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Case No: QB-2019-000155

IN THE HIGH COURT OF JUSTICE
QUEEN'S BENCH DIVISION

Royal Courts of Justice
Strand, London, WC2A 2LL

Date: 14 October 2021

Before:

Mrs Justice Lambert DBE

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Between:

Casey Castello	**Claimant**
- and –	
Stefan Gonschior	**Defendant**

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- -

Vanessa Cashman (instructed by **Irwin Mitchell**) for the Claimant
Alice Nash (instructed by the **Medical Protection Society**) for the Defendant

Hearing dates: 7 to 9 July 2021 and 29 July 2021

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Approved Judgment

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

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MRS JUSTICE LAMBERT DBE

This judgment was handed down remotely by circulation to the parties' representatives by email, release to BAILII and publication on the Courts and Tribunals Judiciary website. The date and time for hand-down is deemed to be 1030 on Thursday, 14 October 2021.

Mrs Justice Lambert:

1. This is an action for damages for personal injury and financial loss arising from the alleged negligence of the defendant, a cosmetic surgeon, during a closed rhinoplasty procedure which he performed on 10 November 2014. It is common ground between the parties that, pre-operatively, the claimant had a deviated septum. The deviation was to the left and affected the upper part of the septum, that is, that part of the septum which is closer to the bridge of the nose. The claimant alleges that the defendant's negligent surgical technique during the rhinoplasty procedure led to a further septal deviation, this one to the right and closer to the tip, leaving her with a sigmoid or "S" shaped deviation of the septum. The claimant contends that, as a result of this further deviation, her right nasal airway is significantly (95%) occluded and she suffers from breathing difficulties which affect her all of the time but particularly at night. She contends that her voice now has a nasal timbre which was not present pre-operatively. She suffers from panic attacks and other psychiatric symptoms and her condition overall has had, she says, a significant impact upon her personal relationships and her professional life.

2. The action came before me for my determination of liability and quantum. The claimant was represented by Ms Vanessa Cashman and the defendant by Ms Alice Nash. I repeat my thanks to them and to all concerned for their assistance during the trial.

The Issues

3. Given the way in which the evidence had emerged during the trial, I directed the parties to provide me with an agreed list of the relevant issues in closing. As predicted, the issues for me now are relatively narrow. It is helpful to set them out at this stage.

Breach of Duty

4. The parties agreed that, if the claimant were successful in establishing on balance that the right septal deviation was caused by the defendant's surgical technique then it would follow that he was in breach of duty. During the expert evidence a number of possible mechanisms by which the septal deviation may have occurred were postulated. The parties were in agreement however that, whatever the mechanism, if the right septal deviation was caused directly or indirectly by the defendant during surgery, then his surgical technique was deficient. Under this topic therefore there is only one forensic question for me: whether as a matter of fact the claimant's right septal deviation was caused by the defendant's surgical technique (the claimant's case) or whether it was pre-existing (the defendant's case at the close of the trial).

5. I mention three points:

    i) First, the claimant's pleaded claim asserted that the right septal deviation had been caused either by an intentional or accidental manipulation of the septum. Ms Cashman now limits her case to the assertion that the damage to the septum was caused by accidental manipulation of the septum. This was an appropriate concession given the absence of any evidence supporting a case

that the defendant had intentionally operated upon or otherwise manipulated the septum during the course of the rhinoplasty.

ii) Second, the claimant's pleaded case included the allegation that the claimant had not been counselled or advised of the risk of breathing difficulties following intentional septal manipulation. This allegation also falls away because of the way in which the claimant now limits her claim. Whether the Particulars of Claim additionally raised an allegation of failure to counsel about the risk of breathing difficulties following accidental manipulation of septal tissue is not clear. The allegation does not appear within the Particulars of Breach but is referred to as part of the claimant's causation case. In any event, whether pleaded or not, the point is not pursued. It follows that a good deal of the evidence which I heard concerning the risks of which the claimant was or was not advised, is no longer of central relevance.

iii) My third observation relates to the Defence. The claimant (correctly) submits that the Defence is non-committal on the question of whether the right septal deviation existed pre-operatively, only putting the claimant to proof that the right septal deviation arose as a result of surgery. The defendant asserted, as did his expert, that the right septal deviation pre-dated the surgery and this approach informed the defendant's closing submissions. No application was made to amend the Defence. However, no formal objection was taken by the claimant and it seems to me that there is no unfairness in my approaching the case on the basis of the case as advanced in submissions at trial. This is not however to undermine Ms Cashman's various points to me arising from the possible "evolution" of the defendant's case.

Causation

6. The parties have also provided me with an agreed list of the issues which they submit are relevant to causation and quantum. Those issues include the severity of the right septal deviation; the extent of the claimant's breathing difficulties; the cause of the claimant's current breathing difficulties and whether the right septal deviation causes or contributes to those difficulties; the effect of the breathing difficulties upon the claimant's work and personal life; and whether she has a psychiatric condition and, if so, the likely cause. I agree that those issues (to a greater or lesser extent) need to be addressed and note at this stage only that there is a good deal of overlap between the topics which I need to consider when answering the breach of duty question and those relevant to causation.

Chronology of Events

7. The following chronology is taken from the claimant's medical records. It is intended to be largely uncontroversial, but I am conscious that the claimant disputes the accuracy of a number of the records (both of the defendant and general practitioner) on the basis that they are either wrong or not complete. I identify the points of difference (to the extent that they remain relevant) in my summary of the claimant's evidence.

8. The claimant was 44 years of age on 16 September 2014 when she consulted the defendant in connection with the appearance of her nose. She had been unhappy with the size and shape of her nose for many years. She had been in an abusive relationship for some years and had been bullied by her partner about the shape of her nose. She had therefore decided to get her nose "fixed" as she put it as part of her plan to lead a new life. She was in a new relationship and was planning to get married in August 2016.

9. The defendant was, at the time, a consultant cosmetic surgeon in private practice at the "Make Yourself Amazing" Clinic ("the MYA Clinic") in Fitzroy Square in London. He has since moved back to his birth country and is currently in practice in Berlin.

