy staff while she was an in-patient between 17 and 22 January 2008. After seeing the full records, the Claimant accepted that there could not be any substantial criticism of the treatment and management of the Claimant's physiotherapy requirements while she was an in-patient. However, up until the time that Mrs Schofield was re-examined by Dr Fox, it is right to say that she still maintained some criticism of this part of the management of the Claimant by the Defendant. Her position changed when she was re-examined by Dr Fox. She indicated in her re-examination that she no longer criticised the management of the Claimant during the time when the Claimant was an in-patient. Her criticism of the Defendant was limited to management by the SWAT Team on discharge of the Claimant, and of the class itself on 20 February 2008.

61 I am clear that the change in the position advanced by Mrs Schofield in re-examination only came about because it was clear from Mr Kennedy's cross-examination of her, and from the answers she gave to some of my own questions, that she was going wholly overboard in her criticism of the Defendant. I am unable to accept Dr Fox's suggestion that it was because she sought to clarify the evidence she gave before her re-examination. In fact, her response to the first series of general questions asked by Mr Kennedy was to say that the Defendant was guilty of a gross breach of duty which 'applied throughout' and that 'every person who saw the Claimant was in gross breach of duty' and, in some cases, 'had failed to discharge [the duty] in any relevant way at all.'

62 That was the general tenor of Mrs Schofield's evidence on this and other issues. She was not prepared to accept that there was any part of the assessment of the physiotherapy needs of the Claimant by the Defendant which was correct. It was plain to me that she was troubled by the fact that she had conceded that the Defendant's

physiotherapy treatment of the Claimant while she was an in-patient could not be criticised.

63 The plain fact is that no criticism by Mrs Schofield of any part of the assessment of the Claimant carried out by the Defendant prior to the physiotherapy class on 20 February 2008 (whether as an in-patient or after her discharge from hospital) can be justified. I provide a few examples of why I found Mrs Schofield's evidence on this aspect unsatisfactory.

64 One of Mrs Schofield's criticisms about the pre-20 February 2008 physiotherapy treatment of the Claimant after proper copies of the hospital notes were seen by her is summarised at page 3 of the joint statement prepared by her in conjunction with Mr Errington in response to Question 1 of the Claimant's Agenda:

> "It would be expected that trying to achieve active knee extension should have been emphasised to Mrs Kennedy. It is not shown in the notes or from what Mrs Kennedy herself recalls, whether this was emphasised to her…"

65 That criticism is repeated by Mrs Schofield at page 8 of the joint statement in response to Question 5 of the Claimant's Agenda:

> "[Mrs Schofield] considered that the physiotherapy staff failed to [advise the Claimant of the importance of regaining full knee extension and encourage knee extension exercises]."
>
> "There is no written evidence either in the in-patient stage or of the notes of the SWATT team that such a specific and routine aspect of Mrs Kennedy's rehabilitation was verbally emphasised. There is no evidence that specific exercises were checked and progressed by the SWATT team. A booklet with exercises encouraging knee flexion and extension was provided. However, Mrs Kennedy has stated that these suggested exercises were not gone through with her by the physiotherapist; and that at no time had the importance of trying to actively lock out the knee into full extension been stressed to her."
>
> "Also, at no time was she made aware of the fact that she was not achieving a fully actively extended knee as illustrated in the exercise in the booklet."

66 I find the criticism to be entirely unsubstantiated. In the first place, the Physiotherapy Department booklet, which the Claimant acknowledged receiving and acting upon, specifically stated that it was important that the Claimant got her 'knee bending as soon as possible; otherwise, you will develop stiffness which may be permanent. You must also make sure that your knee goes out straight. **Do not** be tempted to rest with a pillow under your knees, as this will stop them from going straight.' The position could not have been stated more clearly to the Claimant. But, quite apart from that, in response to a specific question from Mr Kennedy, the Claimant accepted that one purpose of the exercises she was shown to do after her operation was to achieve active knee extension and that that was an important part of her recovery.

67 The suggestion that the exercises were not gone through with the Claimant by the physiotherapist is simply incorrect. In the course of giving evidence, the Claimant said that she had been shown what exercises she needed to do by the physiotherapist and had, in fact, undertaken them successfully – a fact clearly borne out by the hospital records, of which page 89 of Bundle 'MR', recording 'Exercises as per plan', is a clear example. The suggestion that at no time had the importance of trying to actively lock out the knee into full extension been stressed to her is also plainly incorrect as the hospital notes demonstrate, though not in those terms; so is the suggestion that 'at no time was she made aware of the fact that she was not achieving a fully actively extended knee as illustrated in the exercise in the booklet'. Given that she herself knew what her range of movements were, and there is a careful recording in the hospital notes of the range of her movements over time, that suggestion – which involves an assertion that the physiotherapists did not explain to her what she already knew and what they had recorded in her notes – simply lacks substance.

68 By the time Mrs Schofield gave evidence, the account that the Claimant had given to the court was known to her. In spite of that, she continued to maintain those criticisms of the Defendant, and only changed her position during the course of her re-examination by Dr Fox.

69 The members of the SWAT Team who assessed the physiotherapy needs of the Claimant after her discharge were Mrs Katie Goldby on 22 January and Mr Ellerington on 23 January. The member of the SWAT Team who completed the orthopaedic transfer form on 24 January 2008 (page 2 of Bundle 'MR') referring the Claimant to outpatient physiotherapy treatment was Ms Chloe Franklin. The criticism made by the Claimant is that neither Miss Goldby's assessment of the Claimant on 22 January nor that of Mr Ellerington (who was not a qualified physiotherapist) on 23 January was adequate. In addition, Ms Chloe Franklin who had signed the transfer sheet on 24 January 2008 confirming that the Claimant was ready to attend the physiotherapy class had neither seen nor assessed the Claimant and could not, therefore, have been able to confirm that the Claimant was ready and able to attend the physiotherapy class.

