Neutral Citation Number: [2022] EWHC 1585 (QB)

Case No: QB-2019-004599

IN THE HIGH COURT OF JUSTICE
QUEEN'S BENCH DIVISION

Royal Courts of Justice
Strand, London, WC2A 2LL

Date: 20 June 2022

Before:

JEREMY HYAM QC
(Sitting as a Deputy High Court Judge)

- -

Between:

ROGER JOHNSON	**Claimant**
- and -	
ANDREW WILLIAMS	**Defendant**

- -
- -

Satinder Hunjan QC (instructed by **Stewarts**) for the **Claimant**
Mary O' Rourke QC (instructed by **Bevan Brittan**) for the **Defendant**

Hearing dates: 23, 24, 25, 26 and 27 May 2022

- -

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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JEREMY HYAM QC

This judgment was handed down by the Judge remotely by circulation to the parties' representatives by email and release to The National Archives. The date and time for hand-down is deemed to be at 10am on Monday 20 June 2022.

Jeremy Hyam QC:

1. The Claimant, Roger Johnson, is a professional footballer. In January 2017 he suffered a meniscal tear to his left knee whilst training. That was treated by the Defendant who is a specialist knee surgeon. The operation appeared to go well. The meniscal tear healed. Unfortunately, his knee subsequently showed signs of infection. On 9th March 2017 after some blood tests were taken he was advised to have urgent surgery to remove the infective material in his left knee. That surgery was also undertaken by the Defendant. The operation took place on 17th March 2017.

2. This claim concerns the treatment he received on that day. It is the Claimant's case that in the course of that surgery, described by the Defendant himself as an 'aggressive' procedure to remove infective material from the knee joint to prevent the development of septicaemia, iatrogenic damage was negligently caused to the tendon that crosses the knee joint on the medial side of the patellar. That tendon is known anatomically as the medial retinaculum. Its function is to hold the patellar in place.

3. The main evidence for a rupture or tear in the medial retinaculum was said by the Claimant to be two- fold. First, a fluid filled egg-shaped lump appeared a few days after surgery on the medial side of the Claimant's left knee (i.e. in the location of the medial retinaculum) and continued to refill despite repeated aspirations on 27th March, 30th March and 6th April; and second, an MRI scan of the egg-shaped fluid filled lump conducted on 11th April 2017 (some 25 days after surgery) which showed a 3cm diameter tear to the medial retinaculum.

4. The Claimant's case in opening was that the only possible and likely cause of the medial retinaculum rupture was surgical error on 17th March 2017 by the Defendant. It was said that the suggested alternative causes put forward by the Defendant namely infection and the Claimant's failure to follow post-operative instructions were so remotely unlikely they could effectively be rejected, and in those circumstances the court could properly conclude that although undoubtedly an unusual and unexpected complication, it was surgical error by the Defendant which caused the damage.

5. It was the Defendant's case that no damage occurred during surgery on 17th March 2017, but rather that the damage occurred subsequent to surgery and probably after an ultrasound scan on 27th March 2017. The Defendant's case was that the burden of proof lies on the Claimant and while he does not have to prove anything, other explanations offered by him or his expert Mr Anand, for example, that the rupture was due to infection, failure to follow post-operative instructions, of multifactorial origin, or evolved gradually, were entirely plausible causal mechanisms.

6. Satinder Hunjan QC appeared on behalf of the Claimant and Mary O'Rourke QC on behalf of the Defendant. I am grateful to them for their help. At the end of opening submissions there was a joint application to narrow the preliminary issue from that initially ordered by Master Cook to the following two issues:-

    i) Did the Defendant cause a large tear/defect in the Claimant's medial retinaculum on 17th March 2017 in the course of surgery (a synovectomy procedure).

ii) If so, was it negligent to have done so.

7. I acceded to that joint application because it became evident that the causation issue as to what would have happened to the Claimant (in terms of his return to football and the continuation of his playing career) but for the rupture to his retinaculum, involved a mixed question of medical and footballing expertise. The evidence on this issue was insufficiently complete to allow it to be fairly determined at the hearing.

8. By the time of closing it was accepted by Ms O' Rourke QC for the Defendant that if, (contrary to the Defendant's case) he did cause a large defect, hole or rupture in the course of surgery to the left medial retinaculum of the Claimant's knee without noticing it and therefore without responding to it appropriately, then this would have been negligent. Thus, by the end of the evidence and submissions, the sole issue which I am asked to determine in this case is: whether the Defendant caused a large rupture or defect in the medial retinaculum of the Claimant's left knee on 17th March 2017 in the course of surgery (a synovectomy procedure to remove infected material from the knee).

Background

9. Synovectomy, as its name suggests, is the cutting out of synovial tissue. It is done with a powered instrument referred to in the evidence variously as a 'shearer' or 'shaver' which sucks, cuts and shaves out tissue. The purpose of the procedure is to remove bacteria and avoid infection developing. It is usually followed by (and was in this case) a washout procedure to ensure as little as possible residual bacteria remain after surgery. Surgical intervention is required because antibiotics may not be able to penetrate the knee joint. In the Defendant's expert evidence it was recognised that damage to the medial retinaculum during synovectomy is a risk of surgery, albeit an extremely low one. Mr Anand (the Defendant's orthopaedic expert) referred in particular to reports in the literature relating to arthroscopic synovectomy performed for chronic inflammation as seen in rheumatoid arthritis. On the basis of this literature Mr Anand observed:-

> "Arthroscopic synovectomy in a reasonably experienced surgeon should carry an extremely low risk of retinacular rupture. The risk of inadvertent injury to the capsule can occur and is most likely dependent on the condition of the soft tissues, which can be affected by infection and inflammation. "

10. In the joint statement at question 6, both experts were agreed that causing a large rupture to the retinaculum would constitute "*an extremely rare and unusual complication following synovectomy".*

The Pleadings:

11. The Claimant's pleaded case is that the Defendant was negligent because at the time of surgery performed on 17th March 2017, the Defendant:-

i) Failed to undertake the surgery with appropriate care and damaged the medial retinaculum causing a large defect in the same;

ii) Failed to recognise at the time of the surgery that he had damaged the medial retinaculum (and if it was recognised failed to record the same);

iii) Failed to advise the Claimant that he had damaged the medial retinaculum during the surgery and that the damage caused during surgery was resulting in the continuing swelling and pain which were likely to be and in fact have been career ending for the Claimant as a professional footballer;

iv) Attempted to explain the damage that had been caused by him at the surgery as being a very unusual complication and it "*being hard to know how this happened"* when he knew or should have known it had been caused at the surgery by him damaging the medial retinaculum and causing a large defect.