10. The defendant used a pro-forma work sheet for note taking purposes. The document was populated with a series of headings with space for notes. The defendant told me (and I accept) that his entries were made contemporaneously with the consultation.

11. It is common ground that the claimant reported, as recorded verbatim by the defendant, that she felt her nose was too long and that it was over-projected. The defendant noted the crooked appearance of the nose caused by an indentation on the right-hand side (due to the left septal deviation) and that, overall, it was too large. He quoted the claimant's self-description that she had a "*Turkish nose*".

12. He annotated the pro-forma with three diagrams which demonstrated the line of the nose from the bridge to the tip. The first diagram showed the pre-operative line of the nose (with a deviation to the left), the second showed the line of the nose immediately following the operation (straight) and the third showed the line of the nose after healing (a hatched line deviated slightly to the left). The defendant told me that the purpose of these diagrams was to illustrate to the claimant that, after a surgical straightening of the septum, the healing process may cause the cartilage to try to "*snap back*" into its original line. He noted no breathing difficulties or nasal obstruction. He recorded that the claimant told him that she had used cocaine every weekend for 12 years.

13. The section of the worksheet in which the defendant recorded his findings upon examination was set out in four sections under four headings: profile, frontal, basal and internal/nasal breathing. Within the profile section the defendant noted the convex dorsum and the moderate over projection of the dorsum and tip. In the section relating to the frontal view, he recorded that there was no marked flaring of the nostrils and that the nostril show was normal. He drew a further diagram demonstrating the line of the nose. His notes relating to the basal examination showed the left nostril to be slightly narrower than the right. The defendant made no notes in the section headed "internal/nasal breathing" even though, as the claimant points out, one sub-topic within that section concerned the position of the septum.

14. The worksheet included four pre-printed diagrams of noses in profile: a straight nose, a curved nose, a straight nose with tip lead (slightly turned up) and a nose with a mild curve. The diagram with the curved nose was circled and the diagram with the nose which was straight but with a "tip lead" was crossed out. Above the diagrams, the

defendant annotated the worksheet with the words "*not accurate, no promises, might not happen*" (his emphasis).

15. In terms of the planned operation, the pro-forma worksheet included six options. Two were circled. The "Rhino 1100" closed rhinoplasty and the "Rhino 3000". It is common ground that the numbers indicated the price for each operation. The Rhino 1100 was a closed procedure (all incisions within the nose). The Rhino 3000 was an open procedure with incisions (and therefore visible scarring) outside the nose. The worksheet was annotated by the defendant stating that the closed procedure would not deal with the crookedness of the nose but if the open procedure was selected then the crookedness would be addressed. A further series of three diagrams, each of which were annotated, shows the location of the incisions for the open and closed procedures (and for an alar base reduction).

16. The final page of the worksheet is headed "*Discussed risks (non-exhaustive, all problems can be irreversible*)". Nine risks appear on the pro-forma. Each risk bears a handwritten tick. They include the risk of "*nasal obstruction, permanent difficulty in breathing*". The page has been signed by the claimant and by the defendant alongside the statement that "*the benefits and risks of Rhinoplasty have been clearly explained to me. If I go ahead with surgery I accept these risks and limitation*".

17. The suite of documents from the consultation include "*Chaperone Notes*" which were signed by the chaperone, Ms Bentley, to confirm that the information listed had been provided to the claimant. The Chaperone Notes comprise seven paragraphs, the fifth confirms that one of the risks of surgery was to cause breathing problems. There is a further document which runs to nine pages: "*Consent to (Septo)-Rhinoplasty Risk Complications and Limitations*". The document includes various pieces of information and advice concerning risks. One of the risks identified was of permanent breathing problems requiring revision surgery is a possible outcome. The claimant and the defendant both apparently confirmed (by their signatures) that this document had been given to the claimant on 16 September 2014.

18. Following the consultation, the claimant elected to undergo the closed rhinoplasty procedure, the Rhino 1100. There was, therefore (and this is common ground) no question that the procedure would address the left septal deviation. The crooked appearance of the nose caused by the indentation on the right side was not the object of the procedure: what was intended by the procedure was limited to the removal of the dorsal bump and some remodelling of the tip of the nose.

19. The procedure was performed on 10 November 2014. Before the rhinoplasty, the claimant signed a further consent form which, once again, confirmed that the crookedness of the nose would not be addressed. The form included a list of complications to which the defendant added *"No perfection. No guarantee. No refund. No touch up free*" (his emphasis). The claimant and defendant's signatures also appear on a further consent to surgery form which formed part of the nine-page booklet of risks.

20. The defendant's operation note recorded that, during the procedure, he made inter-cartilaginous incisions bilaterally and a transfixion incision. He noted that he lowered the dorsum and the tip of the nose and that he performed lateral transcutaneous

osteotomies and infractures. The anaesthetic record indicates that the patient was prepared for surgery at 14.30 and that the end time of the procedure was 15.30. Allowing for prepping therefore, the defendant estimated that the surgical procedure took around 45 minutes.

21. The claimant was kept in the clinic overnight. She was seen by a nurse at seven and fourteen days post operation. At seven days, it was recorded that there were no signs of infection. At fourteen days it was recorded that "*both nose and breasts healing well, patient states she is happy with results. No concerns raised*".

22. On 20 January 2015, at eight weeks after the operation, the claimant was seen by the defendant. He recorded that the patient was "*very happy with nose*" and that she was "*breathing well*". A follow up appointment in 12 months was arranged. However, on 19 May 2015 at 190 days post operation, the claimant returned to the clinic where she was seen by the nurse. The record of the consultation reads: "*patient completely blocked to (L) nostril and has to sleep on her (L) side in order to breathe at night. Patient also states that she has a menthol taste in mouth and has to "sniff very hard" in order to taste her food. Review by GP who states symptoms are as a result of maxilla facial trauma. I have explained that Mr Gonschior no longer works here at MYA. Am currently working very hard to arrange appointments for Mr Gonschior to review patients. I explained this process may take some time and apologised for this. Patient appears understanding*".