70 I am unable to accept any of the criticisms made by the Claimant. I am unable to see what examination or enquiries of the Claimant either Ms Goldby and Mr Ellerington could have undertaken over and above what is recorded in the notes they made, particularly given that a proper assessment of the Claimant as an in-patient (which is now no longer subject to criticism) had taken place over the course of the few days before 22 January. In her unchallenged evidence, Ms Goldby stated that her assessment of the Claimant involved, inter alia, reviewing the Claimant's medical records (particularly those at pp 53 to 92 of Bundle 'MR', which included the document at page 58 that provided a summary of the Claimant's previous history), checking that the Claimant was carrying out her

exercises, and discussing any issues which the Claimant had. She made a full and proper account of any issues the Claimant had (including recording the fact that the Claimant's knee was swollen and asking her to apply ice to it), and dealt with those issues properly and appropriately. Her notes at page 93 of Bundle 'MR' may not have been made with the exactitude that Mrs Schofield thinks is necessary. However, they were perfectly adequate. Although Mr Ellerington did not give evidence in these proceedings, I find it difficult to understand either how his assessment of the Claimant based on the notes he made, or the adequacy of the notes themselves, can be criticised. Nor, I find, does any point of substance arise on account of the orthopaedic transfer sheet being signed by Ms Franklin, and not by a physiotherapist who had (presumably recently) seen and assessed the Claimant. It is unlikely that the transfer sheet would have been signed without Ms Franklin having considered all the relevant records and information which were necessary for her to come to a proper view that the referral of the Claimant for outpatient physiotherapy was appropriate. I do not consider that it was necessary for her to see the Claimant. I entirely reject the suggestion that she should have done and that because she had not, the Claimant could not be said to be ready for outpatient physiotherapy. If I accepted this quite remarkable proposition, it would be tantamount to my accepting that unless a written referral to outpatient physiotherapy was made by a physiotherapist (or other professional) who had recently seen a patient or unless the referral sheet recorded the fact that the person signing it had seen the underlying documents justifying the referral, it should not be accepted. That proposition is simply misconceived.

71 I found both the written and oral evidence of Mrs Schofield on the monitoring of the Claimant while the Claimant was an in-patient, and by the members of the SWAT Team, to be unjustifiably and unreasonably over-critical of the Defendant. I prefer the evidence of

Mr Errington. Like him, I cannot see any basis upon which the Defendant can be criticised for the care of the Claimant prior to the incident on 20 February 2008.

72 If there is any breach of duty on account of the failure on the part of the Defendant to assess the Claimant properly, it can only be on the basis of the care and management of the Claimant on 20 February 2008.

73 I have already dealt with the evidence of the Claimant and Ms Wilkinson in relation to the incident that occurred on the day. It is now necessary for me to deal with the factual evidence of Ms Fitter, and the expert physiotherapy evidence in more detail.

74 The physiotherapy class at which the Claimant suffered the rupture of her patella tendon on 20 February 2008 was run by Ms Fitter. She was assisted by Ms Wilkinson, a second-year physiotherapy student, and Ms Sharp, a physiotherapy assistant.

75 The substance of what Ms Fitter's had to say about her role in the running of the class and in the care and management of the Claimant at the class are set out in the following excerpts of her witness statement:

> "7. I had not met Mrs Kennedy prior to 20 February 2008, and this was my first and only involvement in her care. Prior to the class, I met Mrs Kennedy at reception and walked to the gym with her."
>
> "8 Mrs Kennedy apologised for not attending the class before, and I established that this was because she had been unwell, rather than due to problems with her knee. She said that she was feeling much better now. I was not too concerned about this, given that a TKR is major surgery. The leaflet given to patients undergoing a TKR details exercises which can be undertaken whilst lying down, as some patients may be generally unwell following surgery, but will still need to exercise the joint to regain full function."

"9. Whilst walking to the gym, I carried out a subjective assessment on Mrs Kennedy. I asked her if she had any problems or concerns about her knee. She said she was still experiencing swelling, but I explained this was normal but we would measure her swelling and monitor it. I advised her to continue using ice to reduce the swelling."

"10. I asked Mrs Kennedy if she was experiencing any difficulties with the home exercise program, to which she replied she was not having any difficulties."

"11. I watched Mrs Kennedy mobilise into the gym. She was walking with the aid of a walking stick, which was her own. She appeared to be relatively comfortable. I also analysed her gait, and did not notice any apparent difficulties in relation to her stage of rehabilitation."

"12. We carry out subjective assessments on patients before they begin the group class and make sure that they have been able to perform the exercise at home without difficulties, as we did with Mrs Kennedy. Patients are referred by SWATT as being ready to attend class. Indeed, I can see from the medical records that Mrs Kennedy's range of movement had improved post-operatively and in particular was 0-85 degrees by 23 January *[sic]* 2003. This indicated that she was progressing well."

"13 Classes have a maximum of 10 attendees. They are of varying ages, and all at different stages in their recovery, therefore the emphasis is on individual patients' abilities. We would emphasise to each patient, including Mrs Kennedy, that they remain within their physical limits."

"14. I would focus on new patients, such as Mrs Kennedy, on the way to the gym. Should a subjective assessment flag up an issue, then I would carry out an objective assessment before the class, looking at their range of movement, posture and examining the joint. For instance, if during the subjective assessment a patient complained of pain in their calf, I would assess them for deep vein thrombosis. It may be that following an objective assessment, I would advise a patient not to join the class that day, or not to do a particular exercise."

"15. In Mrs Kennedy's case after carrying out a subjective assessment, I was satisfied that she was ready to join the class, and there were no issues or concerns which would stop her from carrying out any of the exercises. I did not consider that an objective assessment was required prior to Mrs Kennedy starting her exercises. She was mobilising well given the TKR

was five weeks previously, and she reported that she had managed her exercises well at home."

"17. The class involved a circuit of different exercises. As Mrs Kennedy was a new patient, I asked Georgina to assist her by demonstrating each exercise to her and then supervising her as she did them. Georgina had assisted me before in the TKR class, and as such, I was confident in her ability to assist Mrs Kennedy."

"18 I asked Mrs Kennedy to pick an exercise to begin with and she chose the 'sit to stand' exercise…

"19. Mrs Kennedy completed the sit to stand exercises without any difficulties. She then moved on to the next exercise, 'mini-squats'…"

"20. I observed Georgina standing in front of Mrs Kennedy, and Mrs Kennedy completing a mini-squat with the correct technique. I then moved to completing the class register. While doing this, I heard a scream…Mrs Kennedy… appeared to be stuck in a squat position. She then toppled to her right…and…fell."

"29 Mrs Kennedy was not asked to perform a mini-squat without assessment… I carried out a subjective assessment of Mrs Kennedy on the way to the gym. Having done so, I had no concerns whatsoever about Mrs Kennedy and I considered it was appropriate for her to join the class. We do not undertake objective assessments of each patient at the beginning of a physiotherapy class such as that attended by Mrs Kennedy, otherwise we would have no time for the class itself. As explained, I carried out a subjective assessment, and would only then progress to an objective assessment should any issues arise from the subjective assessment. As stated no issues or concerns arose from my subjective assessment of Mrs Kennedy. There was no need for an objective assessment in her case."