12. By its Defence the Defendant denied that he caused the alleged or any defect or damage, that there was no such damage to recognise and record, and that the damage "*arose thereafter from a weakening of the retinaculum by the previous infection and by the Claimant's behaviour in terms of mobility and rehabilitation."*

Chronology

13. I set out below what I consider to be the key chronology of events. In doing so I largely rely on the contemporaneous medical records but supplement them by certain parts of the oral and written evidence.

14. On 31st January 2017 the Claimant, then a professional footballer with Charlton Athletic Football Club, underwent surgery to repair a meniscal tear in his left knee which had occurred during training. The surgery was carried out by the Defendant. It appeared to go well and the tear was repaired with good stability.

15. There are several entries in the notes between 31st January 2017 and 24th February 2017 suggesting that the Claimant was not being fully compliant with post operative instructions. For example, on 6th February 2017 it was recorded by Mr Thrush, the club physiotherapist: "*Not wearing brace regularly despite advice to have it on at all times when up and about*". Similar advice is repeated on 13th February 2017. Around 20th February there is evidence that a holiday abroad was being considered by the Claimant. This holiday was discussed at a review with the Defendant on 24th February. There was some dispute as to whether at this meeting the holiday had already been booked and was presented as a *fait accompli*, or whether, as the Claimant and his partner said, he would not have gone without the Defendant's approval. I find that the holiday did at least have the approval of Mr Thrush and the club, and that the Defendant, even if he may not have recommended it, did not at the review meeting of 24th February 2017 set out any substantial opposition to the plan for a holiday to Thailand that had already been agreed to by the club.

16. Whilst on holiday in Thailand the Claimant had problems with his knee. He noticed swelling to the suprapatellar pouch. He was advised to ice and elevate his knee. There was a concern about possible infection. He purchased some crutches whilst abroad. When he returned on 9th March 2017 (where he had been using the crutches) his knee was swollen. The knee was aspirated under guidance. The cultures taken on 9th March

were chased and on 16th March 2017 confirmed a suspected infection. The Claimant's CRP (C-reactive protein level) was noted to be 80+ (a marker of infection) and it was agreed that urgent synovectomy and washout was required to save the meniscal repair. The Defendant explained in his letter of 17th March 2017 that the infection was a serious complication and could not only be career-ending but knee-threatening.

17. On 17th March 2017 the Claimant underwent the arthroscopic washout and synovectomy of the left knee which is the subject matter of this claim. The Defendant's operation note recorded that "*excellent views*" were obtained through the antero-lateral and antero-medial views. He recorded that "*a pleasing clearance of synovium was achieved*" and that "*there was no evidence of any objective infection, but the tissues were oedematous*". No defect or rupture to the retinaculum was reported to have been seen by the Defendant, nor any extravasation of fluid from any rupture, defect or hole.

18. Mr Thrush noted on 17th March: "*Admission bloods showed CRP well over 100 and on scope there was evidence of infection. However the meniscus had healed satisfactorily and as such Mr Williams removed the sutures. The joint surfaces had been preserved. Player will require repeat wash-out in a few days time*."

19. On 19th March 2017, two days later, the Defendant undertook a further washout and arthroscopic debridement of the Claimant's left knee. The Defendant's note of that arthroscopy procedure recorded that '*good views were achieved'* and he made specific findings in his report of the procedure with respect to the patella-femoral joint, the medial compartment and the intercondylar notch. He washed out with 15 litres of saline, introducing fluid under pressure from a pump. Once again, no tear or rupture to the retinaculum or capsule was reported to be seen by the Defendant, nor any extravasation of fluid from any rupture, defect or hole.

20. Mr Thrush's note of the outcome of the procedure recorded: "*no sign of active infection now inside knee joint. Awaiting microbiology and blood results. Will stay in hospital for next few days."*

21. On 20th March 2017, Dr Jones, the Charlton Athletic Club Doctor visited the Claimant. His note records:-

> "Drain to be removed. On IV ABx Roger threatening to leave before the end of the week. Advised to follow instructions of Mr .Williams"

22. I was informed that the drain was in fact removed at 0950hrs that morning which would place Dr Jones's visit around 0900hrs.

23. On 21st March 2017, a note made by one of the physiotherapists attending on the Claimant recorded at around 1415hrs: "*Some mod swelling Med. Knee but soft*". Under the heading "*Advice*" the following is recorded: "*Some swelling med knee but not painful and soft – encouraged ⇑ ice + ELEVATE*"

24. On 22nd March 2017 the Claimant was discharged home. He was seen by the Defendant shortly prior to discharge who recorded:-

> "V well…..small VMO haematoma – tender"

"*VMO*" is shorthand for the vastus medialis oblique muscle. It is one of the quadriceps muscles on the inside front of the thigh, just above the knee.

25. On 23rd March 2017 there was a home visit by the club physiotherapist Mr Thrush suggestive of non-compliance with post-operative instructions. He records:-

> "Home visit by AT: Player answered door FWB [Full weight bearing] without crutches. Explained the importance of crutches to offload and to assist with swelling Knee remains grossly swollen with watery fluid. Player concerned regarding 'haematoma' on medial side of knee. Mr Williams aware of this and indicated possible small vessel damage during surgery as potential cause. Advised player to continue to ice regularly and elevate as much as possible. To use crutches for mobilisation to help offload joint"

26. The Claimant was plainly worried about the build-up of fluid on his knee and as a result of a text message the night before, a further (unscheduled) visit was made by Mr Thrush on 24th March. Mr Thrush's note records:

> "Player worried about build up of fluid on medial side of knee over last 48hrs. No pain but significant swelling
>
> O/E: Significant collection of fluid on medial side of knee in 'egg- type' formation. Boggy/ watery fluid. No significant heat Retains good ROM with full extension possible Quads inhibited somewhat by · the fluid but is able to SLR with small lag Mobilising PWB on 2 x [crutches] ok"

I infer from this note that by now the Claimant was mobilising his knee and was partial weight bearing on two crutches.