23. The claimant was seen at the MYA Clinic on 22 July 2015, in the defendant's absence, by Mr Frati another cosmetic surgeon. He recorded that: "*Pt unhappy about outcome/breathing problems/running nose. Still settling down. Good outcome. Good shape. Septal deviation, right middle vault retraction collapse (it was before) according to before photos. Bilateral inferior turbinates hypertrophy. Advised to wait 1 year since original surgery for revision to d/w management. Bilateral inferior turbinectomy + 1 x or 2 x right spreader graft*". In January 2016 she sent an email to the MYA Clinic in which she said that her nose was getting worse and she was unable to breathe at night or when sitting.

24. There are three entries in the general practitioner records which were the focus of questioning. On 13 May 2015, the claimant attended her GP surgery complaining of feeling tired all of the time and not sleeping well for the previous few months. It was recorded that the claimant's mother had recently been diagnosed with bone cancer and had a gloomy prognosis. The claimant was said to be apparently coping well but suffering from aching and a sensation that her hip was clicking. She was waking up tense and gripping the side of her bed. It was further recorded that she was worried that she too might have cancer but she was going to college which she was enjoying. There was no mention in the note of the claimant complaining of any difficulty with her breathing.

25. On 29 April 2016, the claimant was recorded as suffering from a flare up of benign paroxysmal positional vertigo. It was noted that the claimant had to commute some distance to work by car but that she was unable to drive at present due to vertigo and so needed more time off work. Again, there was no reference to breathing difficulties.

26. The first entry in the GP records in which breathing difficulties were noted is 8 June 2016. The claimant was reported to be suffering from generalised anxiety and "*has problems sleeping at night due to nasal obstruction following rhinoplasty and wakes feeling anxious, has palpitations during the day, takes things out on partner*".

27. Finally, in spite of the Master's refusal of permission to the claimant to rely upon it, the trial bundle included a short medico-legal report of Professor Martin Birchall. Professor Birchall is a Professor of Laryngology and a consultant in ear, nose and throat surgery. He examined the claimant on 11 October 2019. He noted severely diminished airflow through the right nostril and moderately diminished airflow through the left nostril as measured by misting and direct observation. On naso-endoscopy, he identified a severely distorted nasal septum with deviations affecting both sides of the nose and thickening of the nasal septum. He commented that this would be a "*typical picture following for example a septal haematoma (an undrained post traumatic clot in the nasal septum). The septum is causing obstruction bilaterally but particularly on the right-hand side*".

The Evidence

28. For practical reasons, both the claimant and defendant gave evidence via video link. I also heard evidence from two experts: Professor Kirwan for the claimant and Professor Lund, for the defendant. Professor Kirwan gave evidence via the video link from North America, Professor Lund in person.

The Claimant

29. There were a number of differences between the claimant and defendant concerning the consultation of 16 September 2014. In spite of the focus upon the defendant's surgical technique, some of the differences between the parties remain relevant (to witness reliability and credibility) and so need to be mentioned and in due course resolved.

30. The claimant told me that the consultation on 16 September 2014 was very short and that it lasted no more than 20 minutes or so. She denied that the defendant had told her that the line of the nose might "ping" back after surgery in spite of the diagrams in the medical records which apparently illustrated this possibility. She told the defendant that she wanted a "*pixie nose*" and that the shape of the nose which she wanted was not the one which had been circled by the defendant but the one which he had crossed through, that is, the nose with the "tip lead". She remembered the defendant telling her that at the end of surgery and following healing she would have "*the perfect little nose*". She denied telling him that she had taken cocaine every weekend for 12 years, saying that she had told him only that she had taken cocaine on 12 occasions at weekends. She accepted that she had been informed about some of the general risks of surgery but, even though accepting that it was her signature at the foot of the page, she denied that she had been counselled about all of the risks which appeared on that page. She denied for example that she had been told that rhinoplasty might lead to irreversible breathing problems, telling me that the possibility that she might not be able to breathe properly would have been so frightening that she would not have been prepared to take the risk. Although she could not be certain, she did not think that she had been given any document to take away and read. In any event

she told me that she had made her decision to go ahead with the procedure on 16 September during the consultation because the defendant had reassured her that he could do what she wanted and he had told her throughout the consultation that everything was going to be fine.

31. Her understanding was that her recovery was complicated by more bleeding than had been expected and so she had been kept in hospital overnight. As to the post-operative consultations she denied that she told the defendant on 20 January 2015 that her breathing was "OK". She told me that even by this stage she was suffering from "*severe difficulty in breathing*". She said that there was simply no air flow through the right side of her nose and the left side had drastically reduced air flow. She told me that she was not, contrary to the defendant's note, happy with the appearance of the nose as it was still much bigger than she had expected it would be. She also told me that she had never been told by any member of the MYA staff that the defendant had left the clinic and that she only found out by chance when she bumped into a former MYA employee at a laser clinic where she was receiving treatment. This was in early 2016.

32. The claimant acknowledged that she had seen her GP on 13 May 2015 and that there was no entry recording a complaint of breathing difficulties. She explained that she was tired and anxious because of her mother's ill health and she was focussing upon her. So, she said, there were a lot of things which she did not say. She told me that her problems with her nose, in particular her breathing difficulties, caused her to stop working in April 2016. She had worked front of house as a receptionist at a company. However, she found that her blocked nose was obvious to others as she had to clear her nose by forcing air through her left nostril. Her nose was also always running. She therefore left her job because she was embarrassed and self-conscious. She said she was very unhappy to have to hand in her notice. She acknowledged that the GP record entry for June 2016 did not make reference to her having to leave her job because of breathing problems but because of a different problem (vertigo). However, she maintained that the sole reason she had had to leave her work was because her nose was running constantly and she had difficulty in breathing.

