Neutral Citation Number: [2020] EWCA Civ 1523

Case No: B3/2019/1499

IN THE COURT OF APPEAL (CIVIL DIVISION)
ON APPEAL FROM
Anne Whyte QC sitting as a Deputy Judge of the High Court
Claim No: HQ15C01195

Royal Courts of Justice
Strand, London, WC2A 2LL

Date: 18/11/2020

Before :

LORD JUSTICE DAVIS
LORD JUSTICE NUGEE
and
LADY JUSTICE ELISABETH LAING DBE

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Between :

Barry Frederick Hewes	**Appellant**
- and -	
(1) West Hertfordshire Acute Hospitals NHS Trust	**Respondents**
(2) East of England Ambulance Service NHS Trust	
(3) Dr Pankaj Tanna	

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Richard Booth QC and Martyn McLeish (instructed by **Anthony Gold Solicitors**) for the **Appellant**
Alexander Hutton QC and Erica Power (instructed by **Capsticks LLP**) for the **First and Second Respondents**
Alexander Antelme QC and Victoria Woodbridge (instructed by the Medical Protection Society) for the **Third Respondent**

Hearing dates: 4-6 November 2020

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JUDGMENT

Lady Justice Elisabeth Laing DBE :

Introduction

1. This is an appeal from a decision of Anne Whyte QC, sitting as Deputy Judge of the High Court ('the Judge'). Leave to appeal was given by McCombe LJ on 13 December 2019 on five out of seven grounds.

2. On this appeal, the Appellant (who was the Claimant below) was represented by Mr Booth QC and Mr McLeish. The first and second Respondents, West Hertfordshire Hospitals NHS Trust ('Trust 1'), and East of England Ambulance Service NHS Trust ('Trust 2') were represented by Mr Hutton QC and Miss Power. The third Respondent, Dr Pankaj Tanna ('the GP'), was represented by Mr Antelme QC and Miss Woodbridge. I thank all counsel for their written and oral submissions.

3. Paragraph references are to the paragraphs of the Judge's judgment, unless I say otherwise.

The facts

4. This summary is closely based on the facts found by the Judge. As she recorded, the claim concerned the management of the Claimant's case by all three Respondents on one day, 12 March 2012.

Cauda equina syndrome ('CES')

5. As the Judge explained in paragraph 2, cauda equina syndrome ('CES') is commonly caused by the prolapse of a large disc in the spinal canal. This compresses a bundle of nerves which transmit messages to and from the bladder, bowel, genitals and saddle area, interfering with sensation and movement. Once it has been diagnosed, it is seen as an emergency, because unless the pressure on the nerves is released quickly, they can be damaged permanently. A clinical diagnosis of CES is confirmed by an MRI scan.

6. There is a group of symptoms, described as 'red flags', the presence of which may lead a clinician to suspect CES. Often, as in this case, a patient has severe pain in his lower back, and sciatica. The red flags include numbness (or hypoaesthesia) in the saddle/peri-anal, or genital area, or in the urethra. Most patients who go to an accident and emergency department ('A and E') with suspected CES are not, in fact, suffering from it. There are different types of CES, depending on the extent of nerve damage. These include CES Incomplete ('CESI') and CES Complete, or Retention CES ('CESR'). All patients with CES experience a continuous deterioration, but the rate of deterioration varies between patients. Sometimes the deterioration is complete within hours. Other patients' CESI never reaches CESR. It was agreed that, in general, on balance of probability, the outcome of surgery for patients with CESI tends to be good, whereas it tends to be poor for patients with CESR. It is therefore vital, once a clinician suspects CES, that an MRI scan is done as soon as possible (or as soon as is reasonably possible), and that, if CES is found, the patient has decompression surgery as soon as possible (or as soon as is reasonably possible).

The background facts

7. The Judge said (paragraph 5) that the background facts were only disputed to the extent which she indicated in her summary (paragraphs 6-17). The Claimant is 50. He has a history of pain in his lower back. An MRI scan taken in January 2012 showed bulges in two discs (L4/5 and L5/S1). He was given a caudal epidural on 22 February 2012. On 11 March 2012, he went to an Urgent Care Centre ('UCC') in Hemel

Hempstead with worsening back pain. He was seen by an out-of-hours GP and given a prescription. He was told to consult his GP if he became worse, and that, if he became numb, that would show that he needed immediate hospital treatment.

8. The Claimant went to bed at 0100 on Monday 12 March. He had urinated just before he went to bed. He woke at about 0500 in pain. His groin had become numb. His wife called the UCC at 0543. She called an ambulance at 0602. She spoke to one of Trust 2's operators.

9. At 0604, the GP, who was an out-of-hours GP, spoke to the Claimant on the telephone for about five minutes. Out-of-hours is a very busy service generally. There would probably have been a queue behind the Claimant of between 10 and 20 calls.

10. At the start of the call, the Claimant said that in the last hour he had 'developed numbness in my bum and leg'. The numbness went down his left leg to his calf and he had pins and needles in his foot. He was asked whether he had had any difficulty, or accidents, in urinating or in opening his bowels. He said that he had not. He had not, however, tried to urinate that morning, and it was painful to sit on the toilet.

11. The GP asked the Claimant where exactly the numbness in his bum was. The Claimant said that it was in his left buttock and all the way down his leg. The GP explained that he was particularly interested to know whether the Claimant felt numb around his back passage, genitalia and groin. The Claimant said that his testicles felt numb. The GP recommended that he go to Watford General Hospital ('the Hospital') immediately as that was where the A and E department was. They would organise an urgent scan there, and get him to see an orthopaedic doctor.

12. The GP specifically told the Claimant that it would not be helpful to go to the UCC. The Claimant told the GP that he would go to the A and E department at the Hospital. The GP explained that there were important nerves which could get pinched. That was 'more serious', and could lead to symptoms in the bowel, bladder, anus or genitalia. If the Claimant was getting those symptoms, he should go to the A and E department at the Hospital. The GP's notes record that he considered that this was potentially a case of CES ('??') and that he had advised the Claimant to go to the A and E department at the Hospital for an urgent review. He also recorded that the Claimant had 'no abdo pain, no urinary/bowels sx [symptoms], no numbness in perianal area, reports developed numbness under genitals/saddle area in the past 1 hr, and pain increasing ++'.

13. The Claimant's wife spoke to Trust 2's clinician at 0632. The clinician arranged for an ambulance to be sent under normal road conditions. It arrived at the Claimant's home at 0721, left at 0738, and arrived at the Hospital at 0819. He was handed over to Trust 1's care at 0827. Trust 2's handover sheet recorded numbness in the Claimant's left buttock, leg and foot. The Claimant was seen by Dr Roffey, an FY2 A and E (that, is a junior hospital doctor who was in his second year of his foundation training) at 0920 in the 'Majors' area of A and E. He noted the report of saddle numbness and that there had been no obvious disturbance of the Claimant's bowel or bladder. On examination, he found 'good anal tone'. He did not diagnose CES, but referred the Claimant for orthopaedic assessment in the light of 'new neurology'. His treatment plan included pain relief and admission for a further scan. His notes record that the Claimant was 'accepted' in the orthopaedic department at 1040. No allegation of negligence was made against Dr Roffey.

14. The Claimant was next seen by Dr Kirkby, who was in the first year of her foundation training, and who was an on-call orthopaedic doctor. The Judge recorded that there was an issue about when Dr Kirkby assessed the Claimant. The Claimant believed it was at about 1000, whereas Dr Kirkby thought that it was nearer 1040. Dr Kirkby examined the Claimant. She noted that the Claimant's groin was numb and that he had not opened his bowels or urinated since the previous evening. She noted that the Claimant's perianal area was not numb and that his anal tone was normal. The Claimant's wife could remember Dr Kirkby examining the Claimant's rectum, but she remembered that, when asked, he had said that he could not feel that examination.