27. On 25th March 2017 the Claimant was seen by the club doctor Dr Jones who recorded:-

> "Swelling persists but no evidence infection. Advised use crutches, rest, offload and game ready. To report any illness or deterioration in symptoms Repeat bloods"

28. The same day there was contact between Dr Jones and the Defendant who noted as follows:-

> "PROGRESS
>
> I was contacted yesterday and sent photographs of Roger's knee. Whilst he was well, pain free and generally improving, a lump had appeared on the medial side of his left knee. I suggested elevation, rest and compression and it was decided he would be reviewed by Dr Chris Jones at lsoKinetic this morning and have bloods sent away.

> I discussed the situation with Dr Jones this morning. Roger was well in himself and he was apyrexial. He had no pain, the knee looked quiet and the swelling was minor. There was a significant lump on the inner side of the knee which was non-tender. It increased in size with active knee contraction. CRP was 24.5 which was a further significant improvement from blood tests taken on Wednesday. ESR is now 52.
>
> PLANS/CONCLUSION
>
> We discussed the fact that the leg should be left to rest and Roger should keep his activities to a minimum. He can be reassessed on Monday. I have asked to be called for an update at that point."

29. It appears therefore that the lump which initially had been noted by the Defendant as small had over the course of three days or so become egg-shaped, and "*significant*" in size. It remained non-tender but had increased in size with active knee contraction. There are photographs of the knee taken on or about 23rd or 24th March that show this egg-shaped lump on the knee.

30. The Claimant does not appear to have been seen on 26th March (a Sunday) but was seen on Monday 27th March when he underwent an ultrasound guided aspiration of the fluid in the lump. The relevant note recorded:-

> "Aspiration of knee under ultrasound guidance. Samples sent 1) Haematoma (xtracapsular) 2) Knee joint sample (blood stained) Roger. well in himself and no signs of active infection. Will see Mr Williams in 3/7 Continue Linezolid 600mg BD until 5th April at least."

31. Although not referred to at all in the pleadings and only in passing in his witness statement, the Defendant at trial said he considered this note and the radiologist's ultrasound report of particular significance. That ultrasound report (carried out by one Dr Justin Lee) read:-

> "Preliminary ultrasound demonstrates a large subcutaneous haematoma on the medial aspect of the knee which extends proximally deep to the vastus medialis. In addition, there is a moderate size effusion within the joint.
>
> Following informed verbal consent, the haematoma was drained to near dryness yielding 44 ml of heavily blood-stained haematoma fluid. The knee joint was subsequently aspirated to near dryness yielding 24 ml of heavily blood-stained haematoma type fluid.
>
> Sample sent to pathology. Procedure performed under ultrasound guidance and aseptic conditions using lidocaine for initial anaesthetic."

32. The Defendant said he considered this note significant for three reasons. First, because there was an implication from the absence of a reference to it, that no defect had been seen by the radiologist, and if there had been a 3cm diameter hole in the retinaculum it would have been obvious on ultrasound. Second, the fact that there were two separate aspirations suggested that there was no communication between fluid in the egg-shaped lump and the effusion in the knee joint and that also suggested there was no hole in the retinaculum at that point. Third, because of the location of the haematoma, which is noted as extending proximally deep to the vastus medialis. This description identifies an area superior to the point where the lump appears in a subsequent photograph taken by the Claimant on or about 1st to 3rd April.

33. In other words, the Defendant was saying that he thought that the causal mechanism of the lump filling with fluid before 27th March was different from the causal mechanism after 27th March. Before 27th March, the cause was a haematoma caused by small vessel damage during the procedure on 17th March. This would account for his own finding on 22nd March of a small VMO haematoma shortly prior to discharge, and the larger lump that was photographed on or about 23rd and 24th. He said it explained why the radiologist identified both a haematoma and an effusion within the joint and why there needed to be two separate aspirations. He said he thought that after 27th March, (i.e. when a similar lump reappeared within approximately 24 hours of drainage with ultrasound on 27th March) that the cause of the filling or refilling was a rupture to the medial retinaculum occurring at some point after 27th March but before 30th March when he himself drained the egg-shaped lump.

34. This theory (which emerged for the first time in oral evidence) as to there being two rather than one causal mechanisms for the lump that appeared on the medial side of the Claimant's left knee and which kept refilling after aspiration/drainage was described by the Claimant's expert Mr Paul as "*far-fetched*".

35. I consider this emerging theory of the Defendant in his oral evidence has to be judged against the contemporaneous notes he and others made at the time. The Defendant next saw the Claimant on 30th March 2017. At that time he noted:-

> "Thankfully Roger is now well in himself. He has swelling within the joint and also an extra-articular collection deep to the medial side. This was drained on Monday [27th March] and has there has been no growth from the fluid. Roger's bloods have been repeated today.
>
> Roger was keen for repeat aspiration and I undertook this today. Under aseptic technique using chlorhexidine to prepare the skin, 80ml of liquid haemarthrosis was removed from the joint cavity. 40mg Durolane was injected into the joint cavity. This decompressed the extra-articular swelling. He had full active extension and was bending to 90 degrees. The wounds are well healed and the sutures were removed today."

36. Mr Thrush's note of the same consultation is also informative:-

> "R/V Williams today. Dr Jones present at appointment.

> …
>
> 110mls fluid drained from knee (old clotted blood)which immediately reduced the haematoma. Knee drained to near dryness Blood re-taken today and CRP has reduced to 5 which is very pleasing considering only 2-weeks post initial synovectomy.. Mr Williams reiterated to player that the meniscal repair continues to look favourable and that he remains hopeful of a successful outcome once the knee has settled. RTP [return to playing] will be a minimum of 12 weeks from now and will be dependent on the knee remaining dry following the aspiration today. Any further swelling and/or aspiration, or indeed further surgery, would of course delay this RTP timeframe.
>
> T/C from M' Williams to report back on findings from today's consultation. Explained the need for the aggressive synovectomy and it may be that a small vessel was caught in the procedure leading to the extracapsular haemarthrosis. Player will likely need further MRI in the coming weeks just to check on the health of the knee joint surfaces.
>
> Plan: PJV response in knee over coming days To remain on cover antibiotics for further week Cont compression, elevation and ice No leg exercises at this stage until knee is dry and quiet."

