Neutral Citation Number: [2022] EWHC 1963 (QB)

Case No: G90LV010

IN THE HIGH COURT OF JUSTICE
QUEEN'S BENCH DIVISION
LIVERPOOL DISTRICT REGISTRY

Liverpool Civil and Family Court
35 Vernon Street, Liverpool L2 2BX

Date: 28/07/2022

Before :

THE HON. MR JUSTICE TURNER

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Between :

Jaclyn McCaul	**Claimant**
- and -	
Lancashire Teaching Hospitals NHS Foundation Trust	**Defendant**

- -
- -

Gerard Martin QC and **Sara Sutherland** (instructed by **Jackson Lees**) for the **Claimant**
Erica Power (instructed by **Hempsons LLP**) for the **Defendant**

Hearing dates: 11, 12 and 13 July 2022

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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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THE HON. MR JUSTICE TURNER

The Hon Mr Justice Turner :

1. This is a clinical negligence claim. On 28th June 2017, the claimant underwent an operation at the Royal Preston Hospital. The purpose of the procedure was to increase the hitherto restricted blood flow to her right leg. It was carried out by Mr Spachos, a consultant vascular surgeon. Unhappily, the outcome was very poor. The leg did not thrive. On 4th July, a below knee amputation ("BKA") was performed. Even this procedure proved to be insufficient. Finally, on 17th July, an above the knee amputation ("AKA") was carried out.
2. The claimant's case, as originally pleaded, alleged a number of shortcomings in the management of her treatment leading up to the operation of 28th June. However, all of these were abandoned shortly before the trial. The only remaining criticism relates to Mr Spachos's performance of the operation of 28th June. Had this procedure been carried out with reasonable care then, although the BKA would still have been required, it is alleged that the later AKA would not have been necessary. The defendant, which is vicariously liable in respect of any negligence which may be proved against Mr Spachos, denies both liability and causation. It has been ordered that the issue of quantum, should the claimant succeed at this stage, will be determined later.
3. Despite the fact that the scope of the disputes between the parties was significantly reduced by the claimant's recent concessions, there persisted a considerable number of areas in which the expert evidence remained in a state of conflict. I have not attempted in this judgment to resolve or even identify each and every such conflict. To do so would have rapidly engaged the law of diminishing returns. The parties may, however, rest assured that I have carefully considered the entirety of the evidence and that where I have omitted to make any finding it is not one which would have changed my view of the central issues in the case.

BACKGROUND

4. The claimant, as a heavy smoker, was vulnerable to the development of arterial disease. Matters came to a head on 12th May 2017 when she presented to her GP with a two week history of blackening to the fourth toe on her right foot. She was admitted to the Royal Preston Hospital on 30th May. Two days later, a CT angiogram revealed stenosis of the right common iliac artery.[1]
5. The claimant was treated with angioplasty on 8th June. This is a procedure which involves inflating a small balloon within the affected area with a view to widening the artery and enhancing the flow of blood.

[1] Appended to this judgment is a simple diagram illustrating (for the benefit of those who, like myself, have no specialist medical knowledge) the anatomical features relevant to the claimant's presentation at that stage.

6. The claimant was discharged on the day following her operation. However, her right leg continued to deteriorate. She was re-admitted on 26th June with necrosis of the right foot. A CT angiogram revealed an occlusion at the site of the earlier angioplasty which had probably been caused by a thrombosis.
7. Further surgery was required to address the claimant's continuing problems. This was the operation performed by Mr Spachos which is alleged to have been carried out negligently.

THE CLAIMANT'S CASE

8. The CT angiogram performed following the claimant's re-admission was recorded to have revealed that the right common iliac artery was 50% patent whereas the common femoral artery was fully occluded.
9. At 5pm Mr Joseph, the surgeon of the week, went on his ward round and recorded that he had explained to the claimant that she was at "high risk of limb loss". He later went on to discuss the case with Dr Mathew, a consultant interventional radiologist. On 27th June, their recommendation was recorded by a trainee, Mr Porter: "Dr Joseph – he has reviewed images with Dr Mathews (sic.), they feel right common iliac angioplasty/stent plus right CFA thrombo-endarterectomy plus patch is best way forward."
10. The claimant went on to sign a consent form in which the proposed procedure is recorded as "right iliac angiogram + or – proceed to right common iliac artery angioplasty/stent plus right common femoral artery thrombo-endarterectomy plus patch."
11. It is common ground that the operation actually performed by Mr Spachos was limited to the endarterectomy and patch. It did not include an angioplasty to the right common iliac artery. His operation note is silent as to his reasons for departing from the plan.
12. In brief outline, the claimant's case, supported by the expert opinion of Professor Braithwaite, consultant vascular surgeon, is that it was negligent of Mr Spachos not to proceed with the angioplasty and, had he done so, it would not have become necessary subsequently to perform an AKA. A BKA would have sufficed.