15. Dr Kirkby's notes referred to the Claimant's recent medical history and to the fact that he was under the care of a consultant, Mr Dyson (a member of Trust 1's orthopaedic team). Her note described what had happened when the Claimant had gone to the UCC the day before. Under the heading 'Problems and Diagnosis' she wrote 'L5/S1' bulging and L5/SI protrusion, ? Cauda equina'. She discussed her management plan with Dr McKenzie, the Registrar. It included an MRI scan, x-rays, pain relief, 'Bladder scan-? Retention' and 'nil by mouth' in case surgery was needed, and a discussion with the Registrar 're cauda equina'.

16. The Claimant was given morphine at 1045, which relieved his pain. Dr Roffey filled in forms asking for an x-ray and MRI scan 'probably on instruction'. The Claimant was given a spinal x-ray at 1123. At 1159 a form asking for an MRI scan was put into the Computerised Radiological Information System ('CRIS'). That form did not refer to a diagnosis of CES or possible CES and was not marked urgent. The Claimant alleged that that was negligent. The Claimant had a bladder scan at 1203. The volume of his bladder was recorded as 621 ml. The Claimant was advised by a nurse to try to urinate, but he could not.

17. The Claimant's details were put into the CRIS at 1326. He had an MRI scan between 1333 and 1350. That was about 90 minutes after the MRI request was put into the system. At 1445, a urinary catheter was inserted. The Claimant could not feel it. The residual volume was 625 ml. Dr McKenzie recorded his review as orthopaedic registrar at 1500. It described the Claimant's 'Painless urinary retention' and said 'neurology worsening'. The plan was that there should be an urgent discussion with Mr Langdon (the orthopaedic consultant at the Hospital) 'for theatre today…Impression: cauda equina'. The MRI of the lumbar spine showed a 'massive L5/S1disc herniation which occupied 'most of the central canal'. A further note at 1500 recorded a discussion with the National Hospital for Neurology and Neurosurgery in Queen Square, London ('QSH'). QSH would review the scans and arrange for the Claimant's transfer, if necessary. A nursing note at 1800 recorded that CES had been confirmed and that the Claimant was to be transferred urgently to QSH. An ambulance arrived at the Hospital at 1835, left at 1935 and arrived at QSH at 2009. The Claimant was admitted at 2034 and taken to theatre at 2230. Surgery started at 2300. As the Judge observed, 'some 17 hours or so had passed' between the points when the GP suspected CES and when the Claimant had the necessary surgery (paragraph 16).

18. The Judge did not doubt that the Claimant had suffered significantly and would continue to do so. She praised his dignified approach to the litigation (paragraph 17).

Was there any relevant policy?

19. The Judge noted that there was (and is) no relevant local or national policy for CES which applied to referrals from primary to secondary care (paragraph 18).

20. The Society of British Neurological Surgeons had published 'Standards of Care for Established and Suspected [CES]' ('the Standards'). It noted that the clinical assessment of patients with suspected CES is difficult. It provided that all cases of suspected CES should be referred to and assessed at the local A and E department or orthopaedic/neurological service 'depending on local facilities and arrangements'. All emergency departments receiving such patients should have an agreed protocol with their spinal service for the assessment, imaging and referral of such cases. Whether an MRI scan was needed should be established. MRI scans should be done locally if possible. Patients with suspected CES must have access to a 24-hour MRI service. If CES compression is confirmed by an MRI scan, the local specialist unit must be told immediately, and the scans made available. The patient should be directly transferred to the unit with the images and documents. If the clinical and radiological assessment indicates that surgery might reduce long-term damage, it should be done immediately.

21. The Judge noted that the Standards had not been agreed nationally or ratified by the British Orthopaedic Association or the British Association of Spine Surgeons, and were not mandatory for orthopaedic units, although they were well known to neurological and orthopaedic spinal surgeons.

22. The Hospital had a policy dealing with admission to hospital for patients with back pain, including CES. It was aimed at doctors in their Foundation years, senior house officers and specialist registrars, orthopaedic surgeons on the on-call rota and orthopaedic surgeons with an interest in spinal surgery (which would include Mr Langdon). The Judge quoted from this policy in paragraph 22.

23. The evidence of Dr Roffey and Dr Kirkby was that they did not know about this policy. Mr Langdon said that the policy had never been approved or ratified by Trust 1. He thought that all junior doctors in A and E and orthopaedic departments knew that suspected cases of CES were potentially urgent, whether or not they knew about the policy. The accepted policy at the Hospital was that any confirmed cases of CES were referred elsewhere, usually to QSH. The Judge considered the causal relevance of Trust 1's failure to have a policy (because it was not ratified) and of Dr Roffey's and Dr Kirkby's ignorance of that policy later in the judgment.

24. The National Institute for Clinical Excellence ('NICE') had published guidelines about sciatica. Those listed 'red flags' for CES and for other spinal conditions. There was evidence that they should have been familiar to competent GPs. The guidance in relation to a patient with sciatica who showed 'red flags' was to admit or refer urgently for specialist assessment using clinical judgment.

The Claimant's case below

25. The Judge described the allegations against the Respondents in paragraphs 4 and 26-28 of her judgment.

26. The Claimant's case was that the GP did not make the right kind of referral when he suspected that the Claimant might be suffering from CES, early in the morning of 12 March 2012. The GP, having suspected CES, should not just have advised the Claimant to go to A and E, but should have contacted the Hospital to ensure that the Claimant was urgently assessed by the orthopaedic team as an 'orthopaedic expected patient', bypassing A and E and saving time.

27. His case against Trust 2 was that Trust 2 did not give his transfer by ambulance to the Hospital the right priority, so that he arrived there 19 minutes later than he would have arrived had his transfer been given the right priority. Trust 2 admitted that there should have been 'Green 2' response in the Claimant's case within 30 minutes. Trust 2 admitted that the failure to assess the Claimant at 0632 was a breach of duty. It led to a delay of 19 minutes. Trust 2, however, denied that this delay had any causal effect. It was agreed that if this was the only avoidable delay, it was de minimis, and no loss flowed from it.

28. His claim against Trust 1 was that Trust 1 managed his case negligently. He was potentially a surgical emergency. He was not seen quickly enough, with the result that the investigation and treatment was delayed. The diagnosis of CES should have been made sooner. Once Dr Kirkby suspected CES, she should have called Mr Langdon, arranged an urgent MRI scan, marked the MRI request form as urgent, and mentioned CES or suspected CES. The Claimant's MRI scan should have interrupted the list of elective scans.

29. Each Respondent was responsible for causing him permanent and avoidable injury and loss of function. His case was that he had not developed CESR by the point at which, absent the Respondents' negligence, he should have been operated on. Had he been operated on sooner, he claims, on balance of probability, he would not have suffered the injuries which he in fact suffered.

30. The Judge described the issues in more detail in paragraphs 26-28.

The issues on causation

31. As the Judge explained, the Claimant argued, on factual causation, that had the Respondents not been negligent, the Claimant would have had decompression surgery by 1500, and his prognosis would have been much better. The Respondents' case was that this was unrealistic given the resources of a district general hospital. It was unlikely that he would have been operated on before 1500 (paragraph 29). On legal causation, the Claimant argued that had he had decompression surgery before 1500, he would not have developed CESR. Trust 1's case was that when the Claimant was admitted, it was likely, already, that he was in urinary retention but that he would, unavoidably, have developed CESR by 1203, and certainly by 1445/1500 when it is likely that Dr McKenzie saw the MRI scan. 'It is therefore unlikely…that any decompressive surgery before that time would have impacted upon his condition and prognosis' (paragraph 30).