37. That note clearly suggests that as at 30th March 2017, the Defendant continued to consider that the likely cause of the extracapsular haemarthrosis (the lump which he drained) was small vessel damage occurring in the course of the procedure.

38. On Monday 3rd April the Claimant attended the training ground and was seen by Mr Thrush who made the following note which expressed some ongoing concern about compliance with instructions:-

> "Player popped in to TG [training ground] today for quick review of knee. Knee was drained on Thursday last week by Mr Williams which reduced the haematoma to near dryness. However, by the next morning the knee had filled again. No pain reported. Player walking FWB and not using crutches as advised. Also arrived with no compression on, despite advise for compression at all times with double tubigrip. Player states he is compressing at home, but difficult to know whether this is the case or not.
>
> 0/E Player is well in himself Significant haematoma over the medial side of the knee again which is filled with watery fluid. However, the rest of the knee appears very well and looks the best it has looked since the original operation with minimal swelling."

39. He was also seen by Dr Jones on that day who recorded:-

> "Roger sent an updated Photo of his knee. This illustrates that the swelling had returned within 24 hours of aspiration by Mr AW.
> I explained to Roger that I had sent the photo to Mr AW. Current plan of repeat bloods this week remains the same."

40. On Thursday 6th April 2017 a further aspiration and drainage of the swelled lump was carried out by Dr Jones. After further discussion with the Defendant it was considered that an MRI was required.

41. On Tuesday 11th April an MRI of the knee was duly carried out. The findings on MRI were that there was disruption of the medial patellofemoral ligament and medial retinaculum disruption with fluid which appeared to have herniated medially into a subcutaneous fluid collection measuring 5cms x 1 cm. The size of the defect itself is not recorded in the MRI report but it has been measured by the experts and there is agreement that the rupture is approximately 3cms in diameter.

42. Mr Thrush's note of his review of the MRI is as follows:-

> "**• Mri knee without contrast**
>
> 3T MRI today as ordered my Mr Williams to check integrity of joint surfaces following infection.
>
> However, significant damage to the medial retinaculum/capsule lining which is resulting in communication of fluid between inter- articular space and extra-capsular region, hence the large pocket of medial swelling since discharge from hospital following the synovectomy and 2 x washout procedures. MRI also reports chondral damage to trochlea, but this is likely to be old and unrelated to current knee symptoms. Lateral meniscal repair appears to be in good health and intact. Plan; Await review of MRI by Mr Williams,"

43. The findings on MRI were a surprise to the Defendant and he immediately wanted a second opinion. On 12th April having considered the MRI report he wrote to Professor Haddad (another knee specialist) from whom a second opinion was sought as follows:-

> "Yesterday Roger had an MRI scan which shows disruption of his medial retinaculum. It is hard to know how this happened, since with synovectomy at no point did I feel that there was deep penetration to the capsuled fibular. Nevertheless by managing this would weaken the retinaculum and hence a rupture has occurred. There is no suggestion of ongoing infection, but I have suggested we repeat the blood markers today. I feel it prudent to get a 2nd opinion at this stage given that this is an unusual complication and that it has the potential serious implications of Roger's career as it could become career ending. I plan to see Roger at 3:30 pm today and I would be grateful if you could call me with your thoughts prior to this."

44. Professor Haddad's assessment did not identify how the rupture came to be caused but explained that the reason the swelling kept returning despite aspirations was because of a defect in the fascia of the tendon. He said:

> "I have looked at the MRI scan which shows a reasonable configuration of the lateral meniscus and fortunately very little in the way of bone marrow oedema in the knee as a whole. There is however some synovitis and a big defect in the medial retinaculum. I have explained to him that the reason the medial swelling has kept recurring in spite of aspirations is that there is a defect in the fascia, and therefore it communicates with the knee joint. I am concerned as to why the knee joint is still that swollen and have explained that this could be post-operative but could also be related to low grade infection**.**"

45. Mr Thrush's note of the consultation with Professor Haddad is again illuminating as to the thinking of the treating doctors at the time and the potential attribution of the rupture to the initial synovectomy procedure:

> "Consultation with Prof Fares Haddad (clinic note attached): Prof Haddad took a detailed history and reviewed the knee on the bed as well as the MRI from yesterday. AT and players partner present at the consultation. Prof Haddad explained the seriousness of the injury to the medial capsule which has occurred as a result of the recent synovectomy. This damage will most likely require surgical repair to bring the two ends of the capsule together following which a period of immobilisation of the knee will be required in a brace to ensure the' capsule heals satisfactorily. As a result the likely time frame for a return to sport will be "several months".

46. Following Professor Haddad's consultation there was a meeting involving the Claimant, his partner Ms Butler, Mr Thrush, Dr Jones and the Defendant on 12 April. Mr Thrush's record of that meeting is as follows:-

> "Mr Williams explained that the MRI was originally undertaken to look at the joint surfaces which can sometimes be affected by infection. However, whilst the MRI has revealed the joint surfaces to be OK. it has shown a significant hole in the medial retinaculum of the capsule which is causing communication of the synovial fluid into the extracapsular space resulting in a large swelling on the medial side of the knee. Mr Williams explained the nature of the synovectomy procedure that was necessary due to the joint infection and the necessary aggressive nature of this procedure to ensure all the infected tissue was removed. Unfortunately this has resulted in the tear in the medial capsule which will now need to be repaired, as previously indicated by Prof Haddad. Player became very emotional with this news"

47. I have summarised these notes in some detail above because it is clear from them that what the Claimant was being given to understand, at least by the time of the meeting

on 12th April, was that he had suffered swelling in the medial aspect of his knee as a result of the synovectomy procedure and that this swelling had required repeated drainage because there was communication between the knee joint and the site of the swelling through a hole in the medial retinaculum. Given the way this was explained it is entirely understandable that in evidence before me the Claimant and his partner thought they had been told that the defect in the medial retinaculum had been caused by, and in the process of, the synovectomy procedure.

48. However, it is also right to say that both the Defendant and Professor Haddad were at pains to say that is not what they had said or meant. For example, Professor Haddad explained (by way of factual evidence rather than expert comment) in his statement at paragraph 9: "*My impression was that it [the medial retinaculum] had potentially been weakened by surgery and then torn afterwards. If I had thought that the retinaculum had been torn during surgery, I would have said this to the Claimant during the appointment and written this in my letter to the Defendant*".

