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Case No: QB-2021-000895

**IN THE HIGH COURT OF JUSTICE**  
**KINGS'S BENCH DIVISION**

Royal Courts of Justice  
Strand, London, WC2A 2LL

Date: 1 August 2023

**Before:**

**HER HONOUR JUDGE CARMEL WALL sitting as a JUDGE OF THE HIGH COURT**

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**Between:**

**OXR**  
**(a Child BY HIS FATHER AND LITIGATION**  
**FRIEND, IXR)**  
**- and -**  
**MID AND SOUTH ESSEX HOSPITAL NHS**  
**FOUNDATION TRUST**

**Claimant**

**Defendant**

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**Ms R. Marcus** (instructed by Fieldfisher LLP) for the Claimant  
**Dr P. Ellis** (instructed by Kennedys LLP) for the Defendant

Hearing dates: 14, 15, 16 June 2023  
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**APPROVED JUDGMENT**

**This judgment was handed down remotely at 10.30 am on 01 August 2023 by circulation to the parties or their representatives by e-mail and by release to the National Archives.**



**Her Honour Judge Carmel Wall:**

**Introduction**

1. OXR was born on 8 May 2011. He is now aged 12. When he was aged five, he did what many other children do. He inserted a foreign body into his ear. His mother did what other responsible parents do in that situation. She sought medical help. This trial has been concerned with whether the surgery that followed on 4 April 2017 was negligently performed.
2. In October 2022 OXR and his family received devastating news. OXR was diagnosed with alveolar rhabdomyosarcoma of the right forearm. He has undergone intensive treatment and there is optimism though uncertainty as to his prognosis. In view of this very recent change in his circumstances, although this trial was intended to address all issues of liability and quantum, I have ruled that it will now be concerned with issues relating to breach of duty and causation; and if appropriate, the assessment of past losses, an interim general damages award and the assessment of the multiplicand on which future losses are to be calculated. The final determination of general damages and determination of the multiplier which both depend on greater certainty regarding OXR's life expectancy stand adjourned.

**The Factual Background**

3. The factual background is not disputed.
4. On the morning of 3 April 2017, OXR reported to his mother, that he had put something into his ear. She could see an object in his right ear which she initially thought might be a piece of lego because that was what OXR had been playing with. She contacted her General Practitioner who advised her to take OXR to a hospital accident and emergency department.
5. OXR arrived at Broomfield Hospital's Accident and Emergency Department around 11.00am. He was seen by the triage nurse who recorded at 11.56am, "with mum. Inserted small piece gold lego triangle into R ear. Just visible at triage..."
6. Dr Win, an ENT Senior House Officer ("SHO") was called and reviewed OXR at 13.00. He recorded the history as "Child put ?toy found on floor in bedroom in his ear at 10am. Bit painful now. No discharge."
7. On examination Dr Win noted a yellow semi-translucent foreign body in the right ear canal. He noted that at that point it was obstructing half of the tympanic membrane. He recorded "? Plastic". He observed "some trauma seen in floor of ear canal with dried blood."
8. Dr Win attempted removal of the foreign body using a wax hook, crocodile forceps and suction but this was causing discomfort to OXR who was unable to tolerate it further.
9. The diagnosis recorded by Dr Win was "?plastic foreign body in right ear". His treatment plan was to administer Sofradex drops and then to re-attempt removal of the foreign body.
10. While waiting, OXR was comfortable and fell asleep.

11. At 14.50 Dr Win made a further attempt to remove the foreign body. The clinical notes record “appears bead-like/semi precious stone? Mother states she had a beaded bracelet which snapped. Thought she had hoovered all pieces.”
12. Although OXR’s mother thought that she had not provided this information until after the object had been removed, she conceded that she might have been wrong in that recollection about timing. As Dr Win could not have recorded this information unless it was provided at the time, she must have said this to the SHO at that early stage.
13. Dr Win used crocodile forceps and suction in further attempted removal but OXR could not tolerate this. The notes record “pt anxious/unable to stay still”.
14. No criticism or allegation of breach of duty is made with respect to these attempts by the SHO to remove the foreign body.
15. Dr Win then had discussions with Mr Jain, the ENT Specialty Registrar. It was decided that OXR would need emergency surgical intervention the following day. His parents consented to surgery with the risks identified as “bleeding, tympanic membrane perforation, general anaesthesia risks”.
16. The nursing note timed at 15.30 records “S/B ENT. Unable to retrieve ?lego piece. To come back to Phoenix @ 0730 on 4.4.17 for G. A.”
17. OXR was sent home, to return to hospital on 4 April 2017 for emergency surgery. He continued with the ear drops overnight. He was comfortable and slept well.
18. Although OXR’s parents were surprised that he had been discharged overnight, there is no dispute that this was appropriate management.
19. On 4 April 2017, OXR returned to Broomfield Hospital for surgery.
20. A record made following the ward round at 09.15 records “child placed ?gem stone in Rt ear yesterday. O/E: wax coloured ?gem stone deep in Rt ear canal”.
21. The surgery to remove the foreign body was undertaken initially by Mr Jain. Mr Jain was not able to remove the foreign body. He sought assistance from Mr Puvanendran, a Consultant ENT Surgeon who was operating in an adjacent theatre.
22. Mr Puvanendran removed the foreign body which turned out to be a gold coloured translucent piece of glass – probably a fractured glass bead. Its overall shape was similar to a wedge with rounded and also angled sides coming to a sharp point like a shard. On measurement its dimensions are agreed to be 8mm in length (at its longest point), 6mm at its widest point and 3.5mm deep but it is irregular in shape. I have had the chance to see and feel it during the trial.
23. It is common ground that while in theatre, OXR sustained a tympanic membrane perforation and disruption to the entire ossicular chain (the three connecting bones in the ear). The oval window (base of the stapes bone) was partially sheared off and there appeared to be leakage of the perilymph.
24. After removal of the foreign body, Mr Puvanendran discussed the need for an urgent surgical repair with OXR’s parents. They gave consent to an ossiculoplasty which Mr

Puvanendran then carried out. No criticism is made of the repair. Both experts regard it as having been carried out to a good standard.