"30. Further, Mrs Kennedy had received several assessments whilst an inpatient… and was visited at home by SWATT. She was assessed by SWATT as ready to attend physiotherapy class. Given the progress she had made following her TKR operation and the good range of movement she had, I agree with the assessment by SWATT that it was appropriate for her to attend the outpatient physiotherapy class. From my subjective assessment of Mrs Kennedy and the history she gave on 20 February, there was no reason why she should not join the TKR class and perform the exercises. Also, it is emphasised to each

> patient to do only what they are comfortable with when performing the exercises."

76 In the course of giving her oral evidence, Ms Fitter clarified the terms of her witness statement as follows:

(a) Although she had been running the physiotherapy classes for only six weeks or thereabouts at the Defendant-Trust, she had, in fact, been running them for more than six months elsewhere in her previous employment. The classes themselves had been running for a significant, if not substantial period, as she had taken over their running from another person;

(b) She stated that the assessment of whether a patient should be referred for 'one to one' physiotherapy was undertaken either when the patient was in hospital or when the patient was being seen by the SWAT Team. The Claimant had not been referred for one to one physiotherapy;

(c) The information that Ms Fitter had about the Claimant prior to the start of the physiotherapy class on 20 February 2008 included the orthopaedic transfer sheet contained at page 2 of Bundle 'MR 2';

(d) In order to ascertain whether, and the extent to which, a new patient was able to participate in a physiotherapy class, Ms Fitter's standard practice was: (i) to consider the terms of the transfer sheet in order to obtain basic information about the patient's medical condition, his physiotherapy needs and requirements, and his ability to participate in the class; (ii) to observe the presentation of the patient which would give her obvious information about the patient, such as his height and weight; (iii) to seek information from the patient, by a 'question and answer process', about his current medical condition that was or could be relevant to his ability to participate in the class.

This involved Ms Fitter obtaining information from the patient about, among other things, any problems he was still experiencing from the consequence of the operation and any concerns he had about his medical condition; and (iv) conducting a detailed observation of the patient – such as in relation to his ability to stand, sit and walk, and mobilise – from the time when he and the other patients were collected for the class to the point in time when the class was ready to begin. The assessment did not finish once the class commenced. Ms Fitter observed the patients whilst they were doing the exercises so that she could monitor them and address any problems or concerns that arose in the course of the exercises being undertaken. Ms Fitter said that her standard practice was applied on that day in relation to the Claimant, and that no issues whatsoever had been identified in relation to her assessment of the Claimant, based on that practice, to suggest that it was not appropriate for the Claimant to participate in the class or do any of the exercises;

(e) Ms Fitter indicated that if there were any specific issues that might relate to or impact on the physiotherapy treatment that was to be provided to the Claimant, she would have expected to be made aware of it by the orthopaedic surgeons involved in the Claimant's treatment and management or by the physiotherapists who had assessed the Claimant prior to her attending the physiotherapy class on 20 February 2008. She had not been made aware of any such issue. On the contrary, the orthopaedic transfer sheet completed by the SWAT Team had described that the Claimant's 'relevant post-op precautions/protocol, & problems' to be 'routine'.

(f) Ms Fitter confirmed that even if she had assessed the Claimant in the manner in which it was suggested by Mrs Schofield that the Claimant should have been assessed, she would have

reached the same conclusion as she had on her actual assessment of the Claimant that day – namely that there was no reason why the Claimant could not participate in the physiotherapy class or do any of the exercises at the class.

77 I accept the substance of the factual account given by Ms Fitter. So far as the account related to the events that occurred on 20 February 2008, it largely confirmed the account that Ms Wilkinson gave, and I have already indicated why I found Ms Wilkinson account more reliable than that of the Claimant. I, therefore, accept Ms Fitter's account of those events. So far as Ms Fitter's account related to her standard practice for new patients, the application of that practice to the Claimant, and the conclusion that she drew from her assessment of the Claimant, I also accept what she says. I could find nothing in the questioning of Ms Fitter by Dr Fox that suggested that the account she gave of those matters was incorrect. Dr Fox's criticisms, and those of the Claimant's experts, of Ms Fitter related primarily to whether it was appropriate for the Claimant to do the mini-squat exercise, whether the manner of her assessment of the Claimant was appropriate, and whether the outcome of that assessment was correct. So far as there was any suggestion on the part of the Claimant that the factual account Ms Fitter gave concerning those matters was incorrect, I entirely reject that suggestion.

78 Mr Errington asserts that there is no part of the assessment made by Ms Fitter that can be criticised. In his first report dated 28 September 2012, he states:

> "5. From the Action Plan included within the notes it states 'all new patients who have been referred into the knee class to receive a short assessment. Active range of movement (AROM), muscle strength, patient concerns and difficulties, footwear and ferrules. This would be most appropriate for patients who have been referred into the class from SWAT and have not been previously seen within the department.'"

After referring to the relevant medical and other notes relating to the Claimant and setting out relevant excerpts from the statements of Ms Fitter, Ms Golby, and Mr David Shaler, the Claimant's son-in-law, Mr Errington states:

> "…considering the level of progressive independent mobility, it is my opinion this would make Mrs Kennedy a very good candidate for outpatient physiotherapy and attendance at a general knee rehabilitation class."

79 Mr Errington then refers to the actions of both Ms Fitter and Ms Wilkinson at the class, and concludes as follows:

> "7.2 It is alleged that Mrs Kennedy was not properly assessed prior to … undertak[ing] the Knee class and this led to a breach of duty… The witness statement of Mrs Carol Gray does not support this allegation neither does the medical notes as Mrs Kennedy was 'assessed daily by the physiotherapy team following her operation on 17.1.2008', with the exception of the 20.01.2008 up until 23.01.2008 when it was considered that Mrs Kennedy's issue was no longer one of mobilization. Mrs Kennedy had been referred to the outpatient's knee class by the SWAT [Team] by way of the Orthopaedic Transfer Form and by doing so indicated that Ms Kennedy was appropriate for physiotherapy classes as opposed to requiring physiotherapy on a one to one basis. It is my opinion that referral to the knee class by this method appears to have been standard procedure and as such Lisa Fitter had no reason to suspect that Mrs Kennedy was unsuitable for attendance at the knee class."
>
> "7.3 … It is my opinion that in such circumstances rehabilitation class assessments will often entail a subjective assessment regarding the present status of the patient which Lisa Fitter carried out in her discussion with Mrs Kennedy. Mrs Kennedy reported as having no problems or concern with the exception of some swelling around the knee which would be normal at that stage following such a procedure. Mrs Kennedy also stated that she had no problems with her exercise programme that had been provided by the SWAT."
>
> "7.4 It is also my opinion that it is normal for a physiotherapist to visually assess a patient's quality of movement prior to commencement of any exercises. This is a core skill of all musculoskeletal physiotherapists who use this technique as a

relatively covert exercise in collecting information regarding a patient's gait pattern, although to the patient this will not be seen as a formal assessment, it will often form part of an *observational movement analysis* assessment…" (Emphasis in italics supplied by me).