33. Since giving up her work as a receptionist, she has retrained as a beautician. She did a college course which caused her financial loss. However, she told me that she had been forced into taking a job which allowed her to be flexible and stand up. She greatly enjoys working as a beauty therapist. She attributes the breakdown of her relationship with her fiancé to the effect of the rhinoplasty. She has suffered from depression and anxiety attacks. Her breathing problems continue. She feels that her voice has a nasal quality and she says that people often tell her that she sounds as though she is "bunged up". This causes her to be self-conscious and rather paranoid. She told me that she is desperate to undergo a surgical revision of her nose and has identified a surgeon in Los Angeles who specialises in revision of "botched surgery".

34. The claimant's witness statement also recorded that she had searched the internet to find out about the defendant. She had discovered from a website called "RealSelf" that a number of former patients of the defendant had complained of similar problems to hers.

Jensen Cavendish and Danielle Francis

35. Both gave short evidence on behalf of the claimant. Mr Cavendish is the claimant's former fiancé. He works as a bodyguard and chauffeur. He told me that he was shocked when he saw the claimant after surgery as she looked bloody and bruised. He took her home the next day and had to carry her into her house. He described how the claimant's personality was changed by the effect of the operation, becoming fractious and aggressive and suffering from panic attacks. This caused the relationship to break down. Ms Francis is the claimant's sister. She told me that the claimant had been very self-conscious about her nose, hence her wish to have a rhinoplasty. After the procedure however, the claimant was hugely disappointed with the shape of her nose and complained of difficulty breathing. Her sister has become introverted and now rarely goes out. When she does, she says her nose is always running. She told me that her sister's nose was still "*witchy*" in appearance but now she also has physical problems with breathing and a runny nose which is "*very irritating and rather gross*". In her view the claimant's voice now has a nasal quality. She says that she has had a rhinoplasty procedure herself and was surprised to learn that the procedure which the claimant had undergone had been a closed procedure which she understood to be rarely performed.

The Defendant

36. The defendant had no recollection of the consultation with the claimant in 2014 and his answers reflected his usual practice. He told me that he had prepared his pro-forma worksheet as an aide memoire to ensure that nothing would be left out of the pre-operative consultation. He said that he did not go through every topic heading in the worksheet, just those that seemed to him to be relevant and that, if he did not consider a feature to be relevant or important, then he would make no record. He acknowledged that he had made no record as to the state of the septum within the section internal/nasal breathing, but he told me that he had illustrated the line of the septum in his diagram of the frontal view. He interpreted his diagram as showing the deviation in the septum to the left in the upper part of the nose and also a slight curvature to the right in the lower part of the nose. He denied that he had not looked at the nose properly: he told me that he had touched it, palpated it, checked the claimant's breathing and examined the interior of the nose with a torch sufficiently to confirm that there was no issue with septal perforation. He denied that he had mistaken the claimant's wishes concerning the shape of the nose: he said that she had not mentioned her wish for a "*pixie nose*" and that if she had done so then he would have recorded it verbatim. He accepted that he may not have informed the claimant that she had a mild deviation in the lower right side of the nose. He explained that his operative technique would have included dissection of the muco-perichondrium sufficient to free it from the underlying cartilage to enable him to reduce the dorsal bump but that he would not have extended his dissection lower than needed. In his view it would not have been possible for him to have created a further deviation in the septum towards the tip as this was well away from his operating field and even if he had caused a bleed/haematoma (which he did not accept that he had done) he did not believe that a haematoma would have led to the creation of a sigmoidal deviation. The defendant confirmed that he had received other complaints when in practice at the MYA Clinic and that the dissatisfaction rate was around 1%.

The Experts

37. The claimant relied upon the evidence of Professor Kirwan, an aesthetic plastic surgeon based in North America. He qualified in Manchester and holds a number of UK qualifications but currently practises in Norwalk Hospital in Connecticut. His curriculum vitae records that he is "*widely recognised as an expert in aesthetic surgery of the face, breast and body*". He cites around 25 or so publications. Seven relate to breast surgery, three to surgery/liposuction of the lower limbs and those others which are described concern general aspects of plastic surgery such as the autografting of burn wounds, wound management and various forms of imaging. His teaching symposia and courses attended appear to relate to breast reconstruction.

38. Professor Lund, for the defendant, is an Honorary Consultant Ear, Nose and Throat Surgeon and Professor Emeritus in Rhinology. She is the chief editor of Rhinology. In her clinical practice she deals with diseases of the nose, allergies and inflammatory responses to infection and nasal tumours. She readily accepted that, in respect of any outstanding issues concerning the standard of care of a cosmetic surgeon, she would defer to Professor Kirwan. However, on the issues which required a knowledge and understanding of nasal anatomy and nasal function, she claimed a substantial and superior expertise.

39. There was some, but only limited, common ground between the experts. They agreed that septal deviations can be congenital or caused by injury or trauma. They also agreed that the claimant had a left sided deviation in the upper section of the nose and a deviation to the right in the lower section, although there was a disagreement as to the severity of the right sided deviation. They agreed that the absence of nasal symptoms did not indicate the absence of a deviation (which might be wholly asymptomatic).

40. The expert evidence focussed upon two topics: the mechanism(s) whereby the septal deviation in the lower portion of the nose might inadvertently have been caused by the defendant's surgery and the claimant's current condition and the cause(s) of her condition. I outline their respective positions below.

41. Professor Kirwan told me that the septum could have been damaged by the defendant during or as a consequence of his dissection of the muco-perichondrium (the fibrous structure which lies adjacent to the septum) prior to refining the dorsal bump of the nose. He told me that some surgeons do not dissect this structure but chose to make an incision through it. He made no criticism of the defendant's decision to dissect, rather than incise, but postulated that the dissection may have been over-extended too close to the "floor" of the nose causing damage to the septum either through direct trauma or by the formation of a haematoma. He told me that the distance between the dorsum and the septum is only in the region of eight to ten millimetres and that when a closed procedure is being performed then "*you are looking down a dark hole into a dark tunnel with a light*" and an inadvertent over-extension of the dissection and some slippage of the instrumentation might well happen. Alternatively, he postulated that the defendant, when seeking to dissect and elevate the muco-perichondrium to gain access to the cartilage or bone, may have inserted his instrumentation into the wrong plane causing damage to the septal cartilage. He accepted that his third postulated mechanism, that the nasal speculum might have been used in an inferior turbinate

outfracture in such a way as to fracture the septum, could be safely disregarded in the absence of any suggestion that an outfracture had been performed.