25. The relevant parts of Mr Puvanendran's operation record are as follows:

- Diagnosis: (1) fb [foreign body] (glass) in right ear  
(2) ossicular disruption/oval window breach
- Findings: (1) Glass in EAC [external auditory canal] (Right)  
(2) TM –[tympanic membrane] perforation – reconstructed w TF [temporalis fascia] graft  
(3) ossicular disruption – malleus in EAC )  
Incus displaced ) repositioned  
Stapes displaced )
- (4) oval window ruptured – muscle patch over window
- Procedure (1) Fb removal – manipulated – v. difficult wedged (VJ) [Vineet Jain]  
On removal TM disruption noted  
Malleus in EAC  
...  
(3) End aural incision  
(4) ... TM in shreds  
...  
(6) Ossicular discontinuity noted  
- stapes displaced footplate not over oval window  
Oval window breach noted  
(7) muscle patch and blood over oval window – stapes repositioned  
(8) incus and malleus repositioned – Spongostan to maintain position  
...  
(10) Tf graft for TM reconstruction  
...

26. OXR's parents were warned that it was likely that OXR would suffer hearing loss. This was understandably shocking and distressing news for them. OXR was kept in hospital overnight and discharged the next day with follow up appointments arranged.
27. OXR suffered with poor balance in the immediate aftermath of surgery and was not able to attend school. When reviewed on 24 April his balance was improving.
28. At his next follow up appointment on 22 June Mr Puvanendran referred OXR to the regional otology specialist, Miss Elina Kiverniti, in Harlow. He had no further involvement in OXR's care.
29. Miss Kiverniti advised that OXR should have a hearing aid trial and discussed further surgical options. His parents sought a second opinion and were referred to Mr Jeremy Lavy at the Royal National Throat, Nose and Ear Hospital.
30. Mr Lavy undertook further surgery to OXR's ear on 18 September 2018. Although it was intended this would improve OXR's hearing, unfortunately it failed to do so.
31. OXR now has permanent conductive hearing loss in his right ear. He needs to wear a hearing aid. It is common ground that this damage was caused by the injury to the ossicular chain which occurred while OXR was in theatre.
32. The principal issue in this trial is whether the Claimant has proved on the balance of probabilities that the injury he sustained in theatre on 4 April 2017 was caused by a breach of duty on the part of either surgeon, while attempting to remove and/or removing the foreign body from his ear.

### **The Evidence**

33. I have heard live evidence from OXR's parents. I have no doubt that they have given truthful evidence reflecting their genuine recollection of events and also the progress that OXR has made since surgery. However, they are recalling matters from over six years ago. Their recollection of the detail of conversations during a particularly stressful period is unlikely to be reliable and neither counsel attached weight to this evidence in their closing submissions. Where their evidence conflicts with contemporaneous notes I prefer the latter. On one minor issue (whether Mr Puvanendran brought out the malleus from OXR's ear to show it to OXR's mother in non-sterile conditions before re-inserting it into his ear) the evidence of OXR's mother is inherently unlikely and I reject it for that reason.
34. Both OXR's parents have the clear impression that the level of his hearing impairment has changed over time. The agreed expert evidence is that OXR sustained conductive loss which has not changed since initially sustained. The suggestion that he suffered sensorineural damage and/or more significant impairment has arisen due to rogue audiometry.
35. It is notoriously difficult to obtain accurate hearing test results from a young child. It is also extremely difficult for parents to make an objective assessment of the quality of their child's hearing and whether it has changed. Although I accept the genuineness of OXR's parents' belief, I prefer the objective view of the experts that his hearing loss has remained constant since initial surgery.

36. I do accept the evidence of both OXR's parents that OXR experienced a loss of confidence following injury. This was due to his hearing impairment and the need to wear a hearing aid that was visible to others, including his peers. This affected his social engagement at an important age. Both fairly conceded that his late diagnosis of severe dyslexia also played a part in the difficulties he experienced at school and with his peers.
37. Mr Puvanendran gave live evidence of his role in undertaking OXR's surgery.
38. I found him to be an impressive witness - composed, thoughtful and reflective. He was willing to make concessions where appropriate and listened carefully to the questions he was asked and did his best to address them directly. He took care to focus on what he had personally seen and felt during the operation and took appropriate responsibility in his evidence for the procedure he had undertaken. He did not seek to place blame on others, even when offered the opportunity to do so.
39. I accept that what he told me was his honest and best recollection of what had happened in theatre. He accepts as is inevitable that his recollection of what happened over six years ago is now not as clear as it was previously and much of his evidence has, for that reason, been based on his normal practice and contemporaneous notes.
40. There is no evidence from Mr Jain; nor is there evidence to explain his absence from this trial. The operation record was completed by Mr Puvanendran after the repair was done. The only reference to Mr Jain's involvement in the Operation Record is the recording of his initials after "manipulated - v. difficult wedged". I accept from Mr Puvanendran that this represented the point at which Mr Puvanendran took over the operation.
41. I have considered written reports and heard live evidence from Mr Shaida, Consultant ENT Surgeon and expert instructed by the Claimant and Ms Heathcote, Consultant ENT Surgeon and expert instructed by the Defendant.
42. Both experts are well qualified to give evidence in this trial albeit Mr Shaida conceded during the course of cross-examination that providing expert evidence is not a substantial part of his professional work.
43. I did not find either of them compelling overall. Each had changed their initial view on significant issues without offering cogent reasons for doing so.
44. Mr Shaida had resiled from his initial view that to push the object further into the ear canal and to perforate the tympanic membrane (the first two allegations of negligence in the Particulars of Claim) were indicative of a breach of duty. His explanation for his change in opinion indicated a flawed application of the *Bolam* test. He was also vulnerable to challenge on the grounds that he had sought the views of unidentified colleagues and allowed them to inform his opinion on breach of duty.
45. Ms Heathcote had changed her opinion about the timing (and therefore likely mechanism of injury). Her original opinion had been that the tympanic membrane perforation and some damage to the ossicles had occurred prior to theatre. By the time of the joint statement she agreed that these events had occurred in theatre. When challenged about why she had changed her mind on this significant issue she relied on

Mr Shaida having very strong views about this issue, rather than a change in factual matrix or persuasive objective factor that had influenced her. In another part of her evidence, when pressed about why she did not believe Mr Puvanendran had put his instrument into the middle ear during surgery, her explanation was that it was because of his senior grade and surgical experience. This demonstrated a circular and self-fulfilling approach to the evidence. It suggested she had approached the evidence without a truly open mind about what probably happened.