49. Although it was initially thought surgery would be required to repair the retinaculum it does appear that after the 12th April drainage the rupture was able to heal by itself. Thus on 18th April 2017 it was noted by Mr Thrush:

> "Review appointment with Mr A Williams today, potential for surgery tomorrow Roger explained that since last week his knee effusion has decreased in size. He is not certain that surgery is in his best interest. Assessed by Mr Williams: Extension has reduced and flexion to 100. Swelling on medial aspect knee less."

50. By 20th April 2017 the knee was clearly settling as is recorded by Mr Thrush:

> "Following consultation with Andy Williams on Tuesday, decision made to try period of conservative rehabilitation and strengthening ex as the knee has actually settled over the last few days. …
>
> O/E Knee has settled in terms of swelling since last assessment Small effusion remains but gross swelling in medial pocket has completely gone. Knee remains somewhat warm to touch, but player reports feeling well in himself."

51. The ongoing risk was one of infection and this was monitored. In early July 2017 some raised inflammatory markers resulted in a further washout procedure being carried out by Mr Ball (Orthopaedic Surgeon) because the Defendant was absent. Mr Ball noted during surgery that the medial retinacular tear had healed fully as had the previous meniscal tear. Although he was taken to task by Mr Hunjan QC as to how he could confirm the retinacular tear had 'fully' healed when he would not have been able to visualise it, he explained that having pumped a large volume of water under pressure into the knee joint by way of washout, if there had been any defect it would have been immediately obvious and it was not. Put shortly, he was satisfied that clinically the rupture had healed.

The Factual Evidence at trial

52. The Claimant and his partner Ms Butler gave evidence. I found Mr Johnson to be a honest witness who was trying to tell the truth as to what he remembered and what he had been told. I did not think he was trying to embellish his story and was frank about the fact that before he went on holiday to Thailand after the initial surgery he was fed up with his crutches. He did not pretend to have a verbatim recollection of words said at the meeting on 12th April. While I do not consider it is likely that the Defendant made a formal admission that he had caused injury in the course of the synovectomy procedure, I can quite see how what the Defendant did say may have been construed in this way. Mr Thrush's note of the meeting on this issue is entirely consistent with this:

> "Mr Williams explained the nature of the synovectomy procedure that was necessary due to the joint infection and the necessary aggressive nature of this procedure to ensure all the infected tissue was removed. Unfortunately this has resulted in the tear in the medial capsule which will now need to be repaired".

53. A reasonable interpretation of what this contemporaneous note records is that the aggressive nature of the procedure had resulted in a tear to the medial capsule, in other words that it was the aggressive nature of the procedure that caused (resulted in) a tear to the medial capsule. Whether that is in fact what happened, or what the Defendant meant, is a separate question which I will have to determine, but I do not think the Claimant or his partner who was also present, at fault for thinking that the Defendant appeared to be taking responsibility for the tear occurring.

54. Overall, I considered the Claimant and his partner to have been honest and straightforward in the evidence they gave. However, I have concluded that whatever may have been said or not said at that meeting by the Defendant does not ultimately answer the question of what in fact had happened to the Claimant's knee, and on that issue I found what the Claimant and his partner had to say to be of fairly limited assistance.

Mr Williams, Mr Thrush, Dr Jones, Professor Haddad and Mr Ball

55. Mr Williams, the Defendant, gave evidence and was cross examined in particular about his emerging theory that the tear did not occur until after the 27th March. He answered by saying: "*It is simply a fact that the more one ponders a case the clearer it becomes, and so it is a pity I didn't realise the significance of that scan until fairly late, but it is still of great importance*". He was also pressed on the lack of evidence of non-compliance by the Claimant in the period after the operation of 17th March, and the unlikelihood of infection as a cause of rupture. The Defendant's response was to say that the likely cause of the breakdown was multifactorial, and that the retinaculum, made vulnerable by the procedure and infection, had most likely torn subsequent to surgery. Although it was suggested that because of drainage and the use of a tubigrip swelling might not be immediately obvious the Defendant was clear that if there was a large defect in the retinaculum at surgery it would have been immediately obvious. His ultimate position as he said in re-examination was that: "*I am being accused of causing that defect at the time of surgery, and that is something I could not possibly have done. I also could not possibly have [failed to] recognise I had done it*".

56. I formed the impression that the Defendant, who was and is undoubtedly a highly experienced and skilled surgeon, was genuinely puzzled by how the tear in the retinaculum had occurred as it was such an unusual complication. He was as sure as he could be that it had not occurred either in the course of surgery on 17th March or on 19th March during washout. His main reasons for saying so are that he had good visualisation during the arthroscopy and washout and he would have seen it, and the fluid which was applied under pressure would have extravasated from the defect and made it obvious. Corroborated as it was by the Defendant's expert evidence and to some extent the Claimant's expert, I found this compelling evidence which cannot lightly be put aside. I was less impressed with his after-the-event theorising in relation to the importance of the ultrasound scan and what it did or did not confirm. Certainly at the time of his examination on 30th March 2017, it was clear to me that he considered that the haemarthrosis which he drained had been caused by small vessel damage at the time of the procedure much in the same way as the initial haematoma which had been drained on 27th March under ultrasound. In other words, that until shortly before trial, he considered that there was only a single causal mechanism which explained both the swelling photographed on 23rd/24th March, and the repeat swelling after drainage on 27th March, which he saw himself and drained on 30th March, and which then recurred again within a matter of 24 hours or so, such that by 3rd April further similar-looking photographs of the swelled lump were sent to the football club and forwarded on to him.

57. Mr Thrush who was the club physiotherapist also gave evidence. He was cross examined about the suggested non-compliance of the Claimant with post operative instructions as recorded in the notes. Mr Thrush seemed to me a straightforward witness and he essentially confirmed that which is recorded in his very full and complete notes. From those notes I have already observed that there are a number of occasions both before and after 17th March, where some concerns about the Claimant fully complying with post-operative instructions are noted. I do not think the evidence really allows any definitive conclusions to be drawn as to the causal effect, if any, of such non-compliance.

58. Professor Hadad gave evidence briefly. His statement was tendered and he was cross examined on the impropriety of expressing expert opinion within a factual witness statement. I made it clear that I was only interested in what Professor Hadad had to say on the facts, and on those issues he was not challenged.