32. She said more about the issues in paragraphs 36 and 37. In paragraph 36, she said: 'In the context of the present case, and the Claimant's hypothetical alternative timeline/s, it is agreed between the parties that the court should be guided by what would be regarded as the reasonable time(s) in which particular steps might realistically be taken, as opposed to the minimum achievable. Mr McLeish, on behalf of the Claimant, invites the Court to consider, with care, what that means in an emergency'.

33. She listed the essential issues which, after the evidence, the parties had agreed she should decide, in paragraph 37. I have somewhat re-phrased these, but I consider that my language captures the Judge's meaning.

    i. Should the GP have referred the Claimant directly to the orthopaedic team at the Hospital, rather than advising him to go to A and E? If the GP had done so, what, reasonably, would then have happened?

ii. What difference, if any did the admittedly negligent delay of 19 minutes by Trust 2 make in the context of what reasonably would have happened at other stages in the sequence of events?

iii. Whether or not the GP was negligent, should the Claimant have been referred for an MRI scan sooner than he was? If he had been referred sooner, what would have happened, and when? The Judge listed some of the sub-issues which were raised by this issue.

iv. If any Respondent had been negligent, had it caused the Claimant damage? She had to decide whether, on balance of probability, a more favourable outcome would have been achieved by 1500. She had decided to address all the issues raised by the Claimant, even though, as she appreciated, if she were to find that the Claimant had been in CESR by, say, 1000, that would be the end of the case.

The law

34. The Judge summarised the relevant legal principles in paragraphs 31-35. She referred to two authorities among others: *Bolam v Friern Hospital Management Committee* [1957] 1 WLR 582 which articulates a familiar test and to the further elaboration of that test in *Bolitho v City and Hackney Health Authority* [1997] UKHL 46; [1998] AC 232. It is inconceivable that she did not have both in mind in her approach to breach of duty. She also referred to the judgment of Green J (as he then was) in *C v North Cumbria University Hospitals Trust* [2014] EWHC (Admin) 61 QB in paragraphs 35 and 36. It is inconceivable, also, that she did not have this judgment in mind when she was assessing the expert evidence. She summarised her approach to the expert evidence, which was expressly informed by that decision, in paragraph 35.

The evidence

35. The Judge listed the evidence in paragraphs 38-40. She recorded that she had not heard evidence from Dr McKenzie, who had by then become a consultant (he had also moved to Australia, and his personal circumstances made him very reluctant to take time off work to give evidence in the trial: see paragraphs 62 and 64). On the application of Trust 1, and with the agreement of the Claimant, she had decided to admit his statement as hearsay evidence pursuant to the Civil Evidence Act 1968. The parties disagreed about the weight which she should give that statement. It had not been tested in cross-examination. Her approach to the weight which it was appropriate to give that statement was the subject of one of the two grounds of appeal which the Claimant does not have leave to argue. She also had to decide what weight she should give to 26 separate research publications to which the parties had referred when she assessed the views of the parties' expert witnesses.

36. She also heard evidence from the GP, from Dr Roffey, Dr Kirkby, Ms Devereux (the Chief Superintendent Radiographer at the Hospital), and Mr Langdon, who was on call at the relevant time. She heard evidence from two experts in General Practice, Drs Russell and Swale (on breach of duty and factual causation), two orthopaedic experts, Mr Thorpe and Professor Fairbank (on the same topics), and three neurosurgeons, Messrs Mannion, Crocker and Cowie (on factual, medical and legal causation).

The case against the GP

37. The Judge considered the allegation against the GP in paragraphs 41-55. The keystone of the Claimant's case, as she noted in paragraph 41, was that the '<u>only</u>' (her emphasis) course available to a reasonably competent GP on the known facts would

have been to refer the Claimant urgently to the orthopaedic department at the Hospital and to call them to tell them that he was on his way, and that it was suspected that he had CES.

38. She reviewed the evidence and considered it carefully. Her conclusion was that both experts gave their evidence in good faith, and that there was nothing in their evidence which caused her to prefer one expert's evidence to that of the other. Her view was that '…Dr Swale's evidence is too inflexible when set against the evidence and publications and that Dr Russell's evidence accurately reflects a reasonable position in terms of the options available to [the GP]' at the relevant time. She noted (paragraph 45) that Dr Swale had 'fairly conceded that if I accept the factual evidence I heard from Dr [sic] Langdon (which I do) that any GP who tried at 0600 to refer a suspected CES directly to the orthopaedic department rather than to the A and E department would be informed to go through A and E, then the GP would have discharged his/her duty and the alleged failure to refer to a specialist would not have affected the outcome'. The Judge was referring here to the evidence of Mr Langdon, which, she recorded in paragraph 54, she had accepted, that 'had [the GP] rung the A &E department [sic] between 0600 and 0630 on 12 March 2012, on the balance of probabilities he would have been advised to re-route the Claimant to the A&E department'. She referred to Mr Langdon's evidence again, in more detail, in paragraphs 67 and 68.

The case against Trust 1

39. The next logical issue for the Judge to consider, because if she were to find that the MRI scan should have been done earlier, a finding on this issue would start the clock ticking for the claim against Trust 1, was when Dr Kirkby had assessed the Claimant. She found that Dr Roffey made a handwritten note that the Claimant was 'accepted' into the orthopaedic department at 1040 (paragraph 56). The next question was whether Dr Kirkby assessed the Claimant at 1000, as her notes recorded, or at 1040. For the reasons which she gave in paragraphs 57 and 58, the Judge accepted Dr Kirkby's evidence that the time in the notes was a mistake. The Judge found that Dr Kirkby had in fact assessed the Claimant approximately between 1050 and 1120. There was no allegation of delay in that assessment (paragraph 58).

40. The Judge summarised the case against Trust 1 as 'an allegation that the MRI scan and follow-up surgery were not performed soon enough' (paragraph 60). She recorded, in paragraph 66, those aspects of Dr McKenzie's evidence which she accepted. In paragraph 67, she recorded Mr Langdon's evidence. She commented in paragraph 68 that he gave evidence 'in a measured and thoughtful manner'. She did not find his answers at all defensive. 'It was obvious that he wished to be open with, and assist the court, regardless of the outcome'. In paragraph 69 she summarised the 'uncontested evidence' of Ms Devereux.

41. She then considered three issues in turn in paragraphs 70-71, 72-73 and 74-76.

42. The first issue was whether Dr Kirkby was negligent in consulting the registrar, Dr McKenzie, first, rather than the consultant, Mr Langdon. The Judge decided, for the reasons which she gave, that Dr Kirkby was not negligent in that respect. She also made clear that, even if Dr Kirkby had been negligent, that would have made no difference. She explained that, on this topic, she had preferred the expert evidence of Professor Fairbank to that of Mr Thorpe, for the reasons which she gave. Essentially, speaking to the registrar was one of a number of reasonable options. There was, in

any event, not enough evidence to show that contacting Mr Langdon sooner would have led to a quicker scan, which was the important point.

43. The second issue was the failure to note on the referral form that this was a suspected case of CES and/or that the case was urgent. The Judge acknowledged that it would be possible and helpful to have marked the form in that way, but, on the factual evidence, which she accepted, it was not the form, but a discussion between the relevant doctors and the radiologists which leads to a scan being treated as urgent. In any event, the scan was so treated, because the Claimant was put into the 'urgent' in-patient slot between 1130-1400.