46. Both experts unfortunately had an additional and unexpected difficulty to deal with at trial. By reason of inadvertence, the Claimant's solicitors had overlooked the fact that they had been given the foreign body by OXR's parents at a very early stage of the litigation. It had not then been disclosed until shortly before trial and was the subject of an application to admit it into evidence, heard on the morning of the first day. This put both experts at a disadvantage. Until trial, they had only seen a photograph of the foreign body and not examined the object itself. They could not measure it or feel its texture or carry out any experimentation on it until trial. Although some time was given for a short further agenda to be discussed, I recognise that the timing of this disclosure was likely to cause them difficulty.
47. For all these reasons I have not therefore been able to adopt without reservation the entire opinion of either expert. My approach has been to focus on the specific issues I must decide and then consider, where they differ, whether an expert's opinion on that particular issue has logical coherence and should be accepted.
48. I have also read the hearsay statement of Sylvia Ruck and the evidence of experts in educational psychology (Dr Pugh and Dr Abeles) in the trial bundle. It is common ground that the Claimant now has a diagnosis of severe dyslexia that has had a significant impact on his academic performance in relation to his peers. This evidence has proved not to be controversial for that reason.

### **The Issues**

49. The experts agree and it is common ground that the damage to the tympanic membrane and ossicular chain occurred in theatre and not as the object was inserted or removal attempted before surgery. The timing of the injury is no longer in issue.
50. The key issues for me to decide are, on the balance of probabilities:
  - a. Does the Claimant prove the mechanism of injury on the balance of probabilities?
  - b. If so, does the Claimant prove a breach of duty on the part of either Mr Jain and/or Mr Puvanendran?
51. If breach of duty is established, causation of injury is not challenged. I must then decide the quantum of damages for past losses, an appropriate interim level of general damages and the assessment of the multiplicand for future losses.



What was the mechanism of injury?

52. The live factual evidence on this issue comes only from Mr Puvanendran, the consultant surgeon who removed the foreign body. There is no evidence from Mr Jain about what occurred or what he did during the initial stages of the operation before he sought help.
53. There is some contemporaneous evidence in the operation record completed after the removal of the foreign body and ossiculoplasty.
54. Mr Puvanendran says that after being called in to assist, he would have obtained from Mr Jain a history and information about the foreign body. He understood that from the history taken and Dr Win's examination, it was thought that the foreign body was most probably a gemstone or bead but that it was not possible to be definitive until the object had been removed. Although he accepted this was not recorded in the operation record, it was information he would have sought and been given before embarking on the removal of the object. I accept that account. Mr Puvanendran's understanding was consistent with Dr Win's examination and the likely scenario suggested by OXR's mother and recorded in OXR's notes.
55. Ms Heathcote places reliance on the surgeon having believed that the object was apparently rounded and without sharp edges. Having heard Mr Puvanendran's evidence I do not consider that fairly represents his thought process. While he may not have anticipated that the foreign body would have a very sharp, shard-like point, he does not suggest that he proceeded on the basis of assumption about the shape of the foreign body being the same all the way around. When challenged on the basis that it had not been positively stated anywhere in the notes that the object was a bead he said, "I don't know. Nowhere does it state that. I don't know if it is possible to state that until the object has come out." Similarly, when pressed about why he might have used forceps to try and grab the object, Ms Marcus asked, "Given that you used forceps, you didn't think that this was an entirely rounded, spherical object?" His reply was, "I didn't know is the honest answer. I think there was an object there, it looked curved, it looked rounded, and it is a reasonable thing to try and grasp it with a set of forceps. I can't ascertain the other end of the object because I couldn't see it".
56. I have no evidence from Mr Jain as to whether he made any unwarranted assumptions when attempting surgical removal.
57. Mr Puvanendran described the foreign body as filling the whole auditory canal and obscuring his visibility. He said he was able to get an instrument alongside it only by pushing gently into the soft tissue of the auditory canal which had a small amount of give.
58. Ms Marcus argues that his operation record does not expressly refer to the object filling the entire auditory canal. It describes the removal of the foreign body in these terms "Fb removal – manipulated – v difficult wedged (VJ)". The reference to "VJ" was to Mr Jain. Mr Puvanendran said he had found the object to be wedged when he was first called into theatre. Mr Puvanendran told me and I accept that his reference to "wedged" was intended to convey the idea that the foreign body was filling the canal and he could not see beyond it. I accept his evidence on this point for the following reasons.

59. It is not possible to know the width of OXR's auditory canal. Data in literature produced by both experts about the average width of a young person's auditory canal was not sufficient, as they both acknowledged, to predict this with any confidence.
60. The auditory canal is oval and not round. The foreign body is wedge shaped with some roundness on one face. If placed into a scale model of OXR's ear it is likely that there would be a view behind it towards the middle ear. But that is not a reliable tool to predict the visibility for the surgeon at the time that Mr Puvanendran was called into theatre. At 13.00 on 3 April when Dr Win first attempted removal of the foreign object he noted only 50% of the tympanic membrane was visible. There was then a second attempt at removal by Dr Win at around 14.50 on 3 April and some attempt at manipulation and removal by Mr Jain on 4 April in theatre, the extent of which is unknown. Mr Puvanendran's description of the tissue around the auditory canal being swollen; and blood and debris obstructing his view is a likely scenario. It accords with Ms Heathcote's evidence that on every movement within the auditory canal by this stage, more blood would have been produced. Mr Shaida agreed that if Mr Puvanendran said that the canal was completely occluded so that he had no visibility beyond, there was no evidence to rebut that position.
61. Mr Puvanendran told me that his standard practice when attempting removal of a foreign body would be to use a forceps, a wax hook and the blunt rounded end of a Jobson Horne. He has a recollection of using forceps and a wax hook in this operation but is unsure if he also used the Jobson Horne. His post-operative notes do not help on this particular issue. Mr Puvanendran frankly conceded that his recollection now about the order in which he used instruments is affected by the passage of time.
62. He described his technique as running the wax hook alongside the visible edge of the object, passing it around the back, rotating his hook through 90 degrees and attempting gentle manipulation of the object. The questioning from Ms Marcus went as follows:
- Q: Just to be clear, you say you ran it down the side of the object?
- A: That's correct.
- Q: And then rotate the hook so it's behind the object?
- A Behind the object. Or any available purchase. So, as you pass it along you will feel the object given how tight everything is, and if you feel somewhere where it will grasp, then you would use that to try and manipulate it.
- Q: You're saying that where the ear canal soft tissues are swollen you say that you would essentially be doing this blind and by feel?
- A: yes, that's correct.
- ...
- Q ... you would have repeated that same procedure ...multiple times passing the instrument beyond the back of the foreign body?
- A It's correct, you would ... pass the instrument at different places around the object as well. What you are trying to do is trying to manipulate the object in such a way that you