"7.8 It is my opinion that it would be unreasonable to expect Lisa Fitter or Georgina Wilkinson to carry out a full physiotherapy on every patient that has been referred to the knee class by other competent professionals. Observational gait assessment is frequently carried out by physiotherapists to assess patients' gait and forms a major aspect of physiotherapy training and practice… Group exercise sessions are used widely, throughout the NHS and the private sector especially with the more recent moves towards physiotherapists working in primary care as part of their educational and advisory role…A full assessment would not have highlighted anything remarkable given Mrs Kennedy's level of independence, and would not have stopped Mrs Kennedy participating in the class exercises."

80 Mrs Schofield takes the complete opposite view. In her response to Question 7 of the Claimant's Agenda in the joint statement prepared by her with Mr Errington, she states that there was a failure to assess the Claimant in accordance with a practice which would be accepted as proper by a reasonable and responsible body of physiotherapists and one which withstood a logical analysis of risks and benefits, commenting that:

"… as no comprehensive physical assessment had been applied [to the Claimant] within a week of her class attendance and supplied to the class physiotherapist, such an assessment would have been expected of the class physiotherapist… Such an assessment would therefore identify and highlight Mrs Kennedy's present needs and indicated any possible risks that some of the knee class exercises might provide… One should not rely on a patient giving a totally accurate account of their abilities. This [is] because a patient who has been disabled for a long time might not be able to fully recognise what was considered therapeutically to be normal as compared to abnormal or compromised to some degree. It is therefore unsafe to rely on the patient's own assessment of their abilities."

81 Mrs Schofield stated that the 'observational movement analysis' of the Claimant carried out by Ms Fitter might form part of an overall assessment of the Claimant. However, 'in no way' could Mrs

Schofield consider that that would be a comprehensive and relevant assessment of the Claimant's needs. In her view, the assessment carried out by Ms Fitter did not comply with the 'Core Standards of Physiotherapy Practice' (2005 Edition) ('the Core Standards') in force at the time, and would not be accepted as proper by a reasonable and responsible body of physiotherapists.

82 I prefer the substance of the evidence of Mr Errington over Mrs Schofield. There are many reasons for that. I have mentioned one already. I found Mrs Schofield's evidence on the whole to be unjustifiably and unreasonably over-critical of the Defendant. It is only necessary for me to mention a few others.

83 Mrs Schofield's opinion on what constituted the carrying out of a proper assessment was based primarily on her experience of providing physiotherapy treatment for patients who were referred to her for one to one treatment. She does not work in the NHS and has not done so since 1986. It is difficult, in the circumstances, to see how she could provide a proper opinion on the appropriateness of an assessment carried out by a physiotherapist who was running a physiotherapy class for NHS patients. She accepted as much in the course of giving evidence. In contrast, Mr Errington's opinion was based on what was a considerably more extensive involvement with the practice and procedures of the NHS. There is no substance in the point that as Mr Errington's experience in the last few years has been as a lecturer rather than as a clinical physiotherapist, it is less reliable. The fact is that Mr Errington's work as an academic does not just involve lecturing students in physiotherapy, but teaching them 'best practice', finding them work-placements in the NHS, and assessing their performance to practise as physiotherapists or potential physiotherapists.

84 Mrs Schofield appeared throughout the course of her evidence to be laying down her own standard of what amounted to the carrying

out of a proper assessment. She was prepared to make wide and sweeping statements about what she regarded as best practice without having any real basis for making those statements. An example was her forthright and immoveable view – expressed in answer to Question 7 under the Claimant's Agenda – that there had been a failure to assess the Claimant properly on 20 February 2008 because:

> "no comprehensive physical assessment had been applied within a week [or, as she said in her oral evidence, 7-10 days] of [the Claimant's] class attendance and supplied to the class physiotherapist; such an assessment would *have been expected* of the class physiotherapist…" (Emphasis in italics supplied by me).

When the substance of that proposition was put to Mr Errington, he pointedly observed 'why 7-10 days; why not two to three days'. I can see no basis for Mrs Schofield's wide and sweeping statement. The reason Mrs Schofield gave for her opinion was:

> "… no detailed physical testing of Mrs Kennedy after her discharge from hospital appears to have been applied by the SWATT Team or any other body prior to her attendance one month later at the Knee Class and … no progression of her exercises is noted by the SWATT Team as being provided or monitored… Even if it can be shown that the SWATT team did apply such an assessment, the findings at the time would not be likely to identify her presenting needs and risks nearly a month later on 20 February 2008."

The fact is that every indication at the time of the Claimant's assessment by Ms Fitter was that she was mobilising well, there were no issues with regard to her carrying out the exercises in the physiotherapy class, and that she was ready and able to do the mini-squat. The suggestion that a detailed assessment might have highlighted issues that were not apparent to Ms Fitter on her assessment simply because there was no physical assessment of the Claimant within 7 to 10 days of the class is based on pure speculation. It is hard to see what further information Ms Fitter would have been able to obtain on a more detailed assessment of

the Claimant which she was unable to obtain on her actual assessment of the Claimant.

85 In contrast, Mr Errington's evidence was more measured and proportionate. He was prepared to concede that some of the statements that he had made in his report and in the joint statement might no longer be justified having regard to the evidence he had heard from the orthopaedic experts. For example, he had stated at paragraph 7.4 of his Report that the 'sit to stand' exercise placed more stress on the patella tendon than the mini-squat, and was a good test of whether the quadriceps were strong enough for the mini-squat. He conceded, in the course of giving oral evidence, that this statement could no longer be correct given what the orthopaedic experts had said.