42. In summary therefore it was the claimant's case that the right deviation may have been caused during surgery either by some direct trauma to the septal cartilage during over-extension of dissection or dissection in the wrong plane or secondary to the formation of a haematoma (again by either mechanism).

43. Professor Lund did not accept that either over-extension of the dissection of the muco-perichondrium or dissection in the wrong plane could have caused the right-sided deviation of the septum. She told me that the nasal septum is a relatively large structure of around eight to nine centimetres in length and three to four centimetres in height and that even if there had been some damage to the septal cartilage as a consequence of slippage of instrumentation then only a small portion of the septum would or could have been damaged. She said that the muco-perichondrium is routinely dissected without causing damage to the underlying structures. She said that if the muco-perichondrium were stripped away on both sides to sufficient depth then it might have caused a perforation in the septum but it would have been very unlikely that the defendant's instrumentation would have created a pocket of sufficient depth. In any event, there was no perforation. She said that if the muco-perichondrium had been stripped away on one side only (and not replaced) then it would cause no damage but simply re-grow. She did not agree that the formation of a haematoma would have caused a deviation in the septum, although she accepted that if there had been a haematoma then the septum might have become thickened.

44. Professor Lund said that in her view the septum could only have been deviated if it had been effectively "disarticulated". It is a firm structure with a degree of resilience and "spring". To effectively "disarticulate" the septum would require a minimum of two, possibly three, fractures or incisions into the septum so as to create a "flap" which could then be pushed to one side. Either that, or the surgeon would have had to have made a hole in the septum so that the septum was pushed off base. She postulated that if this had happened then the surgeon would have been aware of the damage.

45. There was limited agreement between the experts concerning the claimant's current condition. They agreed that the claimant currently has a right septal deviation: Professor Kirwan characterised the deviation as severe, Professor Lund that it was moderate only and within normal limits. Both also accepted that the claimant complained of symptoms associated with nasal obstruction. The experts sought to assess the extent of airway compromise: Professor Kirwan by examining the anterior nasal cavity using a Killian nasal speculum and headlight and Professor Lund by the use of nasal inspiratory peak flow measurement. In Professor Kirwan's opinion the airflow through the right nostril was significantly compromised and the airway almost (95%) occluded. By contrast, although she found that the airflow through the right nostril was less than through the left nostril, Professor Lund found that the airflow was within normal limits on both sides, albeit towards the lower limit of normal.

46. Professor Lund did not find the discrepancy between her objective findings and the claimant's symptoms to be surprising. She explained that the sensation of obstruction is a complex response influenced not just by mechanical obstruction due to

anatomical variation but by other factors such as alteration in nasal sensation, the presence of sino-nasal inflammation, turbulence of airflow, psychological factors, as well as environmental factors such as temperature and humidity.

Analysis and Findings

47. I start by clearing the decks of three short issues which arise from the closing submissions.

48. First, the application of the principle of res ipsa loquitur is not apt in this case. There is no dispute between the parties that, if the right septal deviation was caused by the defendant's surgical technique, then he was negligent and the defendant liable for the consequences of that negligence. The question for me therefore is not whether there is or may be a non-negligent surgical cause of the deviation but whether, such right sided deviation as I find to be present, pre-dated surgery or was associated with the surgery. The defendant in this case however applies the principle not to the formation of the deviated septum but to the breathing difficulties alleged by the claimant. The breathing difficulties Ms Nash submits is the "res" or the "untoward outcome". But this analysis overlooks the case advanced by the claimant: the primary injury alleged is the septal deviation and the breathing difficulties are secondary to the septal deviation. Also, although the claimant is not able to assert the precise mechanism by which the deviation occurred, Professor Kirwan has postulated that the damage must have been inflicted during the course of the dissection of the muco-perichondrium, as a result of over-dissection or dissection in the wrong plane, either of which would have been negligent. For these reasons I do not accept the defendant's submission that the principle is, or should be, engaged.

49. Second, I have not been helped by the claimant's reference to other patient complaints. Whilst Ms Cashman places only limited reliance upon those other complaints, I am invited nonetheless to take them into account when considering whether the defendant's surgical technique was deficient. I do not do so. I have no information about why the patients were dissatisfied, whether that dissatisfaction was justified or not and whether the defendant had been in breach of duty. All that I know is that the defendant had unsurprisingly a number of patient complaints. I put this evidence, limited as it is, firmly to one side.

50. Third, I put the evidence of Professor Birchall to one side also. The claimant did not have permission to rely upon his report. Contrary to Ms Cashman's submission, he was not a treating clinician but engaged to perform tests for Professor Kirwan for medico-legal purposes by the claimant's solicitors. The contents of his report were not agreed and Professor Birchall was not cross examined. In any event, even had I taken the report into account, I would have been unable to place any real weight upon his evidence, if for no other reason than as an expert in laryngology his primary expertise is the throat and not the nose. This may explain his use of the rather historical technique of "misting" to assess airflow. Misting involves the patient breathing on to a mirror and then comparing the steam patterns which are produced. This is a technique which Professor Lund told me had been largely superseded in modern practice.

51. Having dealt with these preliminary points, I turn to focus upon the only issue on breach which is left for me to determine: whether the defendant's surgery caused direct trauma to the septum or indirectly via formation of a haematoma leading to the deviation. In addressing this question, it seems to me that it is relevant to consider a number of points: (a) whether there is any reliable record of the course of the septum pre-operatively; (b) by what mechanism the septum may have been distorted during or as a consequence of surgery; and (c) the claimant's current condition and the cause of her symptoms. All three of these issues have a bearing on the single forensic breach question which I must decide.