can remove it and generally speaking, going in the same place repeatedly is unlikely to remove it.

Q Then you are using the hook to pull the object out?

A Yes.

63. Mr Puvanendran was asked about whether he had considered alternative techniques, namely an end aural incision or mastoidectomy, both of which were invasive procedures. His evidence is that he was aware of the options available but “you have to know the choices that you can make, and then you take the choice – or you pick the choice that you think is best and, as long as things are continuing to progress with that choice, then there is no need to do anything more invasive. So, certainly, I was aware of the options but as the object was moving and I was able to manipulate it, then we carried on in that vein.”

64. Mr Puvanendran’s evidence is that it was only after removal of the object that he became aware that the tympanic membrane had been ruptured and the ossicular chain had been disrupted. He described seeing the tympanic membrane in shreds and that the malleus had flopped into the external auditory canal. I accept that evidence. It is consistent with his surgical note which states “on removal TM disruption noted malleus in EAC”.

65. His clear and consistent evidence is that at no point during the procedure was he aware of any sensation that was suggestive of him rupturing the tympanic membrane or disrupting or damaging the ossicles. He said, “You would feel the tympanic membrane -- again, you would feel the tympanic membrane rupture if you were pushing against it and it is intact with a blunt object. If the object has either gone through it or the object has made the initial breach into the tympanic membrane, now the tympanic membrane doesn't have the rigidity that it would normally have. So suddenly going through it at this point, you've already made a hole. The foreign body has made a hole already, so the resistance will be different.”

66. When asked about the process by which the malleus becomes detached from the tiny ligaments and joints holding it in place, the questioning from Ms Marcus continued:

Q: It is right, isn't it that if you pull against those ligaments – those attachments or push against those attachments you will feel resistance?

A: You should do, yes.

Q: So, whether you push or pull against them, you will feel that resistance?

A: Yes, that's correct.

Q: are you saying that you did or didn't feel that resistance when you were pulling – when you were using your instruments?

A: I did not feel – I do not know how much force is required to remove the malleus from a child. I have never done so and I cannot find any literature regarding this. But I did not feel any untoward force or pressure when removing the foreign body.

Q: You told us that if you push or pull against the attachments holding the malleus in place you would, as an ENT surgeon expect to feel the resistance?

A: You'd feel something, yes.

Q: If you feel that resistance?

A: Then you would stop.

Q: Is it right to say that you did not feel that resistance?

A: That is correct.

...

A: If I had any inkling that the ossicles were involved ...then I would have stopped the procedure completely and referred on to the specialist.

Q: .... You have already told us you don't need to see the ossicles to have an inkling that the ossicles might be involved. It would also be the resistance that you would feel?

A: That's correct.

Q: From the attachments of those ossicles?

A: Any concerns, yes, that's correct.

67. I asked Mr Puvanendran about the sensation he felt during the surgery as follows:

J: Do you recall, during the course of the operation, what you felt in terms of the membrane?

A: I didn't feel resistance from the membrane.

... If I'd felt resistance I would have changed my approach.

68. I accept that he was alive to the possibility of using a different approach if he felt that the removal was not progressing with gentle manipulation. I accept his evidence that he did not feel any resistance to indicate risk to the ossicular chain and that if he had done so, he would not have continued but would have considered other options.

69. His evidence is that he was not able to see beyond the object until it was removed when he became aware for the first time of the injury to the ear. He believed the damage might have been caused because the tip of the object was sitting between the ossicles before removal so that the manipulation of it might have twisted the ossicles, disrupted them and partially displaced the stapes footplate. That was what he told OXR's parents when giving them a simple explanation that was intended to convey that impression to a lay person. However, his belief as to the mechanism of injury, though honestly held,

was supposition on his part. At no time did he see the object lodged in the ossicles; nor did he see the position of its distal tip in relation to the tympanic membrane or ossicles. It was only after removal that he was first able to see the malleus lying in the external auditory canal attached to the torn tympanic membrane as his operation record describes.

70. There is no evidence from Mr Jain as to the level of visibility he had during the first part of the operation. There is no evidence about what, if any, resistance he felt when using his instruments and trying to remove the foreign body; or even whether he thought he had caused damage to the ossicles during his attempts at manipulation.