44. The third issue the Judge considered was whether the MRI scan should have been done sooner. Given her earlier findings, the allegation was now, in effect, that the Claimant's scan should have been done before the other two urgent scans in the 1130-1400 slot, or, at least, before the second of those cases. The Judge noted the lack of evidence about the two other cases (one patient with cancer, and a patient with compression of the spinal cord) and about whether there had been any conversation about displacing either patient. The Claimant's case was that the Judge should draw an inference that his case should have had priority. She reviewed the evidence of the experts about this. She noted, importantly, that Mr Thorpe 'agreed that the time taken from logging the scan request to availability of the images was reasonable'. She preferred Professor Fairbank's evidence, as 'more balanced on this issue'. In her view, he 'paid more reasonable attention to the workings of this type of hospital, to oral lay evidence and to the relevant legal test than Mr Thorpe'. There was 'no evidence that prioritisation of the scan was unreasonable'.

The negligence claim against Trust 2

45. In paragraph 76, she said that, as she had rejected the allegations of negligence against Trust 1 and the GP, the 19-minute delay by Trust 2 made no difference, for the reasons she had given in paragraph 27.

Factual and legal causation

46. The Judge nevertheless considered factual and legal causation in paragraphs 78, and 79-92.

Factual causation

47. In paragraph 78 she recorded that Mr Thorpe had accepted that 'the time taken from orthopaedic acceptance to the logging of the scan request was reasonable (1 hour 19 minutes). He also agreed that it would reasonably take some 2 hours 10 minutes from logging the request to scan, scanning, uploading the results to taking the decision to operate. It would take another 90 minutes to prepare the patient for surgery, including anaesthetic induction. The time taken to reach decompression was variable, potentially 60 to 90 minutes. In short, a period of some six and a half hours could reasonably elapse between orthopaedic acceptance and decompression'. In the light of her findings on legal causation, even if Trust 1 and the GP were negligent, the outcome would have been no different, based on the timings conceded by Mr Thorpe. To spell this out: the Claimant's pleaded case was that he was in CESR by 1500. He was 'accepted' as an orthopaedic patient at 1040 (paragraph 40). If six and a half hours are added to 1040, they make 1710. Thus, on Mr Thorpe's own evidence about reasonable timings, the Claimant could not reasonably have been operated on before, even on his pleaded case, his condition became CESR.

Legal causation

48. The Judge commented about the inevitable discussion, by the expert neurosurgeons, of issues which might seem to be the province of urologists. This was inevitable, given the importance of urinary symptoms in the diagnosis of CES. Each was very experienced. They all gave their evidence in good faith. There was nothing to choose between them in terms of careers and experience. Yet they disagreed 'in stark terms' about the point at which, on the balance of probability, the Claimant's 'prospects for a favourable outcome vanished'. The 'root of this disagreement' was in effect, how a patient's condition should be classified, and how (if at all) that choice should be informed by the 'literature'.

49. Mr Mannion believed that 'up until 1500, the Claimant did not fulfil the definition of CESR and that the Defendants' experts have succumbed to inappropriate hindsight because the surgical outcome…was unfavourable'. Messrs Crocker and Cowie considered that the Claimant might have reached CESR by 8am, but, in any event, that no bladder function was salvageable by 1203 pm. As the Judge pointed out in paragraph 82, if the Respondents' experts were to be preferred, the Claimant's case failed on causation, because surgery at the Claimant's earliest possible suggested time (1308) would have been too late.

50. The cause of the disagreement was Mr Mannion's 'steadfast' reliance, based on the literature, on a definition of CESR which included overflow incontinence and some bowel dysfunction. Because the Claimant never showed those symptoms before 1500, Mr Mannion thought that his condition was still CESI. He also considered that patients who have lost the desire/ability to urinate could be either in CESR or in CESI. Mr Crocker and Mr Cowie thought that rigid adherence to the literature was unreliable and not very practical in the modern era when CES tends to be diagnosed earlier than it used to be. They did not see CESR and CESI as hard-edged categories, although they were content to agree working definitions. Their approach was to be cautious about the literature since CES is complex and controversial, and to focus on the 'pathophysiological indicators' in the case in hand. Where a patient is numb from very early in the day, and does not want to, and cannot, urinate, despite having a very full bladder, 'CESR has probably been reached'. All the experts accepted that defining when a patient's condition moves from CESI to CESR was 'very difficult'. The Respondents' experts thought that Mr Mannion was 'trying too hard to "put people into boxes" '.

51. In paragraph 85, the Judge set out the definitions of CESI and CESR which the experts had agreed in their joint report. Patients with CESI have not lost executive control of their bladder. Patients with CESR have a complete loss of bladder function. CESR is diagnosed when a patient has painless urinary retention and overflow incontinence. But the experts agreed that not all patients develop overflow incontinence, because some patients are catheterised before there is any incontinence. 'Incontinence is, therefore, not a prerequisite for the diagnosis of CESR.'

52. The Judge noted that, despite this agreement, Mr Mannion insisted, by reference to academic articles, 'that incontinence is critical in defining CESR' and that the definition in the experts' Joint Statement ('JS') was 'a biological rather than a working one' (paragraph 86). When asked about this feature of Mr Mannion's evidence Mr Booth explained that a 'working definition' is a practical, neurosurgeon's definition, and a 'biological definition' is one based on the literature. Mr Crocker said that bladder function was the best surrogate marker for autonomic

function, and that there was no salvageable bladder function by 1203. The Claimant had lost autonomic bladder function at some point between when the Claimant had last urinated before he went to bed the previous night, and the bladder scan at 1203 (paragraph 87).

53. She then listed the factors on which that view was based. On average, a person feels an urge to urinate when there are between 300 and 400 ml of urine in his bladder. The scan showed a residual volume of 621 ml at 1203. That suggested that there had been a period, before 1203, when although the bladder was full, the Claimant had felt no desire to urinate, suggesting, in turn, that the function of the relevant nerves was impaired. If it is assumed that adults produce, on average, 50 ml of urine an hour, there were 400 ml of urine in the Claimant's bladder at 0800. Yet the Claimant had felt no urge to urinate. That suggested that CESR was established by 0800. By 1203 the bladder was pathologically swollen. The Claimant had been unable to urinate after the scan, when he was asked to. He had not tried to before that, and had not felt that he wanted to. Change in rectal tone is a relevant factor, but 'nowhere near as reliable' an index as bladder function'.

54. She referred to Mr Cowie's evidence. Independently, he had come to the same view as Mr Crocker. He noted that, unusually, the Claimant had been able to describe when perianal numbness set in, at 0453. This meant that the pressure exerted by the disc material on the nerves in the spinal canal was great enough to interrupt electrical function. Irreparable nerve damage/death 'proceeds in a continuous fashion' after electrical conduction stops. Some nerve fibres die sooner than others. It was relevant that the Claimant could not feel the catheter at 1445.

55. The Judge expressly avoided the trap of preferring the evidence of two experts to that of one, merely on the basis that two outnumbered one. She had watched and listened to the experts. That had informed her assessment. She listed several concerns about Mr Mannion's evidence in paragraph 90. For example, she was rightly troubled by the way in which, at a stage when urinary retention was clearly 'a highly relevant issue' he had apparently glossed over it in his report. He had agreed that there was 'clear evidence of painless urinary retention' at 1203 but did not say so in his report. She referred to his 'fixation with overflow'. She speculated that it could be explained by the fact that many articles refer to painless urinary retention <u>with</u> [her emphasis] overflow incontinence, and added that it ignored the 'agreed' position that CESR patients with painless urinary retention are nowadays catheterised before overflow starts.