86 I am unable to accept Dr Fox's submission that the concessions Mr Errington made rendered the substance of the evidence he gave less reliable. His concessions demonstrated to me that his evidence was designed to assist me rather than simply advance the case of the Defendant. Mrs Schofield, on the other hand, appeared, at times, to be giving evidence simply to bolster up the case of the Claimant.

87 Mrs Schofield suggested that there had been a number of breaches of the Core Standards. I could not detect any.

88 I start by acknowledging two points that Dr Fox and Mrs Schofield made about the scope of the Core Standards. I agree with them that the Core Standards apply to all physiotherapy, not just to physiotherapy provided privately to a patient. It follows that a person receiving physiotherapy in the NHS is as much entitled to expect that the Core Standards will be applied to him as a patient who is receiving physiotherapy privately. I also agree with them that a 'one size fits all' approach is wholly inappropriate under the Core

Standards. An individualised – rather than holistic – approach to physiotherapy treatment is necessary. Each patient must be treated by reference to his own individual facts and circumstances.

89 Dr Fox took Ms Fitter through those parts of the Core Standards which he alleged had not been complied with by Ms Fitter. They included the following – the numbers, unless otherwise stated, refer to the numbers of the Core Standards and dealt with by me in the order in which Ms Fitter was questioned about them:

Standard 14.2

This Standard states that 'patient records [must be] written immediately after the contact with the physiotherapist or before the end of the day of the contact.'

Ms Fitter appeared to suggest that this requirement did not apply to the physiotherapy class that she was running. I do not agree with her. The preamble to Standard 14 makes it clear that it applies to all types of physiotherapy treatment, including any treatment received at a physiotherapy class of the kind being run by Ms Fitter on 20 February 2008. However, it is plain to me that there was no breach of this requirement on the part of Ms Fitter because a record was completed by Ms Fitter in full compliance with this requirement – see pages 432-3 of Bundle 'MR', and the critical incident statements that she and Ms Wilkinson completed at pages 62 and 65 respectively of Bundle 'TB'. Of course, because the Claimant was unable to complete all the exercises at the class, the record of her performance of the exercises at pages 432-3 could not be completed. However, that does not mean that Ms Fitter failed to comply with this Standard.

Standard 5

I found the terms of this Standard difficult to understand. The general guidance given in this Standard states that '[w]here appropriate, information collected should reflect the values and needs of the service user and their main carers. Background information collected regarding the patient's presenting problems may come from published research findings or published evidence collections.' Standard 5 is broken down into a number of paragraphs under the heading 'Criteria', and against each heading, guidance of a specific nature is provided about what amounts or may amount to good or best practice.

The summary of Dr Fox's criticism in relation to the alleged failure on the part of the Defendant, and specifically Ms Fitter, is summed at paragraph 16 of his written submissions:

> "This requires that there is written evidence which includes the patient's perceptions of their needs, their expectations amongst other criteria. There is no evidence of these being assessed or recorded. It also requires that there is written evidence of a physical examination carried out to obtain measurable data to include observation, the use of specific assessment tools or techniques and palpational handling. Again, there is no evidence that this was performed to the full extent set out by the Core Standards in respect of the 20th of February physio session."

There is no substance at all in this criticism. I do not see this Standard as imposing any requirement or providing any guidance on how an assessment should be carried out. I accept the substance of Mr Errington's interpretation of the Standard that the matters referred to in it will only need to be recorded to the extent that it is necessary for a proper assessment to deal with those matters, and that the words 'Where appropriate' make that clear. Indeed, the specific guidance under Standard 5.2 makes it clear that the 'extent of the physical examination may be determined by the clinical specialty or by the patient's presenting condition at the time of the examination.' In addition, Standard 4 recognises that information relating to treatment options will, in part at any rate, be

based on local standards and protocols. It is clear that the manner of Ms Fitter's assessment of the Claimant was in line with the practice that obtained at the Defendant-Trust and, according to Mr Errington's evidence, in other Trusts where such classes were run. In any event, given that there is no longer any criticism made against the Defendant in relation to the assessment of the Claimant conducted while she was an in-patient, and I have found none that can be justified in relation either to her assessment by the SWAT Team or the recording of the information relating to her by the members of that Team, it is difficult to see how Standard 5 could have been breached if the Claimant was unable to complete the exercises as a result of the injury. As Mr Errington observed, the assessment of the Claimant was an ongoing process, and included her ability to carry out the exercises on 20 February. Ms Fitter had started completing the form that was intended to record her assessment of the Claimant prior to, during the course of, and following the completion of the exercises. The reason she was unable to do so was because of the Claimant's unfortunate injury.

It follows that I cannot see any basis upon which it can be said that the Defendant, or specifically Ms Fitter, was in breach of this Standard.

Standard 6.1

This Standard states that 'the physiotherapist should consider the aim of treatment i.e. management of deterioration or promotion of recovery. The outcome measure selected should capture information related to the aims of treatment.'

Dr Fox's criticism of Ms Fitter based on her alleged failure to comply with this provision is incorrect. It was plain that the outcome that was sought for the Claimant by the orthopaedic surgeons involved in the Claimant's treatment and management was – as Ms Fitter

states at paragraph 6 of her witness statement and was clear to her from the orthopaedic transfer sheet and from her assessment of the Claimant – to assist with the Claimant's recovery, specifically in order to help 'her regain as much function as possible in the joint' in order to help her 'mobilise and … gain as much independence as possible.' It is difficult to see how Ms Fitter could be said to be in breach of this requirement.

Standards 7, 8 and 10

Standard 7 states that analysis must be undertaken in order to 'formulate a treatment plan, following information gathering assessment.'; Standard 8 states the treatment plan must be formulated in partnership with the patient; and Standard 10 states that the 'the treatment plan [must be] constantly evaluated to ensure that it is effective and relevant to the patient's changing circumstances and health status.'

I cannot see a breach of any of these requirements on the part of the Defendant for all the reasons that I have set out in my observations under Standard 5, above. Specifically, there is no requirement either that a treatment plan is included in one document or prepared by one physiotherapist. The treatment plan will develop over the period of the treatment of a patient. As I have observed under Standard 5 above, the plan for the Claimant was clearly formulated, and correctly and properly reviewed at every stage, including at the class on 20 February when it could not be completed because the Claimant suffered an injury. It is also right to point out that the orthopaedic transfer sheet contained much of the information required by the Core Standards. As Mr Kennedy correctly observes, it contained, in particular, a plan (stating that an increase in the range of movement was desired), and objective (normal movement), thus identifying an outcome measure as required by Standard 6. Although these may not have been stated

with the exactitude that Mrs Schofield thinks was necessary, it contained the essentials of all the information necessary to comply with the relevant Standards, given the operation that the Claimant had undergone (which was designed to relieve pain and improve range of movement and functional ability) and the general objectives of a knee rehabilitation class.