52. The issues also overlap. I start therefore by making some general observations concerning the defendant.

53. I found the defendant to be an open, honest and apparently reliable witness. He readily acknowledged that he had no direct memory of the events in question and was therefore drawing upon his usual practice in reconstructing events. It would have been remarkable if, after such a lapse of time, he had retained any real memory of events. I have no doubt that he was doing his best to make sense of his notes, to understand the criticisms which were made of him and to provide his perspective. I do not accept that he was either arrogant or hubristic (as it was put by Ms Cashman in closing) although I accept that, at times, he appeared to be genuinely bemused by the suggestion that he had intentionally or otherwise traumatised the septum in the lower third of the claimant's nose, an area which was some distance away from his field of operation.

54. The most striking impression I formed of the defendant was his wish to manage the expectations of his patients. His worksheet included (above the diagrams of possible nose shapes) his handwritten annotation that the end result might "*not happen*" and that he could make no promises; his documented risks (in the worksheet and in the patient information leaflet) were extensive and in two places the consent documentation recorded that the claimant was told that the crooked appearance of the nose would not be corrected; the consent form recorded that he was giving "*no promises*" and "*no guarantees as to outcome*"; he drew diagrams to demonstrate that even if the septum were straightened during the operation, it may yet "*snap back*" into near its original position. This all demonstrated a level of caution bordering on the defensive. I find it inconceivable that the defendant would have recorded all of these caveats and risks in his notes and yet not delivered the same message clearly and on multiple occasions in his discussions with the claimant. It was in his interests to convey the message. At one level, what the defendant was seeking to do was to avoid repercussions in the event of the patient being dissatisfied with her appearance: there were to be "*no refunds*" and "*no free touch ups*".

55. It is against this background that I address the first issue relevant to breach of duty: whether there was any reliable pre-operative record of the line of the septum. Ms Cashman's closing submissions here rely heavily on the absence from the defendant's witness statement of any reference to his examination of the internal structures of the nose and any recording (either in his notes or in his witness statement) of a finding that the septum was deviated to the right. She submits that I can be satisfied that there was no internal examination of the nose and no finding of a right deviated septum.

56. Although he has not recorded his examination of the internal structures of the nose in the witness statement, I do not accept that the defendant did not perform an examination of the inside of the nose. I accept his explanation that he did not record it in his witness statement because he did not think that it would be seriously suggested that he had not done so. I am wholly satisfied that a cautious and defensive minded surgeon such as the defendant would have looked inside the nose, even if the examination was brief, limited to his establishing that the septum was not perforated (which would have been a bar to septal surgery) and focussed upon the removal of the dorsal bump.

57. The defendant however went rather further in his evidence to me. He appeared to be suggesting that his interpretation of the diagram in the records depicting the frontal view of the nose was that it demonstrated, not just the obvious left sided deviation, but also a slight right sided deviation of the septum in the lower section. It must be said that his evidence on this point was rather diffident and was not comprehensively explored either in cross examination or re-examination. Indeed, Ms Nash in her closing submissions appears to accept that there was no documented record of the line of the septum which included the right deviation.

58. I find that, notwithstanding my impression of the defendant (above) the diagram to which he refers does not show a deviation of the septum to the right. Any other finding would be inconsistent with the Defence (which was agnostic on the point) and defendant's witness statement. Had it been the defendant's consistent line of thought that his diagram of the frontal view showed a sigmoid deviation, then I would have expected this to have featured in one or both of those documents. For this reason, whilst not finding that the defendant's evidence on the point was intended to be misleading, I do find that this interpretation of his diagram may have a touch of wishful thinking about it. As such, I accept the basic submission of Ms Cashman that there was no documented pre-operative record of a right sided deviation of the claimant's septum.

59. It does not follow however that I find that there is positive evidence to be derived from the defendant's evidence that the septum was pre-operatively straight in its lower course. It is not suggested by anyone that any right sided deviation was apparent externally and to the extent that the defendant focussed on the septum it is likely that it would have been in the area closer to the bridge where the obvious cosmetic defect was present. He told me, and I accept his evidence, that he had inspected the septum to establish that there was no obstacle to surgery in the form or a defect or perforation. Had there been a moderate right sided deviation of the septum, I accept that he may not have paid it much attention given that it was well away from the operating field.

60. I note in this context that the claimant submits that as there was no reliable record of the course of the septum throughout its length (as Professor Kirwan advises there ought to have been) then I should be very slow to find that the right septal deviation was present before surgery. She invokes the words of Longmore LJ in *Keefe v Isle of Man Steam Packet Co Ltd* [2010] EWCA Civ 683 that I should, in these circumstances, judge the claimant's evidence benevolently and the defendant's evidence critically. The problem with this submission is that, as I have already stated, whether the right septal deviation pre-dated surgery involves consideration of a

number of factors. Not just the absence of records one way or the other but how the deviation might have been caused by the surgery. In these circumstances I do not (indeed cannot) look at one part of the evidence in isolation.

61. This leads me on to my assessment of the expert evidence.

62. Again, I start with some general comments concerning the experts. I have already set out their respective qualifications. I have no doubt of Professor Kirwan has considerable expertise in the field of cosmetic surgery generally but see nothing in his professional background which suggests to me that he has, or even purports to have, a specialist interest in the internal anatomy of the nose. His experience as a cosmetic surgeon is extensive but not focussed upon rhinoplasty; his publications range widely but do not touch upon rhinoplasty as a specialist procedure and his listed symposia do not include operations of the nose.

63. By contrast, Professor Lund's professional life's work has involved lesions, tumours and diseases of the nasal structures. She has an extensive and professional life-long experience in surgical procedures of the nose. I am wholly confident that her knowledge of the anatomical relationship of the structures of the nose is infinitely greater than that of Professor Kirwan: she has spent her professional life examining the inside of the nose and understanding the causes of breathing problems, be they mechanical or the result of disease or other factors and operating upon the nose. As she put it to me, she has looked at more noses than Professor Kirwan. I also find for the same reason that her knowledge of the most effective and reliable way of both examining the nose and assessing, objectively, airflow through the nostrils is to be preferred to that of Professor Kirwan.