56. She concluded, in paragraph 91, for seven 'non-exhaustive reasons' that, on the balance of probability, the Claimant was in CESR by 1203, when he had the bladder scan. She accepted Mr Crocker's contention that, rather than trying to fit a patient into one of many different definitions in the literature, a neurosurgical expert was better to rely on his own expertise, the patient's history, and pathophysiology to assess what was happening to a patient. She explained, in paragraph 91(iii) why she accepted Mr Crocker's argument that the literature gave limited help, but she was careful not to discount it altogether. She could not accept Mr Mannion's insistence that CESR could not be confirmed without overflow incontinence and loss of anal/perineal tone. As she explained, overflow incontinence is 'a secondary marker of a loss of executive bladder control which is a surrogate marker occurring hours earlier'. She accepted Mr Crocker's evidence that bladder function was the most reliable means of distinguishing between CESR and CESI. If digital rectal examination ('DRE') is, as

Mr Mannion said, notoriously unreliable as a determinant of CES, it was hard to see how Mr Mannion could rely on it so much as a determinant of progression. She then illustrated that point by reference to the events in this case. The Claimant had a DRE at QSH (at a point when, all agreed, he was CESR) which suggested, only, a partial loss of tone. She accepted Mr Cowie's evidence that some nerve fibres are more resilient than others, which explains why bladder function could be lost, but anal tone maintained.

The grounds of appeal

57. On 13 December 2019 McCombe LJ gave the Claimant permission to argue some of his grounds of appeal. He acknowledged that the judgment was 'carefully reasoned'. He observed when giving permission that he had considered whether it was appropriate to give permission to appeal on any of the grounds, as, to a significant degree, they involved challenges to findings of primary fact, and to assessments of those facts. The skeleton argument, had, however, persuaded him that there was a more than merely fanciful chance of success. He refused leave to challenge the Judge's assessment of the weight she should give to Dr McKenzie's hearsay statement, and to rely on argument that the Judge's approach to the case gave rise to an appearance of bias or of unfairness (grounds 3 and 7).

58. He gave permission to appeal on five grounds.

    i. The Judge erred in law and fact in holding that the GP did not breach his duty of care.

    ii. She erred in both respects in deciding that the Claimant had not proved factual causation against the GP.

    iii. She erred in both respects in not drawing adverse inferences against Trust 1 from the absence of any evidence of a discussion between the orthopaedic and radiology departments about the urgency of an MRI scan for the Claimant, or about the priority to be given to the three patients who were referred to in the witness statement of Ms Devereux.

    iv. She erred in both respects in her decision on factual causation as respects Trust 1.

    v. She erred in both respects in holding that the Claimant had failed to establish legal causation as against any of the Respondents.

Discussion

Two preliminary points

59. There are two initial points which must be made.

60. The question for the court on this appeal is whether the decision of the Judge is wrong. Nevertheless, an appellant in an appeal such as this is not free to invite this court to re-visit the whole case, and to stand in the shoes of the first instance judge.

61. The Respondents, rightly, referred the court to many authorities which state the obvious. They are helpfully summarised in paragraphs 4 and 5 of the skeleton argument of Trust 1 and Trust 2. The most significant of those authorities are referred to by Lord Briggs (with whom the other members of the court agreed) in the judgment of the Supreme Court in *Perry v Raleys Solicitors* [2019] UKSC 19; [2020] AC 352 at paragraphs 49-50). That was a case in which the issue for the Supreme Court was

whether the judge at first instance had gone wrong in his decision on the facts to an extent which enabled the Court of Appeal to intervene. At paragraph 52, Lord Briggs said that the test is whether there is no evidence to support a challenged finding of fact, or that the finding was one which no reasonable trial judge could reach.

62. The trial in this case lasted six days. There were pages of pleadings, witness statements, experts' reports and academic literature for the Judge to absorb before the trial, and to reflect on after she had reserved judgment. This appeal is not a wholesale opportunity to revisit, in detail, her findings of fact, her evaluative assessments, or her mixed findings of fact and law. To use Lewison LJ's vivid metaphor in *Fage UK Limited v Chobani UK Limited* [2014] ETMR 26, at paragraph 114, 'In making [her] decisions the trial judge will have regard to the whole sea of evidence presented to him, whereas an appellate court will only be island hopping'.

63. This court is simply not in the same position as the Judge was, for many reasons.

    i. She was able to evaluate the witnesses as they gave their evidence. There are many aspects of a witness's responses to questions, such as evasiveness (and this can be sometimes be the case with experts), which are not visible from the transcript.

    ii. She was entrusted with making findings of primary fact, both where there was a dispute about the evidence, and where there was a gap in the evidence.

    iii. Her job was to make findings on the balance of probability, which is not a precise science, and involves an assessment of the relative likelihood of events.

    iv. She had to make several evaluative judgments.

    v. She was required to make mixed findings of fact and law, not least, the application of the *Bolam/Bolitho* test.

    vi. The premise of the *Bolam* test on breach of duty is that there may not be one right answer on the facts found, but a range of reasonable answers.

    vii. It is obvious from the dispute on causation, which is one of the two significant issues in this case, that there was a sharp difference of view between the experts, all of whom, the Judge found, gave their evidence in good faith. She had to decide which evidence, on that dispute, she preferred.

    viii. The Claimant's case on appeal is that the dispute about causation is a binary dispute, and is to be resolved by assigning his case to one of two mutually exclusive categories (CESI or CESR). However, the distinctions between the two are imprecise in the literature. There are different definitions, which make categorisation difficult. The real question, which the Judge addressed, is what the outward signs, on balance of probability, showed about the progress of the Claimant's underlying pathology, and at what point in that progress, he had, on the balance of probability, reached the point from which a functional recovery was no longer likely.

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

65. Second, it is trite that a first instance judge has to decide the principal issues between the parties and give reasons for her decision which are detailed enough to enable them to know why they have won or lost the case. A judge is not obliged to decide every single disputed issue, or to give reasons for her reasons, as the Judge appreciated (see paragraph 91: '…for the following non-exhaustive reasons'). In this case, the Judge decided the issues which, the parties had agreed, after the evidence, she had to decide (see paragraph 37). There were four issues. Some involved sub-issues, but this was not a case in which the parties agreed that there was a complicated sequence of issues, each of which was capable of influencing the overall result. It was not, therefore, a case in which she was required to do more than to explain, in a way which was intelligible to the parties, who were familiar with the interstices of the dispute, why she had decided the agreed issues in the way in which she had. Moreover, it is clear from several passages in the transcript of the hearing to which this court was taken by counsel, that the Judge engaged in a thorough and rigorous way with a range of issues which she did not specifically refer to in the judgment; and the parties know that.

66. The Judge was given many building blocks for her judgment, that is, all the evidence, lay and expert, and the parties' submissions. The agreed issues were the framework of the judgment. But they did not dictate its overall structure, or its details. Those were for the Judge to decide, as a result of a cumulative series of assessments which it was for her to make; not for this court. I consider that the Judge is to be commended for having grappled with the details of the evidence and submissions, and for having distilled the essence of those materials into a judgment which deals economically and persuasively with what, the parties had agreed, were the significant issues. The tight structure of the judgment, and its succinctness, are signs that the Judge had carefully navigated the sea of evidence and analysed its essential components into a coherent whole.