Standard 16

This Standard states that patients must be treated 'in an environment that is safe for [them], physiotherapists and carers.' The Standard deals with health and safety matters, and has no application to the facts of the present case.

90 There is no substance in the point made by Dr Fox that the failure to comply with the Core Standards is apparent when one contrasts the physiotherapy treatment which the Claimant received from the Defendant Trust's physiotherapy staff on 21 April 2008 – see p 467 of Bundle 'MR'. It is correct, as I have already acknowledged above, that the Core Standards apply whether physiotherapy treatment is provided under the NHS or privately. However, as Mr Kennedy observes at paragraph 17 of his written submissions, the Core Standards must be read in the light of the physiotherapy intervention that is being considered, and the resources available. The assessment process may differ depending upon whether the patient is being assessed for a knee-rehabilitation class or for one to one physiotherapy. The assessment conducted on 21 April 2008 was for one to one physiotherapy following the rupture of the Claimant's patella tendon. It was, and had to be, more detailed than that for a knee class. If a full assessment of each patient's needs before a knee-rehabilitation class had to take place – which according to Mrs Schofield would take between 25 minutes (in answer to my questions) and 45 minutes (in cross-examination) – it would mean, as Ms Fitter stated in her witness statement, that there

would be no time for the class itself. It would be wholly unrealistic to expect such an assessment to be conducted at a physiotherapy class.

91 It follows that I cannot find a breach of any of the provisions of the Core Standards.

92 I have already indicated that I prefer the physiotherapy evidence of Mr Errington over that of Mrs Schofield. It is right that I also draw attention to the following matters:

(a) There is no criticism of the orthopaedic surgeons involved in the Claimant's care at any stage of the Claimant's treatment. Two points are appropriate for mention in this context, although they may strictly be more appropriate to be dealt with on the issue of causation. First, there was no indication, let alone any suggestion, on the part of the orthopaedic surgeons that the Claimant should not receive physiotherapy or that she should be considered by the team of physiotherapists that would be looking after her for any specific type of physiotherapy. That much is, of course, accepted by the Claimant. Nor is there any suggestion on the part of the Claimant herself that she should not have received any physiotherapy. The only criticism by the Claimant against the Defendant is that she was not properly assessed by the Defendant. If she had been, it would or should have been obvious that she should not have been invited to do the mini-squat exercise on 20 February 2008. Professor Fairclough appeared to suggest both in his written evidence (see paragraph 2.6 of his report dated 14 September 2010) and in the course of giving his oral evidence that the Claimant did not need any physiotherapy. However, I am unable to

accept this proposition. It is plain to me that if there was any reason why it was inappropriate for the Claimant to receive physiotherapy, it would have been flagged up by the team of consultants and doctors responsible for treating or looking after her. Far from flagging anything up, the surgeon who operated on the Claimant advised that the Claimant should 'mobilise FWB [i.e. full weight bearing]' – see p 100 of Bundle 'MR', which, there is no issue, was correctly interpreted on the orthopaedic transfer form as meaning that the 'relevant post-op precautions/protocol, & problems' in respect of the Claimant were to be 'routine' – see page 2 of Bundle 'MR'. Indeed, the orthopaedic experts agreed that 'there was no… mandatory bar from the Claimant undertaking weight-bearing exercises from an Orthopaedic point of view' – a point that Mrs Schofield appeared to accept. Second, whatever criticisms there may be of the physiotherapists who saw the Claimant immediately following her knee-replacement operation and members of the SWAT Team, who saw her after she was discharged, there is no criticism of the Defendant based on the fact that the Claimant was not referred for 'one to one' physiotherapy but was asked to attend a general physiotherapy class.

(b) I cannot see how any part of the action taken by Ms Fitter on 20 February can be criticised. She took her instructions on how to run the physiotherapy class from her employer – the Defendant. As Ms Fitter states, it is difficult to see how she could have run the class if she had conducted a full assessment of every patient. She was entitled to proceed on the basis of the orthopaedic transfer sheet which confirmed that the Claimant had been cleared by her surgeon for physiotherapy

> treatment at a physiotherapy class. Her observation of the Claimant and the information she obtained from the questions she asked the Claimant made it clear to her that the Claimant could participate in the class and undertake the mini-squat. It is very difficult to understand what she did wrong.

93 But the plain fact is that even if she had undertaken the type of assessment that Mrs Schofield considered was necessary on 20 February, her clear evidence was that she would have come to precisely the same conclusion that she did on that day. She would have considered that the Claimant was ready and able to do the mini-squat, and would have found no reason why the Claimant could not do that exercise. She was taken by Dr Fox through all the factors that Mrs Schofield said should have militated against the Claimant doing the mini-squat. She said that she had all those factors in mind – as I would expect a physiotherapist of her then standing to have. I accept her evidence that she did have all the factors in mind, and that it would have made no difference to the course of action she adopted on that day.

94 Mrs Schofield stated in the course of her oral evidence what further steps Ms Fitter should have taken in order to assess the Claimant fully. She said, inter alia, that: (a) at the 'interview stage', Ms Fitter should have asked the Claimant what her fears were, what outcome she was seeking to achieve, what her expectations were, and whether Ms Fitter could tell whether there was any reluctance on the part of the Claimant to provide that information – or as she put it whether the Claimant was 'holding back'. The interview of the Claimant conducted by Ms Fitter as they went to the gym explored all those matters clearly and sufficiently, and she is unlikely to have obtained any information from the Claimant in addition to the information the Claimant gave her; (b) Ms Fitter should have asked the Claimant how much pain she was in, and should have observed

if there were any signs of restriction of the ankle joints and whether she was able to stabilise properly. That was exactly what Ms Fitter did; (c) Ms Fitter should have ascertained, by way of a physical examination, matters such as whether the Claimant was able to straighten her leg independently. Ms Fitter did not have to. She had much of that type of information from the orthopaedic transfer sheet and would have been able to obtain a better assessment of those matters as part of what Mr Errington correctly described was the Claimant's ongoing assessment by Ms Fitter in the course of carrying out the exercises; and (d) Ms Fitter should have looked at the extent of the swelling of the Claimant's knee by examining it. I do not know what more information Ms Fitter would have obtained from that examination which she was not able to obtain from her observation, and interview, of the Claimant.