THE DEFENDANT'S CASE

13. The defendant contends that the fact that the CT angiogram is recorded to have revealed a 50% reduction in the diameter of the right common iliac artery did not, of itself, mandate an angioplasty. Mr Cameron, the expert consultant vascular surgeon relied upon by the defendant, expressed the view that such a level of obstruction should be placed in the moderate rather than the severe category. Furthermore, precise measurements of the scan performed by Professor Gaines, consultant vascular radiologist instructed on behalf of the defendant, revealed that the actual reduction was less than 40%. It would not therefore be surprising if blood flow here remained good. There is not a linear relationship between flow and arterial diameter because, until

the artery is more severely occluded, the velocity of flow increases to make up for the deficit.

14. Operation plans are no substitute for what the surgeon is able to see during the course of his operation. If Mr Spachos was satisfied that the blood flow passing down through the right common iliac artery was good then the angioplasty would not be called for. Indeed, it would be counter-indicated because angioplasty procedures are not without rare but potentially harmful iatrogenic consequences.
15. The central issue therefore arises as to whether or not there was a good flow in the right common iliac and common femoral arteries after the endarterectomy had been performed.

THE CT ANGIOGRAM

16. There was considerable controversy surrounding the question as to the degree of stenosis which would usually be expected to have a material impact upon the flow of blood through the affected artery. Unhappily, there would appear to be a dearth of scientific evidence and helpful studies on this topic. Professor Braithwaite stood by the approach that, in general and according to conventional consensus, a narrowing of 50% was an indication that flow was likely to be impeded. This, indeed was the degree of stenosis recorded on the CT angiogram. However, Professor Braithwaite did not seek to challenge the measurements performed by Professor Gaines indicating that the actual narrowing fell below 40%.
17. This, of course, does not mandate the conclusion that there must have been good flow but it does make it less likely that the degree of stenosis revealed on the CT scan was haemodynamically significant than it would have been had the narrowing been 50% or greater.

MR SPACHOS

18. The purpose of the operation performed by Mr Spachos, consultant vascular surgeon, was to restore the flow of blood through the claimant's compromised arteries and into the leg. The endarterectomy involved removing the material, or blockage, in the lining of her right common femoral artery. As the diagram appended to this judgment illustrates, the site of this procedure lay downstream of the narrowed common iliac artery. No criticism is levelled at the skill with which the endarterectomy itself was performed but it would have been useless unless there was also good flow through the common iliac artery above it.
19. In his witness statement, Mr Spachos said that he did not recall his involvement with the claimant and his evidence was, therefore, based upon the medical records and his account of his usual clinical practice. In the witness box, however, he purported to recall checking her femoral pulse before the operation and having a conversation about her case with Mr Joseph. I do not find his recovered memories to be reliable. He was plainly

very uncomfortable under cross-examination and was, understandably, somewhat defensive in his responses to questions the legitimate purpose of which was to demonstrate a lack of professional care on his part in performing the operation. Nevertheless, I do not conclude that he was deliberately trying to mislead the court but that, under pressure, he lapsed into that state of mild happy hindsight familiar to all practitioners of professional negligence litigation. His lapses, however, were limited and I find that they were not such as to entitle me either to disregard, or even significantly discount, his evidence on broader issues and, in particular, his usual clinical practice.

20. The claimant contends that, taken as a whole, the evidence supports the conclusion that Mr Spachos either did not know about the management plan and/or had made the decision not to perform an angioplasty preoperatively.
21. In support of this analysis, reference is made to the following documents which refer only to a femoral endarterectomy and not to an angioplasty:
    (i) the pre-operative checklist;
    (ii) the anaesthesia record; and
    (iii) the operation note.
22. Although I am not satisfied that Mr Spachos had a distinct memory of checking the claimant's femoral pulse before the operation and finding it to be satisfactory, I consider that he probably did so as a matter of routine practice. This would explain why he formed the provisional conclusion that an angioplasty may well not prove to be necessary. This would also explain why there was no reference to angioplasty on the forms referred to above. It is also to be noted that femoral pulses (albeit indicating nothing more than merely palpable) had been noted on the claimant's admission on 26th June.
23. Nevertheless, I am not satisfied that Mr Spachos went into the procedure without reading the management plan or history of the claimant. Neither the plan not the history mandated the course which the operation should take. On the contrary, it would be wholly wrong to allow the plan or history to dictate a surgical course plainly contra-indicated by what is found during the course of surgery.
24. There was an issue between the experts as to whether Mr Spachos was entitled to be as confident as he claimed to have been that an angioplasty was unlikely to have been necessary following a finding of a femoral pulse. It is not necessary for me to resolve this issue because I am satisfied that, regardless of his views going into surgery, he would not and did not carry out the endarterectomy oblivious to the state of flow into the artery upon which he was operating.
25. In his witness statement he noted:

> "If the inflow from the iliac artery had been poor then I would not have proceeded with the femoral endarterectomy as that would have been pointless…

> "Inflow" is a term used to describe the blood coming down from the heart into the relevant artery. If the inflow to the common femoral artery (i.e. from the common iliac artery) isn't good the flow of blood to the leg is more restricted. I did not have any concerns regarding the inflow during the procedure and if there had not been good inflow from the common iliac artery I would not have performed the endarterectomy."

26. In his oral evidence he said:

> "Mr Joseph and Dr Mathew were giving a recommendation that angioplasty should be performed in conjunction with femoral endarterectomy, so this is a recommendation, this is not an order. MDT decisions can be changed intra-operatively depending on findings, therefore the plan was to cut down in groin, access inflow and, depending on inflow, we either do an angiogram and angioplasty followed by endarterectomy or if happy with inflow do endarterectomy alone...It is intra-operative assessment of inflow…you can only make that decision once you have put your hands on the patient…I [established] a femoral pulse so to have an angioplasty was highly unlikely…what matters is the patient on the table and if the patient is on the table we try to do our best [no time limitations]
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> …
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> When we perform endarterectomy we always have to assess inflow, it is very important so what we do is clamp the arteries above and below the blockage and then we release the top clamp and see what blood flow is from top, so my assessment of inflow is always to access that whooshing sound that blood does when it comes out of artery with force and to assess whether there is blood flow outside the blood vessel even during the systole and diastole of the heart…"

27. I accept Mr Spachos's evidence that he found the inflow to be good and that he performed the whoosh test. This, I am satisfied, would be standard vascular surgery procedure and a consultant vascular surgeon such as Mr Spachos would have done this as a matter of course. As part of the procedure he would clamp the CFA at the inguinal ligament and there would have been no point in clamping an artery without a pulse. This also explains why the operation notes do not make express mention of the existence of a good flow. More salient and worthy of record would have been the finding of a poor flow. It is also to be noted that the operation note refers to a good pulse in SFA (Superficial Femoral Artery) and PFA (Profunda Femoral Artery) both of which are downstream of the CFA.

POST-OPERATIVE DEVELOPMENTS

28. The claimant contends that the absence of a good inflow at the time of Mr Spachos's operation is evidenced by the very fact that an AKA was subsequently required. The force of this contention is, however, significantly diluted by a number of features.
29. On the ward round on the day following the operation, the claimant's right leg was noted to be "warm and well perfused".
30. On 4th July, a BKA was performed. As Professor Braithwaite asserted in his report of 21 December 2021, no reasonable surgeon would have performed a below knee amputation when there was no femoral pulse in a patient who had previously had stable arteries.
31. There is no dispute that the fact that the failure of the BKA does not prove, of itself, that there was poor inflow at the site of Mr Spachos's operation. The experts on both sides agreed that there are cases in which an AKA is required for no clear reason. There were a number of features in the claimant's history which made a poor outcome more likely than may otherwise have been the case. She had a long history of heavy smoking. She presented with peripheral vascular disease at a young age. She had suffered a stroke aged 38 and a transient ischaemic attack aged 51. She was prothrombotic having recently undergone major surgery and was taking Methotrexate which is associated with poor healing.
32. In short, I did not conclude that post operative developments, when taken as a whole, lent sufficient force to the claimant's case to undermine my conclusions as to the presence of a good flow at the time of Mr Spachos's operation. Had I been satisfied, however, that there had not been good flow at the time of Mr Spachos's operation then I would have found causation to have been made out.

CONCLUSION

33. There can be no doubt whatsoever that the claimant has endured a series of terrible medical setbacks which have undoubtedly had a serious impact on her quality of life. No one reading the background history could fail to have considerable sympathy for her after what she has been through. Nevertheless, compensation is only legally justified upon proof of negligence leading to loss. In this case, I am satisfied that negligence has not been made out and that the claim must fail.

APPENDIX

Diagrams & Images

CT Angiogram 1 June 2017