59. Dr Jones, the club sports doctor also gave evidence, but aside from the correction of minor inaccuracies in his statement there was no significant challenge to his evidence which did little more than confirm what was already written in the medical notes.

60. Finally, Mr Ball gave evidence as to his washout procedure on 4th July. He was cross examined as to whether when he operated the retinaculum had 'fully healed' given he could not visualise it directly. The point he made was that the defect had certainly healed sufficiently to have enough tension to retain the fluid that he put in by way of washout under pressure. He first put in 21 litres and then 15 litres. If there had been a defect or hole then leakage would have been immediately evident. There was not.

Expert evidence on Breach of Duty and Factual Causation:

Mr Ashok Paul and Mr Sanjay Anand

61. The Claimant relied upon the expert evidence of Mr Ashok Paul, orthopaedic surgeon. He considered that the 3cm tear occurred in the course of the synovectomy procedure. He said it was impossible for it to have occurred in any other way. He was challenged as to his expertise and in particular the assertion made in his CV that he had been "*the Manchester United Orthopaedic Surgeon for 20 years*". He was invited to accept that this overstated the position to the point of being misleading. He was not and never had been the exclusive surgeon for Manchester United. He had done some work for the club, but he was never employed by them and there were other surgeons who did orthopaedic work too. Such concessions extracted only after repeated questions highlighted a theme of his evidence which was a degree of overstatement and inflexibility with respect to the views he expressed. That said, there was no doubt that as an orthopaedic surgeon he was highly experienced and had relevant experience in sports injuries.

62. Mr Paul acknowledged that to rupture the retinaculum inadvertently and cause a 3cm diameter tear would be a very unusual thing to happen and very unusual for it not to be obvious immediately but he said that "*it happened in some cases*". When cross examined on the "*some cases*" it became apparent that the "*some cases*" he referred to were not cases in the literature, nor cases he had experienced, but simply the fact that the complication had happened in this very case. His approach was typified by an exchange which occurred in his cross examination in relation to the unlikelihood that a rupture might have occurred and not have been seen either initially or 48 hours later on arthroscopy and washout as follows:-

> "A: It can happen
>
> Ms O Rourke: Have you ever seen it happen?
>
> A: It is such an unusual case
>
> Judge: Counsel is putting emphasis on you saying it can happen. If you have seen that happen, that 48 hours later, when there has been a defect in the retinaculum, that you can miss it…
>
> A: It is remarkable but it has happened.
>
> Q: Why are you saying "it does happen"?
>
> A: Because it happened in this case."

63. Mr Paul did not think any other causal mechanism was possible or likely. Even when it was explained that the Defendant would have had to have used the shaver forcefully and repeatedly in the same area of the retinaculum without noticing it:

> "Q: So he would have to shear all the way across six times with this instrument 5.5mm multiplied by 3 gets you the 3 cm tear so he would have to cut the whole width of the shearer times 6; do you agree?
>
> A: Yes, I agree.
>
> Q: You would absolutely be aware of that?

> A: Yes, but it did happen. There is no other possible explanation, absolutely none".

64. This inflexibility (said by Mr Hunjan QC to be consistency) in refusing to consider even as a possibility, alternative explanations, necessarily meant that Mr Paul had to explain why, if a 3cm diameter rupture occurred to the medial retinaculum at the time of surgery on 17th March:

    i) It was not observed at the time by the Defendant even though it would have been immediately obvious;

    ii) The Defendant must have used excessive force (and there was nothing to suggest that such force was used). This was because he explained that without excessive force "*you may get pinhole tears [but] you would not be able to create a defect that is 3 by 3 or 4 by 3."*

    iii) The defect was not seen at the time of the washout even though it would, in his words, have been '*remarkable*' if the operating surgeon had not seen it during washout.

    iv) The defect did not produce at least some immediate swelling.

65. I am afraid I found Mr Paul's explanation on these issues less than compelling. Rather than seek to explain how his theory was consistent with the absence of any visible signs of rupture, he reasserted that "*it happened*" and that therefore the Defendant must have missed it because every other explanation was impossible. This seemed to me to be far too extreme and inflexible a position to take for such an unusual complication. It is true of course that he provided partial explanations for how the rupture might have been missed by the Defendant. For example, he said it might have occurred towards the end of the procedure, the Defendant would not have been looking for it, and that on 19th March the hole was so large that the extravasation would have been less obvious; but none of these partial explanations were compelling either as a matter of opinion or logic.

66. By contrast Mr Anand for the Defendant was more balanced and cautious. He considered that the tear/defect probably did not occur at the time of the surgery. In cross examination it became clear that this was essentially because the defect would have been obvious and would have been seen both on 17th March and also on 19th March during washout where fluid is used under pressure and that fluid would have extravasated from the defect.

67. There were however some aspects of Mr Anand's evidence however which were less than satisfactory. For example, in his report to the Court, and while saying it was difficult to be precise, he timed the formation of the rupture to the time when the large egg-shaped swelling appeared on the Claimant's leg on or about 23rd March 2017. However, in his oral evidence, and after hearing the Defendant give evidence, he pushed back the date of formation of the rupture to the window after the ultrasound on 27th March 2017 and before the examination and drainage by the Defendant on 30th March 2017. His reasons for doing so mirrored those of the Defendant namely that:-

i) The radiologist had confirmed a subcutaneous haematoma but had not identified any tear and he would have been expected to do so if it was present thus his silence on the issue was proof that there was no tear on that date.

ii) The radiologist had drained the knee not from one but two entry points (the joint and the haematoma) and obtained subtly different liquids "Haematoma fluid" from the haematoma and "Haematoma type fluid" from the joint.

iii) The fact that there had to be separate aspirations of the knee joint was suggestive of there being no communication between the joint and the hematoma.

68. In cross examination Mr Hunjan QC took Mr Anand to task over this significant change of position. Why, he asked, were these (seemingly obvious and important) points not raised before? Why had Mr Anand, who had identified the formation of the retinaculum defect as having occurred at a time synchronous with the initial appearance of the egg shaped swelling the Claimant's leg, moved the date of the formation of the tear to a date after the ultrasound scan? Why, when he had clearly noted the content of the ultrasound scan in his report did he only now attach significant weight to it?