#### *Expert evidence*

71. Both experts, Mr Shaida and Ms Heathcote have expressed their respective opinions on the mechanism of damage.

#### Mr Shaida

72. Mr Shaida's opinion set out in the joint statement and confirmed in his oral evidence is that the most likely mechanism of injury is that a surgical instrument, the wax hook, passed into the middle ear and then came into direct contact with the ossicles, most probably hooking the malleus and pulling it laterally, so that the malleus and the remainder of the ossicular chain were disrupted by the direct use of an instrument and not indirectly by the movement of the foreign body itself.
73. In his first report he first considered the mechanism of injury at paragraphs 7.6 – 7.8. This was in the context of his belief that the surgical notes indicated that the foreign body was wedged against the ossicles. This was not correct. Nowhere in Mr Puvanendran's notes does he say that he saw this or was aware this was the position and it is not his evidence. He has consistently said that he could not see beyond the foreign body until after its removal. His belief about the position of the object's distal tip being within the ossicles is conjecture.
74. Predicated on that misunderstanding, Mr Shaida suggested possible scenarios for the damage to have occurred – that Mr Jain pushed the object further in and dislodged the ossicles (para 7.8); or that during attempts to remove the foreign body the wax hook caught on the ossicles and pulled them out (para 7.8). As Dr Ellis observed, these suggested mechanisms were both expressed as possibilities and not probabilities.
75. Mr Shaida considered the mechanism of injury further at paras 7.10 – 7.12 of his first report. He considered it unlikely that the damage was done by OXR on insertion or during attempts at removal in outpatients. His view was that the likely scenario was that the foreign body was pushed deeper during surgery during attempts at removal. Once it was found to be wedged against the ossicles, as he erroneously believed to be case, then the removal of the malleus (with damage to the incus and stapes) was caused at this time (para 7.12). He did not expand on precisely how that was likely to have occurred.
76. In the joint statement his position on mechanism of injury crystallised and was clarified in answer to question 5. His opinion (and where he disagreed with Ms Heathcote) was that the foreign body could not have caused the avulsion of the malleus. This was

because “According to Mr Puvanendran’s statement the malleus had been pulled laterally (towards the outside) and was lying in the ear canal. To pull the malleus laterally would require something to be hooked behind the malleus and pulled outwards. This could not be done by the foreign body as it does not have anything to catch the malleus. In addition excessive force would be required to pull the malleus out from its attachment to the eardrum and the ligaments that anchor it, and also to pull out the incus and stapes that the malleus is attached to. It is likely that the instrument used to try and remove the foreign body ie a wax hook was pushed past the bead to try and hook it out, the wax hook was pushed too deeply and caught on the ossicles and then was pulled with excessive force so the ossicles were pulled out.”

77. When Mr Shaida gave his oral evidence he was made aware, through cross-examination, that his belief that the surgeon noticed that the foreign body was wedged against the ossicles was not correct. He also, importantly, had the chance to examine the foreign body itself.
78. Following examination and measurement of the foreign body Mr Shaida’s conclusion was that the foreign body must have gone into the ear canal with its long edge longitudinally against the side of the auditory canal and the tip facing inwards. Even allowing for the uncertainty in the assessment of the size of OXR’s auditory canal, the foreign body could not have been inserted crosswise because it would not have fitted, even on a generous estimate of the width of the auditory canal.
79. The experts agree that the distance between the eardrum and the bone on the inner part of the middle ear is 2 – 3mm. They agree that therefore the furthest the foreign body could have been pushed into the middle ear was 2 – 3mm because it did not penetrate further. At least 5 – 6mm of the object would still have been within the external auditory canal.
80. Mr Shaida’s view was that the object could not have been manipulated into a position whereby the sharp tip of the wedge was behind the malleus or in the gap between the malleus and incus. That was because of the shape and dimensions of the foreign body and the position of the foreign body, lying longitudinally and constricted by the auditory canal, relative to the malleus, sitting with its handle pointing slightly inwards. Mr Shaida’s explanation was that as the foreign body was rotated by the surgeon, it might have pushed the malleus handle to the side and inwards but could not displace it outwards. Further, the movement of the foreign body could not cause the top of the malleus to pivot outwards because the top of the malleus is constricted by bone in the attic area of the middle ear. Thus, Mr Puvanendran’s observation of the malleus having come out laterally or “flopped” in the external auditory canal, confirmed in his oral evidence, was not consistent with the foreign body itself having caused the damage when manipulated during attempts at removal.
81. Instead, the most likely scenario was that the damage was caused through direct contact between a surgical instrument and part of the ossicular chain – either through a single sharp movement pulling on the malleus, or a slow pull on the malleus causing the chain to break at its weakest point, or possibly involving initial direct trauma to the incus and stapes caused in multiple attempts to remove the foreign body that initially weakened the chain. It was not possible to know which of these possibilities had occurred.

82. However, when the instrument came into contact with the ossicular chain in any one of these scenarios, Mr Shaida's view was that the surgeon would feel the resistance of an intact ossicular chain. If Mr Puvanendran was able gently to manipulate the foreign body as he described and remove the object but did not feel resistance from the ossicles when he did so, Mr Shaida's explanation was that the damage to the ossicles and detachment of the malleus was done before Mr Puvanendran took over in theatre.

### Ms Heathcote

83. At the time Ms Heathcote wrote her first report, she believed that the tympanic membrane perforation had occurred before the examination under anaesthetic (see para 9.01.04). Her position on this changed after her discussions with Mr Shaida.

84. Prior to that, her view was that the damage was inevitable because of the position and nature of the foreign body. She believed that some dislocation of the malleus was likely to have occurred prior to surgery so that when the object was removed, further disruption followed because the ossicular chain was already weakened. "I felt that going in – an object goes in and it causes some disruption, and an object comes out and it causes more disruption."

85. By the time of the joint statement, she agreed with Mr Shaida that on the balance of probabilities the damage to the tympanic membrane had occurred in theatre and not before. Her opinion at the time of making the joint statement was that it was the sharp end of the foreign body that had perforated the tympanic membrane and caused dislocation of the malleus and not a wax hook, albeit she no longer maintained her initial view that the object had caused damage to the membrane and ossicular chain when inserted or before surgery.

86. When she gave oral evidence she said that having examined the foreign body she was more firmly of this view. Despite having agreed that on balance, all of the damage had occurred in theatre (so that no damage had been done as the object was inserted or manipulated prior to surgery), she remained of the view that the damage to the ossicles was more likely caused by the object itself being manipulated and not directly by a surgical instrument. She suggested that the foreign body, on being pushed in, had gone between the malleus and incus, putting strain on the joint, possibly rupturing the joint, and then when rotated, had brought the malleus outwards as the object was pulled out. Once the malleus handle came out with the tympanic membrane, the ligaments supporting the head would be disrupted. She agreed the malleus was enclosed in the bony attic restricting its movement. She suggested that the movement of the foreign body might have been a pivot which could cause the malleus to move laterally when attached to the tympanic membrane. That was why she said it had come out laterally into the auditory canal without being pulled.

87. She accepted that the position in which Mr Puvanendran found the foreign body meant that it had to have moved laterally towards the surgeon rather than having been pushed inwards. She did accept it was a possibility that the damage was done by one of the surgeons pulling against the malleus and pulling it out; and she agreed that Mr Shaida's theory that the damage was caused by the use of a wax hook was possible.