64. Professor Lund's familiarity with the subject was reflected in the manner in which she gave her evidence, which was both measured and reflective. To the extent that she claimed a superior expertise to that of Professor Kirwan (and Professor Birchall, one of her colleagues) she did so with a disarming modesty and humour. Subject therefore to my being satisfied that Professor Lund's evidence makes logical sense to me, then (and without hesitation) I prefer her evidence to that of Professor Kirwan.

65. It is against this background that I set out my findings concerning the claimant's current condition and specifically, the degree of deviation to the right of the septum in the lower section of the nose and her current symptoms of nasal obstruction. I accept Professor Lund's assessment that the degree of deviation of the septum is moderate only, rather than severe as described by Professor Kirwan, not just because she has looked at "more noses" than Professor Kirwan but because her examination of the inside of the nose was performed using a rigid endoscope. In her opinion (and this was not seriously challenged) this is the most reliable means of examining the inside of the nose.

66. As to the claimant's current symptoms, I accept that the best available objective assessment of airflow is that used by Professor Lund: the nasal inspiratory peak flow measurement. Indeed, on the basis of the expert evidence before me, it is the only objective means of assessment of airflow. Professor Kirwan's conclusions concerning airflow were based upon the claimant's symptoms as reported to him and

to others and the claimant's responses to the Nasal Obstruction and Septoplasty Effectiveness Scale (the NOSE Scale). The claimant's responses to the NOSE questionnaire recorded the severity of her symptoms, but obviously, those reported symptoms are wholly subjective. The NOSE scale may well be used extensively in the USA but I accept that, in the literature, there is some evidence of poor correlation between NOSE scale responses and objective findings. I also accept Professor Lund's evidence that, given it is a wholly subjective assessment, its real benefit (if any) is for the comparative assessment of pre and post-surgical symptoms. Whilst accepting that the peak flow measurement is not perfect, in that it measures airflow through both nostrils and may, as Professor Kirwan explained be subject to a degree of examiner error, nonetheless I find (again without difficulty) that, when used in conjunction with an internal examination of the nose with a rigid endoscope, it is the most reliable means of assessing airflow. For all of these reasons, I find that whatever may be the claimant's symptoms, her nostril airflow is within normal limits, although to the lower end of that limit.

67. I turn to consider the expert evidence concerning the mechanism by which the right septal deviation may have been caused during the rhinoplasty. I note Ms Cashman's concern that she was taken aback by the amplification and expansion by her expert Professor Kirwan of his theories concerning the potential mechanism during cross examination. Her concern is a surprising one given that the way in which the deviation might potentially have arisen as a consequence of the surgery was always likely to be an important element in the court's evaluation of the claim. I accept Ms Cashman's point that the mechanism did not feature significantly in the joint expert note. But the questions posed were agreed between the parties. Nor am I persuaded by the argument that the claimant's legal team had no reason to believe that the defendant disputed the analysis set out in Professor Kirwan's liability report. That report outlined his thinking concerning the possible ways in which the injury to the septum might have arisen and his oral evidence did not significantly depart from his written analysis. The fact that, when cross examined, his evidence was more detailed than in his report is not remarkable: it is just a function of the litigation process. In any event, even taking into account that her expert was not in court, Ms Cashman had sufficient time at the end of Professor Kirwan's evidence and at the conclusion of her cross examination of Professor Lund to take instructions by telephone. Nor was there any application by her to re-call Professor Kirwan. I do not therefore accept that, as she says, there was any unsatisfactory imbalance in the opportunities granted to the experts and to counsel to deal with the various points which arose.

68. I do not accept that it is likely that the claimant's septum was damaged during the course of the rhinoplasty performed by the defendant. I make this finding for the following reasons which, given my views on the relative weight I can attach to the opinions of the two experts, I can set out succinctly.

69. The septum is a relatively large and firm structure. I accept Professor Lund's evidence that, for it to have become deviated, it would have been necessary for it to have been displaced or detached from its adjoining structures at the crest and the base. Professor Lund told me that it would have to have been effectively "disarticulated" in some way or at least that a window or flap were created. This, to me, makes perfectly logical sense given the nature of the structure. I also accept that over-dissection of the muco-perichondrium or dissection of tissue in the wrong plane would have been very

unlikely to have led to such an injury. It would have required the dissecting instrument to slip around three centimetres and a minimum of two or three insults or incisions into the septum. Again, this seems to me to make logical sense.

70. Further, if for some reason, the defendant's instrumentation slipped the necessary distance to bring it into contact with the septal cartilage and cause the disarticulation necessary to cause a deviation then again, I accept that the defendant would have become aware of his error. Professor Lund did not accept that the field of operation was as described by Professor Kirwan (looking into a dark hole). Far from this being a blind, or almost blind procedure as he suggested, she explained that the operation field was exposed with a speculum and with a good modern headlight it is possible to obtain a reasonable visualisation of the area being dissected. I prefer her evidence. I have no doubt that if the defendant had been aware that he had disarticulated the septum then he would have noticed it and taken steps to rectify the defect.

71. Nor do I accept that the deviation was caused by the formation of a haematoma. I accept Professor Lund's evidence that, had a haematoma been formed, then the likely consequence would have been the formation of some thickening of the septum but not a deviation. Professor Kirwan identified no septal thickening during his examination, nor did Professor Lund. Only Professor Birchall found "a degree of thickening" and I have given my view upon his evidence. I accept Professor Kirwan's and Professor Lund's evidence that no septal thickening was present.

72. I am therefore not persuaded on balance that the claimant's moderate right septal deviation was caused intraoperatively by the defendant. I find that the deviation existed before surgery but was probably asymptomatic. There was evidence before me that asymptomatic septal deviations are not an uncommon finding in the "normal" population. There was some interrogation of Professor Lund's proposed range as set out in the scientific literature and in particular whether the upper range was 96% of the population or 63%. There was further interrogation of the basis upon which the authors of the paper which identified the incidence to be 63% was representative of the cohort of patients to which the claimant belongs. I did not however find that this debate advanced my understanding in any relevant way. The literature establishes that a significant number of people have deviated a septum without being aware of it and this contention was not seriously in dispute before me. Whether therefore a significant number is a majority or a minority of the population does not materially affect my conclusions.