The Claimant's submissions

67. The Claimant's submissions were a detailed attack on the judgment. I note here that Mr Booth's case was that only one finding on liability was open to the Judge, but he accepted that, even if he were able to show that her approach to causation was wrong, the case would have to be remitted on that issue.

68. In their introduction to the skeleton argument, counsel made four broad points.

    i. The judgment is 'punctuated' by a number of factual errors. The relevance of these errors (if it is assumed that they are errors) to the Judge's decisions on the agreed issues is not obvious. Immaterial errors could cast no doubt on the Judge's central reasoning. Mr Booth, wisely, in my view, did not take up time with these in his oral submissions. He accepted that this was a difficult submission for him. The Respondents answered those criticisms in detailed written submissions of their own. Having read the competing submissions, I am not persuaded that the Judge made any errors. In any event, even if she had, I am not persuaded that the listed errors begin to satisfy the test described by Lord Briggs in *Perry*.

ii. The Judge failed 'on a number of occasions' to deal with 'the totality of the evidence', including matters which undermine her findings of fact and her assessment of the expert evidence. This submission, even if made out, proves too little. Of course, there is much evidence that the Judge did not refer to. A judge is not expected to summarise all the evidence, but only to refer to the evidence which is significant to the decision. There were few, if any, factual issues in the case, and the Judge did describe, in my judgment, crisply and sufficiently, material disputes between the experts. In any event, it is trite that a failure to mention part of the evidence does not mean that a judge has ignored it. Omissions are only material if they show that the Judge's findings or assessments are wrong, that is, that they were not reasonably open to her on the evidence. I do not consider that this submission begins to satisfy the *Perry* test.

iii. The Judge was wrong to classify a case of suspected CES as 'urgent' and a case in which an MRI scan had confirmed CES, as 'more urgent' or 'an emergency'. I deal with this point in paragraph 77, below.

iv. The Judge failed to make 'any reasoned determination' on what is said to be the central issue; in a case of suspected CES, time is of the essence; treatment must be provided 'as soon as practically possible', and a failure to provide treatment to that standard is 'illogical and irrational'. I deal with this submission in paragraph 72, below.

69. It is not appropriate on an appeal such as this to deal with every single one of the Claimant's detailed criticisms of the judgment. I will, instead, consider seven aspects of the judge's reasoning which are criticised. The criticisms range from an inconsequential criticism to attacks on the Judge's reasoning on the significant issues in the case. None of these criticisms, individually or cumulatively, persuades me that this court should interfere with the Judge's decision.

Did the Judge apply the wrong test?

70. I have already said that it is inconceivable that the Judge, having referred expressly to *Bolam* and *Bolitho*, did not have the test well in mind throughout her process of reasoning. That is supported by her use of the words 'reasonable', 'reasonably' and 'logical' at various points in the judgment. She recorded, in paragraph 36, that the parties had agreed what test she should apply. The Claimant objects that paragraph 36 does not accurately reflect the Claimant's position, because his position was that in an emergency, each step must be taken as soon as practicably possible. Whether or not the Judge accurately recorded her understanding of what the parties agreed, the test she described is legally accurate. To introduce a gloss such as the Claimant now suggests, if it had led to a decision adverse to the Respondents, would, rightly, have prompted an appeal from them. The Judge was right to use reasonableness as a touchstone, while making it clear that what was reasonable depended on the context, and that part of the context was that, on his case, the Claimant was an emergency. The other part of the context is the relatively limited resources of a District General Hospital in a busy public health service with many urgent cases competing for attention.

The case against the GP

71. It is said that the Judge 'failed properly to take into account inconsistencies' in the evidence of Dr Russell, the GP's expert witness. The Claimant points to parts of his evidence, which, it is suggested, are illogical. In particular, the Claimant relies on a suggestion by Dr Russell that a reasonable option for the GP in this case would have been to refer the Claimant for a face-to-face consultation with a GP. This was said to be contrary to the experts' joint statement, and intrinsically illogical. A submission on an appeal such as this that the Judge did not take something into account 'properly' starts from a shaky foundation. But that does not help the Claimant. The Claimant has to persuade the court that no reasonable judge could have taken the approach to Dr Russell's evidence which the Judge took. That submission was not expressly made. If it had been, it would have failed. In any event, the Judge did refer to this particular criticism of Dr Russell's evidence, and explained why it did not affect her overall assessment of his evidence (paragraphs 49 and 51). The Judge could not reasonably be expected to have done more than she did with this point; indeed, it might be said that her approach was a textbook example of how to evaluate whether an attack on part of an expert's evidence should undermine all of his evidence, or not. The real question here is not, as Mr Booth seemed at times to suggest, the credibility of Dr Russell as an expert, but whether the different components of his evidence, judged on their merits, were persuasive. I therefore reject this submission.

72. Without oversimplifying unduly, the case against the GP turned on a straightforward dispute between the experts about whether it was a reasonable course for an out-of-hours GP who had been consulted over the telephone by a patient with suspected CES to advise him to go straight to A and E, or whether the only reasonable course was to ring the orthopaedic department and refer the patient directly to that department. As the Judge knew (and this informed her findings of fact), in the transcript of the call between the Claimant and the GP, which was in evidence, the GP advised the Claimant to go the Hospital 'because that is where the A and E department is, that's where they can organise an urgent scan and get you seen by an orthopaedic doctor'. The Judge also knew that the GP had worked at the Hospital.

73. The Judge resolved that dispute by preferring the evidence of the GP's expert on GP practice, the relevant evidence of the orthopaedic experts, and the factual evidence of Mr Langdon, about what would have happened if the GP had referred the Claimant directly to the orthopaedic department. That is so even if she was wrong about which page of the NICE guidelines Dr Swale referred to in his evidence (see paragraph 46). I doubt, however, whether she was, since the case against the GP had not been presented initially on the basis that the GP had been negligent in not treating the Claimant as a 'follow-up patient' (as that term is used in the NICE guidelines); nor was that case put to the GP in cross-examination. She explained why she resolved that dispute as she did in paragraph 52. That approach was open to her. It is not even arguably wrong. I would also accept the more detailed reasons given by Mr Antelme in his oral submissions and in the GP's skeleton argument for upholding this aspect of the Judge's judgment. I do not consider that there is anything to criticise in the conduct of this busy out-of-hours GP. In a short telephone call he took an accurate history from the Claimant, skilfully elicited a red flag for CES, diagnosed suspected CES, and gave the Claimant sensible and reasonable advice, which was to go to the A and E department at the Hospital where an urgent scan could be organised and he could be referred to an orthopaedic doctor.

74. Mr Booth argued that the Judge was wrong, in paragraph 54, to hold that, even if the GP was negligent, it would have made no difference, because if the GP had rung A and E between 0600 and 0630, he would have been advised, on the balance of probability, to re-route the claimant to A and E. He relied on the judgment of Neuberger LJ (as he then was) in *Wright v Cambridge Medical Group* [2011] EWCA (Civ) 669; [2013] QB 312 for the proposition that if a defendant GP has been negligent in his treatment of a patient, he cannot rely on subsequent negligent treatment of the same patient by a hospital to escape liability. This point does not arise in this case, because the GP was not negligent. In any event, it is not easy to tease a ratio from this decision as the two members of the court who allowed the appeal did so for different reasons. Further, it is clear from the judgment of Neuberger LJ that he was not articulating a legal rule that applies in all cases, in part, because the application of any such rule will depend on what damage was caused by each successive negligent act.