69. I considered this late change in position on behalf of the Defendant's expert did undermine both the credibility and reliability of some of Mr Anand's evidence.

70. Overall I was not persuaded that the ultrasound scan report and the absence of record of a finding of a defect in the retinaculum had the weight that either the Defendant or Mr Anand attributed to it. The radiologist in question was not asked to give evidence, and his written radiology report is not in my view conclusive of the issue. I accepted the argument of the Claimant and his expert that it is possible that the relevant tear (which was not expected to be seen) may have been missed at ultrasound and rejected the suggestion that the fact that report indicated there were two aspirations one from the joint and one from the haematoma was conclusive proof that there was no communication between the joint and the haematoma. As to the subtly different descriptions of the aspiration, "haematoma fluid" and "haematoma type fluid" I was unpersuaded this was a significant difference and note that the Defendant himself did not consider the contents of the aspirations relevant.

Microbiology evidence

71. Expert microbiology evidence had been obtained by both parties but neither expert gave oral evidence. The key answers in the joint statement which were relevant were question 7:-

> "We agree that in our clinical experience we have not seen a case of damage to the medial retinaculum due to infection."

And question 8:-

> "We agree that we are not able to determine the cause of the Claimant's medial retinaculum rupture and we defer to the expert orthopaedic surgeons on this matter".

Conclusions on the Expert Evidence

72. Overall, in making the assessment of whether to accept an expert opinion I reminded myself that the court should take into account a variety of factors including, but not limited to: whether the evidence is tendered in good faith; whether the expert is "responsible", "competent" and/or respectable; and whether the opinion is reasonable and logical. See: *Bolitho v City and Hackney HA* [1998] AC 232. In this context, the task of the court is to see beyond stylistic blemishes and "*to concentrate upon the pith and substance of the expert opinion and to then evaluate its content against the evidence as a whole and thereby assess its logic*." see: *C v Cumbria University Hospitals NHS Trust* [2014] EWHC 61.

73. Weighing the expert evidence in the round and against the totality of the evidence as a whole and in particular the contemporaneous evidence as recorded in the clinical notes, I considered that it was likely that a rupture of the retinaculum at least of some degree had probably occurred prior to the development of the egg-shaped lump on the Claimant's left knee which he became worried about on or about 23rd and 24th March and which he photographed and which resulted in him texting Mr Thrush on the evening of 23rd March.

74. In my judgment, the issue in this case is therefore narrowed as to whether the defect occurred at the time of surgery or in the aftermath of surgery and at some time before 23rd/24th March.

75. While I accept it may be unlikely that the Claimant's alleged 'non-compliance' with rehabilitation instructions was the direct cause of any tear and also accept that the 'low grade' infection which had developed prior to the 17th March by itself is likely to have caused the retinaculum to rupture, it does not necessarily follow that, having accepted that the medial swelling in the left knee was first noted on 21st March, and became concerning to the Claimant on 23rd March, that a 3cm diameter hole (around the size of a 50p coin as Mr Paul described it) was forcibly cut into the Claimant's medial retinaculum on 17th March by Defendant as a result of surgical error. There are a number of reasons for this:-

    i) To create such a 3cm diameter hole the Defendant would have had to use excessive force repeatedly. To cause such a large defect inadvertently in the course of the operation on 17th March was, on its face unlikely.

    ii) The Defendant would have had to move his 5mm shaver backwards and forwards in the area a good number of times and the defect should have been immediately apparent to him. It was not.

    iii) The Defendant is a highly experienced surgeon. That by itself does not mean he may not have erred on this occasion, but no one is suggesting that the hole was caused intentionally and if he did cause it, and fail to notice it immediately, this would suggest a high degree of inadvertence.

    iv) As Mr Anand and the Defendant indicated (and as I accepted) if a hole had been caused it is highly likely that fluid would have extravasated immediately from the hole within the surgeon's field of vision. This ought also to have brought the defect to the Defendant's attention.

v) Even if the defect had not been visualised on 17th March, and any extravasation of fluid had also been missed on 17th March (which I think unlikely if it had occurred), the drains were removed on 18th March at 2pm. No immediate swelling became apparent. While there was some evidence from Mr Paul and the Defendant that peak swelling was likely to occur in a 24 to 48 hour period, I consider it is likely that, as Mr Anand said, at least some swelling in the medial area of the knee would have been apparent by 19th March or 20th March. There is no evidence in the clinical notes that it was. The first trace of medial swelling of the knee being around 1415hrs on 21st March 2017 some four days after surgery.

vi) On 19th March the Defendant carried out a further arthroscopy washout with 15 litres of fluid and further debridement. I consider Mr Anand is right to say that the extravasation through the hole and into subcutaneous tissue should have been immediately apparent at washout. Mr Paul himself considered it would be "*remarkable*" if it had not been observed at washout but said that '*it can happen'*. What he really meant was "*it must have happened in this case*" because there could be no other explanation. He sought to explain how it might not have been observed by the fact that the size of the hole was large and that the extravasation would have been less obvious as it would have mixed more easily with the surrounding fluid. While superficially plausible, I reject Mr Paul's opinion on this point. The focus at washout (much as it was at the washout procedure carried out by Mr Ball on 4th July) would have been, at least in part, on the integrity of the knee joint. If there was a lack of tension or a hole in the capsule I consider it would be most unlikely that at least some extravasation would not have been seen in the course of washout under pressure which is a procedure lasting many minutes. Mr Paul himself acknowledged that a failure to see the what should have been obvious extravasation on 19th March would have been '*remarkable*'.

76. Overall, I considered the chances of a large hole in the retinaculum having been caused by use of the shaver and then missed by the Defendant while undertaking the synovectomy on a single occasion as very unlikely but possible. But to have made the hole during surgery, have missed it, and then failed to observe the defect both on washout on the 17th March and again on washout on 19th March when large amounts of fluid are pumped under pressure into and around the joint over a relatively long period (many minutes) and any defect should have been immediately obvious because of extravasation of fluid through the defect seems to me to be highly improbable.