88. When I asked Ms Heathcote why, between the two possible mechanisms of damage she believed it was more likely to have been damage caused by manipulation of the foreign

body rather than direct contact with a surgical instrument, she said “Because of the grade and skills of the surgeon involved and his experience and that he would have been operating his instruments in the ear canal and not in the middle ear.”

89. Ms Heathcote’s opinion was that on examination of the foreign body and in attempting to manipulate it with a wax hook, there were striations about 1.5mm from the front face that were the only point of traction beyond the front face. She believed that Mr Puvanendran would have caught that edge rather than having his instrument further back because he could not have achieved any purchase to rotate the foreign body from a point further back into the auditory canal.
90. When asked about whether Mr Jain might have caused the damage with a wax hook, Ms Heathcote said she believed if he had done so, he would have taken the foreign body out with the malleus and he had not in fact been able to remove it.
91. Her view was that if a surgeon was working without visual feedback because the object was obstructing his vision of the tympanic membrane and ossicles, the haptic feedback the surgeon would experience from the increased level of resistance from contact between the object and the structure would be so tiny it would not be discernible when compared with the force needed to move the foreign body.

**Findings as to mechanism**

92. I find that the disruption to the tympanic membrane and ossicular chain occurred in theatre before Mr Puvanendran was called to take over the operation. I find that on the balance of probabilities it occurred while Mr Jain was attempting manipulation and removal of the foreign body.
93. I find that before the ossicular chain was disrupted, the operating surgeon would, on the balance of probabilities, have felt resistance from the ossicles before the point of damage. Mr Puvanendran did not feel this resistance. Either Mr Jain did not notice he was experiencing resistance from the intact ossicles before causing damage; or he was aware of the resistance but continued regardless.
94. I find that on the balance of probabilities, the damage and disruption to the ossicular chain (including avulsion of the malleus) was caused by Mr Jain making direct contact with the ossicles when using a wax hook and not indirectly due to contact between the foreign body and the ossicles during manipulation. It may have occurred as the result of one or more than one contact. There may have been some initial contact to weaken the chain at some point beyond the malleus but it is more likely than not that Mr Jain pulled the malleus out of position with his surgical instrument.
95. Having already been separated from its anchoring ligaments and joints, the avulsed malleus and the disruption to the other ossicles and associated damage was only visible in the auditory canal after the foreign body was removed. The foreign body was occluding the auditory canal and completely blocking Mr Puvanendran’s view until it was removed.
96. In making these findings I find Mr Shaida’s explanation of the likely mechanism of damage to be more logical and likely.



97. I found his explanation of the relative positions of the foreign body and the ossicular chain (taking account of the dimensions of the foreign body and the capacity of the auditory canal and middle ear), and the likely direction of movement of the malleus if pushed by the foreign body to be logical and persuasive. The competing suggested possibility (that damage occurred because the tip of the foreign body was sat between the malleus and the incus), conceded in cross-examination to be speculative, is much less likely because I am not satisfied it sufficiently explains the lateral movement of the malleus. Ms Heathcote suggested that manipulation of the foreign body from near to its front face might have caused it to pivot into the ossicles. But because of the dimensions and shape of the foreign body, particularly the width at its widest point (6mm) relative to the auditory canal, that sort of sideways movement is unlikely, as Ms Marcus argued.
98. My conclusion is that Ms Heathcote's suggested mechanism has been substantially influenced by her initial view (from which she departed in the joint statement) that damage was caused to the malleus before theatre. That initial view was based on her impression that the object did damage to the ossicular chain on the way in and so would have done similar further damage on the way out.
99. My impression was that other parts of Ms Heathcote's evidence were developed to fit with her theory, rather than being approached on a completely open-minded basis. Thus, she suggested that notwithstanding Mr Puvanendran's own view (that he would have felt resistance if he was responsible for rupturing the tympanic membrane or damaging an intact ossicular chain), that he probably would not have felt those forces; and that he would not have had his instrument as far back as the middle ear because of his experience and expertise rather than because of anything he described about how his part of the operation had proceeded.
100. I found her explanation of why the damage could not have been done by Mr Jain to be unconvincing. That was because until Mr Puvanendran removed the object it was wedged and blocking the view of the middle ear. Damage caused at an earlier stage could well have lain behind the foreign body. Ms Heathcote herself told me that there was always some urgency associated with removing a foreign body because the surgeon could not know until it was removed what damage lay beyond it. That is compatible with the damage having been caused by Mr Jain before Mr Puvanendran took over and inconsistent with her reasoning.
101. I accept Mr Shaida's opinion that an ENT surgeon, and so by inference a surgeon as experienced as Mr Puvanendran, would or should be aware of some resistance on his instrument from an intact membrane and/or ossicular chain if perforation or disruption was imminent. I am fortified in that conclusion by its consistency with Mr Puvanendran's own evidence that he expected to be aware of resistance and felt nothing to give him any indication that damage was likely to occur. The thrust of his evidence is that he placed reliance on the sensitivity in his hands to guide him in circumstances in which he had no visibility of what was beyond the foreign body. I find he felt no resistance from the structures of the ear. The logical conclusion is therefore, as Mr Shaida recognised when questioned, that the damage to the membrane and ossicular chain had already occurred before Mr Puvanendran began to manipulate the object. There is no evidence from Mr Jain about what (if any) resistance he felt when attempting to manipulate the foreign body. I am satisfied that either he did not recognise the resistance of an intact ossicular chain when he should have done; or he felt resistance but went on regardless.