The case against Trust 1

Urgent and emergency

75. The Claimant attacks as 'sophistic' a distinction between 'urgent and emergent'. It is said that the GP experts did not make such a distinction in their JS. In their skeleton argument, Trust 1 and Trust 2 show, by making three points, that this argument is misconceived. Those points were amplified by Mr Hutton in his oral submissions.

    i. The parties' orthopaedic experts, at paragraph 1(b) of their JS, said 'The experts are agreed: Suspected [CES] requires an urgent MRI scan to confirm cauda equina compression. Cauda Equina Compression demonstrated on an MRI scan is a surgical emergency'.

    ii. This was never in dispute, and was confirmed by Mr Thorpe, the Claimant's orthopaedic expert, in his evidence.

    iii. When the Judge said, on the third day of the hearing, that this was her understanding of the position, counsel for the Claimant did not demur, and the Claimant agreed with the formulation of the relevant issue (see paragraph 37(iii)).

The time which elapsed between Dr Kirkby's assessment and the availability of the scans

76. A central plank of the Claimant's case on breach of duty against Trust 1 must be that the period between his assessment by Dr Kirkby and the moment when the images from the MRI scan were available was unreasonably long. Trust 1 and Trust 2 also show, again by making three points, which were amplified by Mr Hutton in his oral submissions, that this argument, too, is misconceived.

    i. There is no challenge on this appeal to the Judge's finding of fact about when Dr Kirkby assessed the Claimant. This started the clock for the purposes of the negligence claim against Trust 1. Mr Booth expressly accepted, as he was bound to, that that finding 'might extend the period'. As the Judge recorded, significantly (paragraph 58), there was no allegation of delay in Dr Kirkby's assessment.

    ii. This part of the Claimant's case was seriously undermined by Mr Thorpe's concession in his evidence that this period was 'not unreasonable' in the context. I note that the Judge did not, however, rely on that concession alone (paragraph 75).

iii. In a detailed review of the evidence about each segment of that period (skeleton argument, paragraphs 34-64), they show that there was evidence before the Judge, independently of Mr Thorpe's damaging concession, which entitled her to reach the conclusion that there was no unreasonable delay between Dr Kirkby's examination and the point when images were available.

77. A fourth point which took up some time in oral argument was the Claimant's contention that there were two gaps in the evidence which the Judge should have filled by drawing adverse inferences against Trust 1 and Trust 2.

78. The first gap was said to be a lack of direct evidence of any discussion between anyone in the orthopaedic and radiology departments respectively about the need for an urgent scan in this case. The main evidence about this was Dr McKenzie's hearsay statement, which the Judge decided to admit, subject to weight. The Claimant does not have leave to challenge that aspect of the Judge's reasoning. Dr McKenzie's evidence, unsurprisingly, some time after the event, was about his standard practice in a case such as the Claimant's rather than evidence of what he remembered. That evidence was supplemented by the evidence of Ms Devereux on two relevant points: outpatients were scanned between about 0900 and 1130, and the slot between 1130 and 1400 was reserved for scans of inpatients; and any request for an urgent scan had to be approved by a consultant radiologist. I do not consider that the Judge erred in drawing from that evidence the inferences which she did draw in paragraph 64(ii) and which the Claimant criticises, and in accepting, further, those parts of his evidence which she accepted in paragraph 66.

79. The second gap was what was said to be a lack of direct evidence about the cases of the two patients who were in fact scanned before the Claimant. The Claimant argued that one or other of those patients should have been 'bumped' to make way for the Claimant. All three were scanned, not in the elective list in the morning, but in the in-patient slot in the late morning/afternoon (between 1130 and 1400). There was evidence, which the Judge was entitled to accept, that the person who accorded priority to requests for scans was the radiology consultant, who had to agree all requests for scans. Mr Hutton clarified in his oral submissions that it was agreed at trial that the request for the Claimant's scan was uploaded onto CRIS at 1159. By that time, one of the two patients was already being scanned. She was a gynaecological referral with suspected cancer. It would not have been reasonable to remove her from the scanner in order to replace her with the Claimant. The other patient, who was scanned next, had suspected cord compression. The Judge was entitled to infer, on the evidence which this court was shown, that that patient's case was as urgent, if not more urgent, than the Claimant's. The request for the scan in that case was made earlier than 1159. Mr Booth was asked about this point, and did not go so far as to submit that the only inference which the Judge could draw in relation to the two gaps in the evidence on which he relied (of which this was one) was the inference he contended for, that is, an inference adverse to Trust 1. He complained that there was a gap in the evidence which was 'in the gift' of Trust 1; but that gap was partly a product of the fact that the Claimant's pleaded case was that he should have been scanned significantly earlier. Moreover, the Judge cannot be criticised for not, herself, taking steps to require Trust 1 to fill that gap if the Claimant did not ask her to.

Legal causation

80. The final criticism relates to the Judge's approach to legal causation. This issue does not arise for decision, if I am right that the Claimant's criticisms of the Judge's approach to breach of duty do not show that her conclusions about that were wrong.

81. This issue nevertheless occupied six and a half pages of the Claimant's skeleton argument. The Claimant acknowledges that causation in CES cases is complex, and involves a detailed understanding of the literature, the experts' reports and the clinical records. The Claimant also acknowledges that the critical factor in causation was when permanent bladder failure occurred (skeleton argument, paragraph 46). A page is devoted to showing that the Judge misunderstood the literature. This takes matters no further, as her approach, which she explained, was to focus on a pathophysiological analysis (although she did take the literature into account, for what it was worth). Moreover, as became clear to me in the course of the hearing, the literature does not all point in the direction favoured by the Claimant. Finally, the evidence used in the studies on which the literature is based is not reliable: see *Neurological Deterioration in cauda equina syndrome is probably progressive and continuous. Implications for Clinical Management* Todd, British Journal of Neurosurgery, October 2015, column two page 631, under the heading 'Human Studies'.

82. Paragraphs 49-53 assert that the Judge assessed the expert evidence in a way which was inaccurate and unfair, and 45-59, that her findings about causation 'cannot withstand logical analysis'. There is nothing in the first criticism. The Judge explained adequately why she preferred the evidence of the Respondents' experts.

83. The Claimant makes two main points on causation.

84. First, the Respondents' case about nerve death was not pleaded, only emerged at trial, and was confusing and incomplete. The Respondents' case did not explain why the Claimant had some perianal sensation at 1445 and anal tone between 1050 and 1120. It was not open to the Judge to find the DREs were unreliable. Trust 1 had admitted them. There was no evidence to support Mr Cowie's theory (that bladder autonomic and pain nerve fibres are smaller and more liable to compression than larger touch and motor fibres) by which he sought to explain the Claimant's loss of bladder function but his retention of anal tone and perianal sensation. The Respondents had not pleaded such a case.

85. Second, the Claimant gives four reasons why the Judge's finding that the Claimant had lost bladder function by 1203 was unsound.

    i. The Claimant relies on a supposed distinction in the literature between subjective and objective measures of loss of bladder function.

    ii. The Claimant relies on the Judge's supposed failure to recognise that there is a difference between the loss of the desire to urinate, and the loss of the ability to urinate.

    iii. The Claimant relies on the important distinction between overflow incontinence, which, the literature suggests, is likely to be consistent with death of all or most of the autonomic bladder nerve fibres, and mere urinary retention, which may be consistent with some recovery. Even some patients with retention and overflow incontinence recover,

suggesting that these features are not determinative. That is inconsistent with the Respondents' argument that permanent damage has occurred when there is painless urinary retention, with, or without, overflow incontinence, as Mr Cowie appears to have accepted in his report.

iv. The Claimant complains that the Judge did not address the question whether, with earlier surgery, the Claimant's bowel function might have been better.