95 I am unable to accept that that there was any additional information that would have been obtained by Ms Fitter from a full examination that she did not have, or would not have considered, from her actual assessment of the Claimant. The suggestion on the part of Mrs Schofield to the contrary is based on pure speculation. I entirely reject it.

WOULD OR SHOULD A FULL ASSESSMENT HAVE AVOIDED THE MINI-SQUAT

96 I have already indicated that I accept the evidence given on behalf of the Defendant, particularly Ms Fitter, that a 'full assessment' – by which I mean an assessment of the type suggested by Mrs Schofield – conducted by Ms Fitter would not have resulted in the mini-squat being avoided. The question, therefore, that arises in this context is whether a reasonable and responsible body of physiotherapists would have concluded that a full assessment should have resulted in the mini-squat being avoided. That is a matter for expert evidence. However, it is important that I remind

myself that before I accept a body of expert opinion which is reasonable and responsible, I need to be satisfied that, in forming their views, the experts have directed their minds to the question of comparative risks and benefits, and have reached a defensible conclusion on the matter.

97 I entirely accept that both orthopaedic experts agreed that the Claimant was particularly at risk of a rupture of her patella tendon because of her age. They agreed that the Claimant was in the top 10-20% in terms of the age-group undergoing the total knee replacement surgery. Professor Fairclough comes to the clear conclusion that the carrying out of the mini-squat was inappropriate. In the conclusion in his first report dated 14 September, he states:

> "The total knee replacement … appears to have been performed in a standard manner. There is no indication in the records that [the Claimant] had any significant problems."
>
> "The description that has been given was that by the early part of February she was walking reasonably well with crutches, but she was performing physiotherapy at home. The statement from Mrs Kennedy indicate[s] that when she was seen by the physiotherapists on 20/02/2008, she was mobilising well. The description given by Mrs Kennedy is that she was able to walk without difficulty."
>
> "In the assessment at physiotherapy she was asked only at first to stand up out of a chair and then given squatting exercises to do against the wall."
>
> "The purpose of physiotherapy postoperatively is firstly to increase and maintain the range of movements in the knee, and secondly if necessary, to increase muscle strength. From the description that Mrs Kennedy gives, she was a short individual and in order to sit down into a chair, she had to have 90 degrees of flexion. Therefore, the purpose of physiotherapy would not have been to increase the range of movements from a functional point of view. Also, in an 81 year-old lady, who was having little problems at this time, it is unclear as to what the attempts of squatting against a wall was attempting to achieve."

98 Professor Fairclough makes much the same observation at paragraphs 4 to 6 of his third report dated 1 August 2012:

> "4 Mrs Kennedy because of her age and height represented a specific problem. This is not a generic 'all knee replacements need physiotherapy.' All forms of medical intervention whether they be surgical, nursing, or physiotherapy carry risks and benefits."
>
> "5 It is not in contention that individuals who have undergone joint arthroplasty do need to have some form of rehabilitation. There appears, however, to be a confusion as to what the process of physiotherapy is. For any individual a knee replacement surgical procedure is to replace the articulating surface which removes the cause of pain and discomfort and in so doing alters the mechanics of the joint. The effect of that surgery is that muscles especially the quadriceps, which are damaged in surgery, become weak and the joint can tend to stiffen unless range of movements are encouraged. It is the range of movements that are essential and providing that mobilisation is undertaken then strength normally follows, but that can take up to a year."
>
> "6 The return of full muscle power is not essential and indeed not possible to achieve as the 'normal level' is both variable and also deteriorates with age. The essence of physiotherapy is to obtain maximum function which is related to both age and disease process."

99 However, as I have already observed above, there was no indication, let alone any suggestion, on the part of the Claimant's surgeon that the Claimant should not receive physiotherapy or that she should be considered by the team of physiotherapists that would be looking after her for any specific type of physiotherapy. It is plain to me that if there was any reason why it was inappropriate for the Claimant to receive any or any specific type of physiotherapy, it would have been flagged up by her surgeon. He did not. On the contrary, he advised that the Claimant should 'mobilise FWB'. The orthopaedic experts themselves agreed that 'there was no… mandatory bar from the Claimant undertaking weight-bearing exercises from an orthopaedic point of view.' Nor was there any criticism by the orthopaedic experts (or indeed the physiotherapy experts) that the Claimant was not referred for 'one

to one' physiotherapy but was asked to attend a general physiotherapy class.

100 It is or appeared to be common ground between the experts that a mini-squat was not, by itself, an inappropriate exercise to undertake following a total knee operation. Mrs Schofield accepted that it was recognised as an appropriate rehabilitation exercise for patients following a total knee operation, although there were factors that applied to the Claimant which made its use in her case 'completely inappropriate' – see her response to Question 8 of the Defendant's Agenda. The two most important factors that Mrs Schofield contended made it inappropriate for the Claimant to undertake that exercise were the Claimant's age and the fact that she had recent knee surgery.

101 I am unable to accept what Mrs Schofield says. The fact that a patient has had recent knee surgery will feature in every case where a patient attends a knee-rehabilitation class following a total knee replacement operation. As regards the age of a patient, the analysis provided by Mrs Schofield as to why an 80-year old patient should not be asked to do a mini squat – unless perhaps he was an athlete – simply does not stand up to scrutiny. When I asked Mrs Schofield what the maximum age – or 'cut off' point – would be at which the exercise should not be offered to a patient, she said it was 75 years. There is no basis whatsoever for this quite remarkable proposition. It would lead to the absurd result that a patient who was 75 should be automatically barred from carrying out the exercise (unless he was an athlete) but one who was 74 should be subject to a full physical assessment before it could be decided whether he was suitable to carry out that exercise. The proposition is fundamentally misconceived. As Mr Kennedy rightly observes, if there was any substance in such a proposition, it would not only be included in some literature on the subject, but the

Claimant's surgeon would have identified it as a risk factor, rather than stating 'mobilise FWB'.