102. I do accept Ms Heathcote's evidence that it is unlikely that Mr Puvanendran did pass his wax hook completely behind the object. He himself referred to passing the hook along the "visible edge" of the object. But in any event, I accept Ms Heathcote's evidence that when she examined the foreign body, she was able to achieve traction or purchase with the wax hook only on the edge of the surface about 1.5mm from the front of the object, when looking at it from the perspective of it having entered the auditory canal with its longest edge lengthwise. The tip of the distal end would not have provided any traction for the wax hook. If Mr Puvanendran had put his hook behind the foreign body, he could not have achieved the gentle manipulations he describes that allowed him to make progress with the removal of the object. It is probably because of the limited visibility that I accept he had and the wedge shape of the object, that he was simply not aware at the time that the distal point of the object extended beyond the end of his instrument.
103. Dr Ellis invites me not to conclude that the damage must have been done by Mr Jain. He submits that I should rely on Mr Shaida's evidence that it is a critical part of ENT training that if a trainee cannot see beyond a foreign object s/he should stop and seek help. Dr Ellis asks me to infer that Mr Jain followed correct procedure and did seek help before any damage was done.
104. I do not accept that submission in the absence of any evidence from Mr Jain, either in the form of a witness statement or even his own contemporaneous clinical note of what happened during the operation before Mr Puvanendran took over. It is agreed the damage was done in theatre. I have found, for the reasons given, that on the balance of probabilities it occurred through direct instrumental contact with the ossicles. I accept from Mr Shaida and from Mr Puvanendran that the operating surgeon should feel resistance from an intact ossicular chain before causing disruption and damage. If, as I accept, Mr Puvanendran did not feel this at any time, the logical corollary is that the damage had already occurred through the actions of the other surgeon, damaging the ossicles with his instrument.

#### Breach of duty

105. There is no dispute as to the applicable law to determine breach of duty. The standard of care is determined by application of the test in *Bolam v Friern Hospital Management Committee* [1957] 1 WLR 582 (with the additional gloss of *Bolitho v City and Hackney Health Authority* [1997] UKHL 46).
106. Having made my findings as to the most likely mechanism of injury being direct contact between the wax hook and the ossicular chain, I conclude this was in breach of duty.
107. I reject Dr Ellis' submission that the Claimant cannot prove his case because Mr Shaida is unable to determine exactly how the ossicular chain was disrupted (that is, whether by a single hooking contact of the malleus or by multiple contacts; or where precisely within the chain the first contact was made). That is because the breach of duty lies in the direct contact between the instrument and the ossicular chain, causing the chain to be damaged due to dislodgement of the bones, regardless of how many times or at what part of the chain initial contact was made. In any event, while Mr Shaida was prepared to accept there were possible points of weakness along the chain that could have been disrupted through contact, the rationale for his opinion based on

the lateral movement of the malleus is that the most likely mechanism was that the malleus was pulled either once or more than once in order to move it laterally into the auditory canal.

108. Dr Ellis suggested that Mr Shaida had opined that it was possible that contact had been between the incus and stapes which Mr Shaida described as “accidental” in the context of the surgeon having an instrument around the very back of the foreign body and attempting to rotate it. I do not consider his use of the word “accidental” was intended to convey the idea of it being “non-negligent” but rather “unintentional”. Any different interpretation would be entirely inconsistent with the whole tenor of Mr Shaida’s evidence. Further, although Mr Shaida did accept that the point of first contact might have been disruption of the joint between the incus and stapes, he has consistently maintained that the disruption was caused by the use of an instrument and not by the object itself. I accept his reasoning that it is unlikely the damage was done by the tip of the object. He did not at any point of his oral evidence concede the likelihood that it was the object that did the damage directly and not a surgeon’s use of an instrument.
109. Ms Heathcote’s evidence is that any competent ENT surgeon, including a trainee, should be well aware of the position of and distance to the tympanic membrane and the position of the ossicles behind it.
110. There is no reliable evidence as to Mr Jain’s level of visibility. Dr Win refers to a view of 50% of the tympanic membrane. By the time Mr Puvanendran was called into theatre the auditory canal was completely occluded and he had no visibility. If Mr Jain had visibility of either an intact or damaged tympanic membrane, then he should have seen the position of his instrument in relation to the ossicles. To go on and cause damage to the ossicles with his instrument fell below the standard of care to be expected. Neither expert takes any different view.
111. If Mr Jain had no or very limited visibility, then the effect of Ms Heathcote’s evidence is that any competent surgeon would be expected to be able to judge the distance and so would not have proceeded to move his instrument in the area of the ossicular chain so as to cause damage to it. Her opinion, that there was no breach of duty in this case, depends on the damage having been caused by movement of the object. Having rejected her suggested mechanism in favour of damage having been caused directly to the ossicles by a surgical instrument, I do not understand her to be suggesting that there is any conclusion other than that the causing of damage in this way would amount to a breach of duty.
112. Mr Shaida’s evidence, if anything, sets the standard of care higher and so it is not necessary for me to analyse his evidence on this particular issue.
113. There is no evidence from Mr Jain that is capable of rebutting the conclusion that his technique must have been in breach of duty for his hook to have come into direct contact with the ossicular chain. By causing the damage, it must follow that he did not stop attempting to remove the foreign body as soon as he should have done. Inappropriate technique and/or excessive force on his part, on the balance of probabilities, caused the malleus to be torn away and the remainder of the ossicular chain to fail. Having found the damage was caused by direct contact between his wax hook and the ossicular chain, there was a breach of duty for which the Defendant is

legally responsible. It was reasonably foreseeable that once in the middle ear, if the instrument pulled on the malleus, damage was likely to follow.

114. For completeness I record that I do not find any breach of duty proved with respect to Mr Puvanendran's part of the operation. I accept his evidence that he was alive to the risk of doing damage to the ossicular chain; did not feel any resistance when attempting to move the foreign body by gentle manipulation; and had he felt any resistance suggestive of impending damage would have immediately stopped the gentle manipulations he was undertaking. There is no sufficient evidence to suggest that this technique fell below the standard of care to be expected from him.

115. I accept his evidence that he gave consideration to alternative more invasive procedures to attempt removal but as the foreign body was moving under gentle manipulation and removal was progressing, it was not necessary to take these steps which carried greater risk to the patient. Neither expert ultimately opines that this decision based on a risk/benefit analysis is one which no reasonable body of competent surgeons would have made.

116. In any event and for the reasons already given, I consider it unlikely that he put his instrument beyond the point at which it was reasonable to expect an intact tympanic membrane to have sat.