86. Trust 1 and Trust 2 do not accept that the case about nerve death only emerged at trial (see paragraph 101 of their skeleton argument, which was amplified in oral submissions). They point out that all three experts agreed that nerve death can occur within six hours of compression. Both the Respondents' experts relied in their evidence on a distinction between somatic and autonomic nerves (skeleton argument, paragraphs 95 and 103). The fact that the Respondents admitted that the DREs had been done says nothing about their significance. Anal tone was not referred to in the experts' agreed definitions. Mr Mannion accepted in his report that anal tone was not, of itself, a reliable marker. Indeed, the Claimant had some anal tone when he was examined at QSH, at a time when, all experts agreed, he was in CESR. The unreliability of anal tone (as tested by a human observer by DRE) as a marker for CESR may in part be because the internal anal sphincter is controlled by the autonomic nervous system, and the external anal sphincter by the somatic nervous system, and the latter may be more resilient than the former.

87. The next issue is whether or not the Judge's finding that the Claimant had lost bladder function is wrong. There is some conceptual confusion in this part of the case, and it is not helped by the ambiguous language of the experts' agreed definitions. However, those definitions have to be read as a whole, and if the experts agreed that executive control of the bladder is a marker of CESI, then by implication, at least, they also agreed that loss of executive control is a marker of CESR. The Judge accepted that overflow incontinence is not often seen now because patients are often catheterised before that happens. That does not, of course, mean that the point at which it would happen, absent a catheter, is irrelevant, as the experts' agreed definition appears to acknowledge. Overflow incontinence (whether actual, or which would have occurred absent a catheter) may, therefore, represent, in most cases, the point of no return. It does not follow that irreversible damage cannot occur before the point at which there is (or absent a catheter, would have been) overflow incontinence. The point at which a catheter was in fact, or might have been, or should have been inserted is not decisive. Loss of executive control means loss of control of the ability to contract the bladder and to relax the sphincter. A person who has lost executive control of the bladder cannot contract the bladder or relax the sphincter, and so cannot urinate voluntarily. An insensate bladder is one which can no longer transmit to the brain a message that the bladder is full. If a patient's bladder is insensate, then, even though, objectively, his bladder is full, that patient no longer has the desire to urinate. The Claimant had reached that point by 1203. Overflow incontinence is, as the Judge found, a secondary marker of loss of executive control (paragraph 91(iii)). It occurs when the bladder is so full that the sheer pressure of the bladder contents overcomes the resistance which is normally provided by the sphincter. When overflow incontinence occurs is a product of various factors, including how much fluid the patient had drunk before and

after the nerve injury. It can therefore occur after the bladder has suffered irreversible damage.

88. The Respondents' argument, which the Judge accepted, was that the Claimant had lost the urge to urinate by 0800, when his bladder would probably have been full enough to make him feel the urge to urinate, had the relevant nerves been working normally, and had a pathologically (not a 'grossly') distended bladder at 1203, and could not urinate when asked to do so. He had, therefore, by 1203, at the latest, lost executive control of his bladder. At least by implication from the experts' agreed position, the Claimant was, by 1203, in CESR. As Trust 1 and Trust 2 point out, Mr Mannion was not able to refer to anything in the literature which supported the proposition that a patient who has lost the desire and ability to urinate is in CESI, and he accepted that the Claimant was in urinary retention by 1203. Moreover, progress to overflow incontinence is influenced by extraneous factors such as how much fluid the patient has drunk before the nerve damage, as Mr Mannion accepted in his evidence (as Trust 1 and Trust 2 point out in paragraph 86 of their skeleton argument).

89. It is nothing to the point that some patients with CESR recover some, or all, of their function. The Judge had to decide what would have happened on the balance of probability, and that is what she did.

90. Trust 1 and Trust 2 do not accept that the inability to feel an urge to urinate when the bladder is full, and an inability to urinate with a full bladder when asked to, are 'subjective' signs. Objectively, a patient with those symptoms is in urinary retention. While it is true that overflow incontinence is incontestably objective evidence of CESR, it is a marker for something else, which may have happened long before overflow incontinence, that is, the death of the relevant nerves.

91. Finally, Trust 1 and Trust 2 point out that in the presentation of the case, there was no emphasis on bowel function. Bowel function is harder to test, and to evidence, for obvious reasons. The Judge cannot reasonably be criticised for not adverting to this topic in her judgment.

92. For those reasons, I accept that Trust 1 and Trust 2's responses to these two criticisms (skeleton argument, paragraphs 76-112, as amplified in Mr Hutton's oral submissions) are a sufficient answer to them. They are supported, where they overlap, by the submissions made on behalf of the GP.

Conclusion

93. For the reasons I have given, I would dismiss this appeal. I add two things. First, having read, heard, and reflected on, the detailed attack on the judgment in the Claimant's written and oral submissions, and the response to that from the Respondents, I not only consider that the decision which she made was one which was open to the Judge, but that it was the right decision. Second, I agree with all the Respondents that this is not a case of wider general public importance. It is, of course, very important to the Claimant. But it turns on its own facts.

LORD JUSTICE NUGEE :

94. I agree.

LORD JUSTICE DAVIS :

95. I also agree with the judgment of Elisabeth Laing LJ.

96. We were told that, so far as is known, this was the first case directly relating to the treatment of CES which has come before the Court of Appeal. But that does not mean that it raises issues of principle of general application. In fact an appellate court, a court of law, often may need to be careful to avoid making generalised pronouncements on the obligations of doctors in medical situations. What is ordinarily required, in each case, is consideration of whether the responses and procedures actually undertaken in a given medical situation fall outwith the range of reasonable and logically justifiable responses and procedures, applying the *Bolam*/*Bolitho* principles, on the facts of the individual case.

97. The present grounds of appeal are directed at the judge's primary findings of fact and her evaluation of the facts. Regrettably, they in my view fall foul of virtually all the warnings and prohibitions contained in the various recent authorities, as most recently summarised in *Perry*. The selected quotations and citations from the evidence and literature advanced in his most careful and thorough submissions by Mr Booth QC, for example, thus in turn were matched – more than matched – by the counter-quotations and citations in their no less careful and thorough submissions by Mr Antelme QC and Mr Hutton QC. In fact the overall impression conveyed to me, from the arguments, of island hopping in the whole sea of evidence caused me at stages also to wonder (changing the geographical allusion) if Mr Booth was sailing in the Pacific Ocean while Mr Antelme and Mr Hutton were sailing a parallel course in the Atlantic Ocean.

98. As I see it, the judge is to be commended for getting closely to grips with the totality of the evidence and in making, in her careful reserved judgment, a thoroughly rational and cogent appraisal of the evidence. The criticisms of her judgment in the Grounds of Appeal and supporting arguments demonstrably are not made out: indeed some of the criticisms in my view should never have been made in the first place (although in fairness Mr Booth himself, who had not appeared below, wisely moderated at least some of them). It rather troubled me that the appellant's submissions at stages seemed to come close to advocating an approach in effect requiring a counsel of perfection, bordering on strict liability: a long way away from the yardstick of reasonableness.

99. I am, speaking for myself, most surprised, given the circumstances, that the claim against the GP was pursued at all. (I say this irrespective of the, in itself conclusive, causation finding of the judge, having regard to the evidence of Mr Langdon.) As to the claim against Trust 1, the judge's findings both on liability and on causation, on her appraisal and evaluation of the evidence and which appraisal and evaluation were properly and reasonably open to her, are unassailable in the appellate court.

100. Obviously the overall outcome here is very unfortunate for the claimant. But sympathy cannot determine the proper outcome for this legal case. Therefore I agree that the appeal must be dismissed.