102 The Claimant identified a number of other factors to suggest that the mini-squat was 'completely inappropriate' in her case. These factors are conveniently summarised in Mr Kennedy's written submissions under various headings, and I will deal with them, for the sake of convenience, under the broad headings set out in those submissions:

(a) Effusion/Swelling of the knee

I am entirely unable to see how this could have exposed the Claimant to the risk of injury in the manner suggested by Mrs Schofield. In her response to Question 4 of the Claimant's Agenda, Mrs Schofield stated that '… the class physiotherapist on being told by Mrs Kennedy of her swollen knee did not seek to establish her likely quadriceps control of the knee joint prior to asking her to perform relatively demanding physical exercises, the second of which [i.e. the mini-squat] was given to an elderly lady without any consideration or recognition of any possible complication. Not to consider such precautions such as provision of emergency handholds in any elderly patient performing this exercise would not be an acceptable standard of expected care by any physiotherapist.' However, Mrs Schofield accepted that finding a swollen knee was not uncommon after a total knee operation. Three points are appropriate for mention in this context. First, Ms Fitter was aware of the Claimant's swollen knee, obtained information from her about it, and had advised her what to do about it. There is nothing more that any further investigation would have revealed or

anything more that she could have done. Second, it is not clear how this would expose the Claimant to the risk of injury other than an unparticularised assertion by Mrs Schofield that it would. Finally, as Mr Errington correctly observes in his response to Question 9 of the Claimant's Agenda, the significance of the failure to provide handholds is not clear, particularly given the fact that during the mini-squat, the Claimant herself decided that she did not require her walking stick for support. Indeed, no part of the Claimant's case on causation involves any allegation that the injury to her was occasioned as a result of a failure to provide safety equipment, such as emergency handholds.

(b) Previous surgery

Mrs Schofield stated in her response to Question 2 of the Claimant's Agenda that the Claimant's 'previous surgery combined with her 3 major joint replacements of the lower limb … would have affected her balance, proprioception and therefore her safety.' Mr Errington disagreed stating that if this was a risk factor, the Claimant's surgeon should have highlighted this. The age of a patient and the number of major procedures he or she has had, including how recent they were, will undoubtedly be a significant factor in proprioception disturbance. However, like Mr Kennedy, I find it difficult to understand why this factor has any particular significance given the following matters: (i) the dates when the various operations were carried out – see paragraph 6 above; (ii) the Claimant herself said in the course of her cross-examination that she had 'no problems with balance'; (iii) Ms Fitter could not detect any problems with the Claimant's balance when she

observed the Claimant walk to the gym; and (iv) the fact that the Claimant carried out the sit to stand exercises without any difficulty. I also agree with Mr Errington that if this was a risk factor, it would have been identified by the Claimant's surgeon.

(c) Fixed flexion deformity, eccentric contraction and related matters

The orthopaedic experts agreed that a fixed flexion deformity is common in osteoarthritis of the knee.

I accept what the experts say that the Claimant's quadriceps muscle was weak due to the fact that she had a recent operation, she suffered from arthritis and, as I find, she had some extensor lag. Professor Fairclough said that this increased the difficulty in carrying out the mini-squat exercise because of difficulty in controlling the squat. Mr Radford was not able to express an opinion on this. However, he did not challenge Professor Fairclough's opinion. I must, therefore, accept that what Professor Fairclough had to say was correct. However, that did not make the mini-squat inappropriate. As Mr Kennedy righty observes, the Claimant said in her evidence that she had not experienced problems when sitting down such as a sense of falling back into the chair when attempting to sit down. Indeed, Ms Wilkinson had observed the Claimant performing the sit to stand exercise without any difficulty, and had no reason to think that this was likely to prevent her from undertaking the mini-squat. Nor, of course, had the Claimant's surgeon highlighted this as an issue. I cannot, therefore, see what particular significance these factors have in the context of whether

it was appropriate for the Claimant to undertake the mini-squat.

I agree with Mr Kennedy that ‘eccentric contraction’ is similar, in substance, to the concept of extensor lag, and for the reasons set out above, cannot have any particular significance in the context of whether it was appropriate for the Claimant to undertake the mini-squat.

(d) Biomechanics

Professor Fairclough sought to explain why, as a result of the Claimant’s height and weight, the biomechanics of the mini-squat presented an obvious risk to the Claimant of a rupture of her patella tendon. Mr Radford and the physiotherapy experts were prepared to accept Professor Fairclough’s views on this issue.

However, it is important to draw attention to the following matters. First, the explanation of the biomechanics was extremely complex. Even with Mr Radford’s wide expertise and experience as an orthopaedic surgeon, he had to defer to Professor Fairclough on the issue. Mrs Schofield too had to defer to Professor Fairclough on the issue. It is difficult, in the circumstances, to see how a physiotherapist can be criticised for failing to consider the matter. It is important that one should be alert to the dangers of hindsight and should not adopt an unrealistic analysis of what Ms Fitter could and should have done. She was a physiotherapist and not an orthopaedic surgeon, let alone an orthopaedic surgeon of Professor Fairclough’s skill and standing. Given the clear indication in the

> orthopaedic transfer form that the Claimant was ready and able to attend her physiotherapy class, I am unable to see how she or any other physiotherapist could have thought that considerations of biomechanics would militate against the mini-squat being carried out by the Claimant. When conducting any critical evaluation of a person's decisions, the court must avoid falling into the trap of being too wise after the event. Second, in spite of the explanation given by Professor Fairclough, both Mr Radford and Mr Errington continued to remain of the opinion that the mini-squat was appropriate. Third, the Claimant's surgeon had not highlighted this as an issue. Finally, although the mini-squat involved a much greater force on the Claimant's patella tendon than the sit to stand exercise, it was not unreasonable for the Claimant to proceed to it after she had successfully, and without difficulty, completed the sit to stand exercise.

103 It follows that I am unable to conclude that the views of Mr Radford and Mr Errington – that it was not inappropriate for the Claimant to undertake the mini-squat squat on 20 February 2008 – does not withstand logical analysis. I am unable, in the circumstances, to see any basis upon which it can be established by the Claimant that no responsible or reasonable physiotherapist would have permitted the Claimant to undertake the mini-squat. There was nothing inappropriate, let alone 'completely inappropriate' about the Claimant having undertaken that exercise.

CONCLUSION

104 I come to the clear conclusion that neither breach of duty nor causation is established.

105 The claim must, therefore, be dismissed.

ACKNOWLEDGMENTS

106 I express my deep and sincere gratitude to both counsel and to the experts, particularly for their patience on the occasions when I was struggling to understand some of the more complex matters that arose in the claim. I may have disagreed with some of the views expressed by one or more of the experts but that is not because I do not respect what they say. I do.