117. There is no sufficient evidence to show that his technique or use of force was in breach of duty.

118. Applying my findings to the pleaded allegations in the Particulars of Claim, I find paragraphs 23(e), (f), (h) and (i) to be proved. In order to disrupt the ossicular chain through direct contact with his wax hook and in the absence of any evidence from Mr Jain capable of providing a factual basis for concluding that it occurred without negligence, my conclusion is that he must have been utilising an inappropriate technique and/or excessive force while attempting unsuccessfully to remove the foreign body.

### Causation

119. There is no dispute that once the malleus was displaced and the ossicular chain was disrupted, some damage to OXR's hearing would be bound to follow.

### Liability

120. Liability is proved.

### Quantum

#### Special Damages

121. The Defendant does not dispute the heads of loss or amounts claimed as special damages in the Claimant's revised schedule of loss. The sum to which the Claimant is entitled for past gratuitous care (£1,535.00), past travel (£853.90) and past aids and equipment (£110.00) amounts in total to £2,498.90. Interest is agreed in the sum of £36.42 increasing the total to £2,535.32.

General damages

122. The experts agree that OXR has a conductive hearing loss on the right side. Although there were earlier concerns that he might have sensorineural hearing loss, that was due to a rogue audiometry result that was misleading.
123. The experts agree that the impairment is in the mild to moderate range with a functional hearing loss that is mild. A loss in one ear only will have a more limited overall functional effect than the same level of hearing impairment bilaterally.
124. The Judicial College Guidelines (Chapter 5(B)) are of limited assistance. That is because the partial hearing loss categories are primarily defined by reference to noise induced hearing loss which by its nature is almost always a bilateral loss and is usually caused through exposure to noise at work over a prolonged period, and so affects those much older than the Claimant.
125. Ms Marcus argues that the appropriate bracket is 5(B)(d)(ii) which covers moderate tinnitus and noise induced hearing loss (NIHL) or moderate to severe tinnitus or NIHL alone. This provides for a bracket of £14,900 to £29,710. She contends for an award of £25,000 (on the basis of a full life expectancy).
126. She cites two suggested comparators that fall either side of the level of injury in this case. Both decisions are, though, of some age (2011 and 2012) and the uplift for inflation is likely to produce a distorted outcome.
127. Dr Ellis argues that the appropriate bracket is 5(B)(d)(iv) which covers “Mild tinnitus alone or mild NIHL alone” and provides for an award of around £11,720. The counter schedule proposes a figure of £15,000, taking account of an additional surgical procedure and loss of amenity on a full life expectancy basis. He submits the appropriate figure on a full life expectancy basis is on the cusp of the two brackets of (ii) and (iv).
128. The factors I bear in mind when assessing general damages for pain, suffering and loss of amenity are these.
129. Firstly, the overall disability is mild and correctable with the use of an aid.
130. Secondly, the conductive hearing loss, characterised by the experts as “mild to moderate” is on one side only.
131. Thirdly, the Claimant underwent a surgical procedure under general anaesthetic (additional to the removal of the foreign body) for which he should be compensated.
132. Fourthly, the timing of the injury and need to use an aid was at an important stage of the Claimant’s social development when he was aged 5. He is still aged only 12. The impact of hearing loss (and the need to use an aid that is visible to others including his peers) on his social development would be expected to be most acute during his youth. I accept the evidence from his parents that they noticed a loss of confidence following the injury. I recognise though that this also coincided with the time that the Claimant was falling behind his peers academically due to undiagnosed severe dyslexia which is unrelated to his hearing. Some upward adjustment is therefore warranted for the impact

of his age and stage of life, though this must be partially offset by the inevitable impact on his confidence and relationship with peers due to the consequences of dyslexia.

133. Finally, and assuming the Claimant has a normal life expectancy, his loss of amenity due to hearing impairment will last throughout his entire teenage and adult life. That represents a much greater period for any loss of amenity than is generally present for noise induced hearing loss which develops after many years' exposure in a working environment and so when a claimant is much older.
134. The impact of a lifelong loss of amenity that dates from early years justifies putting this award into a higher bracket than the functional loss would, of itself, justify. I therefore consider the appropriate bracket is 5(B)(d)(ii).
135. On the basis of a full life expectancy, I would have awarded towards the middle of the bracket, around £21,500; bearing in mind that the bracket for total loss of hearing in one ear (5(B)(c) starts at £31,310 and the Claimant's level of disability does not approach that level.
136. Because of the present uncertainty over the Claimant's life expectancy, but making allowance for the surgery he has already undergone, the impact on his early years and the years that have already passed since the damage was caused, I award by way of interim general damages the sum of £10,500.

#### Future loss

137. There is no significant dispute as to the heads of loss comprising the multiplicand and the sums claimed for each in the revised schedule.
138. I accept from the evidence of OXR's mother that gratuitous care at a modest level continues. The counter-schedule conceded 12 hours per annum until age 18 (as is now claimed in the revised schedule). Taking a broad brush approach I find that to be a reasonable estimate. The appropriate rate is represented by 67% of £9.60 producing an annual figure of £77.18. Care beyond age 18 is not claimed and in any event would not be appropriate.
139. The global sum claimed for future travel in the revised schedule of loss is conceded in the counter-schedule. It is the equivalent of £83.21 per annum. I find this is a reasonable estimate for annual future travel expenses and applies for life.
140. Triennially the Claimant will require hearing tests (£150); audiology tests (£150); and a replacement amplification device (£2,500). Additionally he will require wax removal twice each year (£120 per annum). The total annual sum for future medical expenses is agreed at £1,053.33. This sum is claimed from the Claimant's 18<sup>th</sup> birthday. Until then it is conceded that he will be treated by the NHS so no additional costs will be incurred.

#### Adjourned issues

141. I invite Counsel to agree directions for the determination of the final award of general damages and of the appropriate multiplier. It may be sensible for there to be a stay for some period given the recency of the Claimant's cancer diagnosis and

treatment; and then in default of agreement the appointment of a single joint expert to report on life expectancy.

**Outcome**

142. The claim succeeds. The Claimant is entitled to judgment in the interim sum of £13,035.32 plus interest on the interim award of general damages at the rate of 2% from 12 March 2021 (which must be calculated).
143. I am grateful to both Counsel, Ms Marcus and Dr Ellis, for their assistance.
144. Finally, I wish to record my very best hopes and wishes for the Claimant's continued remission and future health and wellbeing.