73. Professor Lund did not dispute that the claimant experienced symptoms of nasal obstruction. She accepted that the right deviated septum may have contributed to her symptoms. But as she said however, the reason for symptoms of nasal obstruction can be multifactorial. She told me that anatomic variation such as a deviated nasal septum may become evident due to any event producing soft tissue swelling, without there being any major structural change and this can persist or be exacerbated due to a variety of reasons such as persistent inflammation, hyper-reactivity and neurological change. I accept this evidence. It explains why patients should be informed of the risk of permanent breathing difficulties as a consequence of non-negligent rhinoplasty. I also accept Professor Lund's evidence that the sensation of obstruction may be due to a variety of factors other than anatomical obstruction including

psychological and environmental factors. This leads me on to my assessment of the claimant.

74. I do not doubt that the claimant was doing her best in stressful circumstances to remember what was said and done during the consultation on 16 September 2014, and in the months and years afterwards, but I found her to be, generally, an unreliable and unsatisfactory historian. I take the general practitioner notes just as one example. She was emphatic in her evidence to me that she gave up work in April 2016 because of the problems with her nose. This assertion is however inconsistent with the entry in her records which documents that the reason for her work difficulties was vertigo and the problems with commuting by car – nothing to do with her breathing. She also claimed to have suffered serious breathing difficulties from the outset of her post-operative period. However, the defendant's note of 20 January 2015 suggests that she told him that she was breathing well. Whilst it might be said that the note was self-serving, this would be surprising given that no complaint had yet been made. Furthermore, there is no entry in her GP notes concerning breathing problems until June 2016. Had she suffered as consistently badly from breathing difficulties since the operation as she now maintains then I would have expected there to have been at least some passing reference to it in the GP notes.

75. I take the point that in the middle of 2015 she complained to the MYA Clinic of breathing problems. However, and oddly, that complaint was of problems affecting the left nostril, not the right. This was maintained in the Letter of Claim in which it is recorded that "*following her surgery under the Defendant, she noticed a bump on the right side of her nose. She also had difficulty breathing, especially through the* left side *of her nose*" (my emphasis).

76. There were other aspects of the claimant's evidence which I was unable to accept. For example, she told me that the defendant had reassured her that the surgical outcome would be "*fine*" and that she would have, following surgery, the "*perfect little nose*". I do not accept this evidence for the reasons which I have already set out above in some detail: this evidence is wholly at odds with the defendant's contemporaneous notes which emphasised a very different message. I do not accept her evidence that she told the defendant that she wanted a "*pixie nose*". As the defendant explained to me, had she used these words then, as he had done when recording her concerns over the current shape of her nose, he would have included those exact words in his notes just as when recording her dissatisfaction with the shape of her nose he quoted her phrase that she had a "*Turkish nose*". I do not accept that the claimant's voice has a nasal twang, as she suggests. This was not apparent to me.

77. These parts of her evidence added to my impression of the claimant as an unreliable historian. But I have no doubt that she went into the consultation and the surgery with the hope (perhaps expectation) that she would be given the "*perfect little nose*" and that this would, in conjunction with her breast surgery, improve her confidence. It must have been disappointing to find, following surgery, that the nose was not "*perfect*" in appearance and not as "*little*" as she had hoped.

78. I emphasise that I am not suggesting that the claimant has in any way consciously sought to mis-represent her experience and her history. I am sure that she now

believes that she suffered significant and disabling breathing difficulties through the right nostril which date back to the immediate post-operative period. But reviewing her evidence as a whole I find that it is very unlikely indeed that the claimant's breathing difficulties have been as bad, and as consistently bad, since the surgery as she now suggests they were. This finding is wholly consistent with my conclusion (based on the expert evidence) that the right sided deviation is moderate only and that airflow through both nostrils is within normal limits.

79. I therefore stand back from the conclusions above. They all point in the same direction: that the right sided septal deviation was not caused by the defendant's surgery but pre-dated the surgery; that the deviation has become symptomatic for a number of possible reasons including environmental factors and psychological factors, as Professor Lund advised; that the right septal deviation is moderate only and associated with airflow which is within normal limits, albeit at the lower end of the range; that the claimant's symptoms of breathing difficulties are unlikely to have been as bad, or as consistently bad, as she now claims.

80. This claim therefore fails on breach of duty. I order that judgment will be entered for the defendant

81. In order to assist the parties, I go on to make the following findings relevant to quantum in the alternative (and hypothetical) event that I had found for the claimant on breach.

82. The claim is limited to general damages together with some modest special damages reflecting the costs of revision surgery and a course of cognitive behavioural therapy.

83. The level of general damages to be awarded would have reflected my finding that the claimant's symptoms have not been as bad as claimed; that she did not give up work as a consequence of her breathing difficulties; that she suffers from a history of depressive illness (which is common ground) and that there are or have been a number of independent stressors in her life, including her mother's serious illness and her need to raise two children singlehanded, one of whom has autism. I do not accept that the breakdown of her relationship with Mr Cavendish is attributable to breathing difficulties but to the stress and disappointment caused by surgery which, I accept, she considered had failed aesthetically.

84. I heard short evidence from Dr Morgan and Dr Cutting, both consultant psychiatrists, instructed on behalf of the claimant and defendant respectively. The issue between them was whether the claimant had suffered from a depressive illness and, if so, its severity and cause. Without I hope appearing to be dismissive of the quality of their evidence, the issue is a narrow one. I accept that the claimant was vulnerable to depression and that she has suffered from a mild to moderate depressive illness to which her symptoms of nasal obstruction made a contribution. Again, on the basis that septal surgery is required, the prognosis is good. If I had been making an award of general damages, I would have assessed those damages in the order of £13,000.

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