77. That is not to say that some minor damage might have not have been caused at surgery by the Defendant by the use of the shaver, or that the retinaculum tissue might not have been weakened by the synovectomy procedure and thus became more liable to subsequent rupture. But I consider it to be highly unlikely that this 3cm diameter defect as shown on MRI was caused at the time of initial surgery on 17th March. While of course surgeons, as do other professionals, occasionally make mistakes, or fail to observe things that should have been clear and obvious, it is in my view on the evidence highly improbable that such failure to observe an obvious defect occurred repeatedly on at least three occasions (initial arthroscopy, washout on 17th March, and arthroscopy and washout on 19th March) in this case.

78. The Claimant nonetheless argues that even if very unlikely or '*remarkable*' that the defect was missed, that is, on the balance of probabilities what happened in this case, essentially because it is said, the competing causal mechanisms put forward by the Defendant to seek to explain what happened (e.g. infection, failure to comply with post-operative instructions) are so remotely unlikely that they can effectively be ruled out, thus leaving surgical error on 17th March, as the only realistic causal mechanism for the Claimant's injury.

79. In considering that argument I have reminded myself as to the proper approach to the burden of proof as explained by Lord Brandon in the well-known case of *Rhesa Shipping Co. SA v. Edmunds* [1985] 1 WLR 948 a case heard at first instance by Bingham J. as he then was.

80. In that case a ship, '*the Popi M'* had sunk in calm seas. The competing theories advanced before the judge as to how the ship came to sink were on the one hand that the proximate cause of the ship's loss was a collision with a submerged submarine ("the submarine theory") and on the other that the cause was wear and tear of the shell plating of the ship. Having set out seven cogent considerations which militated strongly against it, Bingham J. expressed his conclusion about the submarine theory in this way:

> "I think it would be going too far to describe a collision between the vessel and a submarine, rupturing the shell-plating of the vessel, as impossible. But it seems to me so improbable that, if I am to accept the plaintiffs' invitation to treat it as the likely cause of the casualty, I (like the plaintiffs' experts) must be satisfied that any other explanation of the casualty can be effectively ruled out."

81. In the present case, I have reached a similar conclusion. While I do not think it impossible that a 3cm diameter tear was caused at the time of surgery, I consider it to be highly improbable. It is therefore instructive to see how Lord Brandon analysed Bingham J's ultimate acceptance of the improbable submarine theory. He said at 951B-D:

> "it is important that two matters should be borne constantly in mind. The first matter is that the burden of proving, on a balance of probabilities, that the ship was lost by perils of the seas is and remains throughout on the shipowners. Although it is open to the underwriters to suggest and seek to prove some other cause of loss, against which the ship was not insured, there is no obligation on them to do so. Moreover, if they chose to do so, there is no obligation on them to prove, even on a balance of probabilities, the truth of their alternative case."

82. I note in passing that that is essentially the position taken by Ms O' Rourke QC in her skeleton argument on behalf of the Defendant in this case. Lord Brandon continues:-

> "it is always open to a court, even after the kind of prolonged inquiry with a mass of expert evidence which took place in this case, to conclude, at the end of the day, that the proximate cause

> of the ship's loss, even on a balance of probabilities, remains in doubt, with the consequence that the shipowners have failed to discharge the burden of proof which lay on them."

83. Lord Brandon then explained at 955H three reasons for rejecting what he described as "the Sherlock Holmes fallacy", a reference to a precept of the fictional detective hero of Sir Arthur Conan Doyle's novel the Sign of Four that: '*once you have eliminated the impossible, whatever remains, however improbable, is the truth*" and also explained why such a precept should not be applied in cases such as the present:-

> "The first reason is one which I have already sought to emphasize as being of great importance, namely, that the Judge is not bound always to make a finding one way or the other with regard to the facts averred by the parties. He has open to him the third alternative of saying that the party on whom the burden of proof lies in relation to any averment made by him has failed to discharge that burden. No judge likes to decide cases on burden of proof if he can legitimately avoid having to do so. There are cases, however, in which, owing to the unsatisfactory state of the evidence or otherwise, deciding on the burden of proof is the only just course for him to take.
>
> The second reason is that the dictum can only apply when all relevant facts are known, so that all possible explanations, except a single extremely improbable one, can properly be eliminated.
>
> The third reason is that the legal concept of proof of a case on a balance of probabilities must be applied with common sense. It requires a judge of first instance, before he finds that a particular event occurred, to be satisfied on the evidence that it is more likely to have occurred than not. If such a Judge concludes, on a whole series of cogent grounds, that the occurrence of an event is extremely improbable, a finding by him that it is nevertheless more likely to have occurred than not, does not accord with common sense. This is especially so when it is open to the Judge to say simply that the evidence leaves him in doubt whether the event occurred or not, and that the party on whom the burden of proving that the event occurred lies has therefore failed to discharge such burden."

Conclusion

84. Ultimately my conclusion in this case is that the evidence leaves me in very considerable doubt as to whether the hole or defect in the retinaculum was in fact caused on 17th March 2017. I certainly cannot say that on the balance of probabilities I consider that that is what happened. On the contrary I think the evidence of the Defendant, Mr Ball, Mr Thrush, Professor Haddad and Mr Anand corroborated to some extent by the evidence of Mr Paul in cross-examination shows that it is extremely unlikely that it did. I cannot rule out other possible causal mechanisms even though they too may be uncommon or unlikely. For example, I do not think it is wholly improbable that the

rupture or defect may have been caused by a multifactorial mechanism between 19th March and 23rd March, i.e. a weakened retinaculum as a result of infection, surgery and washout and some extension and contraction of the knee post-surgery on leaving hospital. Equally I do not find it wholly improbable that a small hole in the capsule and retinaculum which was non-negligently caused and not seen by the Defendant on 17th March or 19th March may have developed and widened as the joint was extended and contracted over the course of three or four days into a large defect in the retinaculum. That would explain why the first signs of the swelling are small on 21st March when they are first noted by a physiotherapist in hospital, and why the initial swelling noted by the Defendant was thought to be a small haematoma but also why by the 23rd and 24th after discharge, and after the leg has been extended and contracted to some extent, the egg-shaped lump developed.

85. In summary, the evidence adduced by the Claimant and his expert has not been sufficiently cogent or compelling to allow me to conclude on the balance of probabilities that the Defendant caused a 3cm diameter defect to the Claimant's medial retinaculum on 17th March 2017 in the course of the synovectomy procedure.

86. In those circumstances, I conclude that the claim has not been proved on the balance of probabilities and for that reason the claim must be dismissed.