Neutral Citation Number: [2023] EWHC 3115 (KB)

Case No.: QB-2021-002451

IN THE HIGH COURT OF JUSTICE
KING'S BENCH DIVISION
ROYAL COURTS OF JUSTICE

Date: 5th December 2023

Before:
MR JUSTICE RITCHIE
- -

BETWEEN

MICHELLE PARSONS

Claimant

- and –

ISLE OF WIGHT NHS TRUST

Defendant

John De Bono KC (instructed by **Penningtons Manches Cooper**, London) for the **Claimant**
Richard Mumford (instructed by **DAC Beachcroft**) for the **Defendant**

Hearing dates: 21st-24th November 2023
- -
APPROVED JUDGMENT

This judgment was handed down by the Judge remotely by circulation to the parties' representatives by email and released to The National Archives. The date and time for hand-down is deemed to be at 10:00 am on 5th December 2023

Mr Justice Ritchie:

The Parties

1. The Claimant was a patient of the Defendant at the St. Mary's Hospital on the Isle of Wight in 2018 [the Hospital].

2. The Defendant is the trust responsible for the standard of clinical care provided at the Hospital.

Bundles

3. For the hearing I was provided with a core bundle, a bundle of medical notes, an authorities bundle, skeleton arguments, a three dimensional skeleton and a 16 Gauge Touhy trocar [the Trocar].

Summary

4. This is a clinical negligence claim. The trial was to determine liability. In summary, in May-June 2018 the Claimant was diagnosed with bowel cancer and advised that she needed a right hemi-colectomy operation. This substantial and risky operation was performed successfully by Mr Nelson on the 2nd of July 2018 at the Hospital. The Claimant has recovered well from it. However, before the operation 10 attempts were made by consultant anaesthetists at the Hospital to site a Trocar into the Claimant's back to provide post operative pain relief by way of epidural anaesthetic. None of these was successful. It is agreed that one of the attempts to push the Trocar into the Claimant's back in fact travelled past the epidural space through the Dura, straight through the spinal cord and out of the other side. This caused damage to the spinal cord at the T11/T12 level and caused a bleed which travelled down the right anterolateral space (front - right) around the cord causing a haematoma (blood) from L1 to L3.

Quantum

5. The damaged nerves in the spinal cord led to the Claimant suffering post operative symptoms including reduced power in her right leg, pain in her right leg, pins and needles in her right leg, right hip ache, occasional giving way and lack of sensation when urinating. These symptoms reduced the Claimant's ability to walk for long distances, stand for long periods, climb and descend stairs and exacerbated her pre-existing anxiety and depression. The Claimant can drive, albeit she has an adapted car so that she uses her left foot instead of her right. She requires a moderate level of care and is no longer able to work as a barmaid, her pre accident employment. She has had to move to a two bed bungalow for level-access accommodation. The quantum of the claim has been agreed at £1.3 million. Liability is in issue.

Terminology

6. I shall use the following shorthand terminology in this judgment:

   POPR: post operative pain relief.

   EPI: epidural anaesthetic. When correctly done this involves using the Trocar to penetrate the Claimant's skin [at the midline of the back in this case] at an

upward angle (and slightly sideways on occasion) and pushing it between the vertebral bones and through:

- the subcutaneous fat,
- then through the back muscle,
- then through the supraspinous ligament,
- then through the intraspinous ligaments,
- then through the Ligamentum Flavum and into the epidural space,

then removing the plunger from the Trocar, inserting a catheter through the Trocar and administering anaesthetic fluid.

WEPI: waking epidural anaesthetic (as above but performed when the patient is awake),

UEPI: unconscious epidural anaesthetic (as above but performed when the patient is under general anaesthetic).

PCA: patient controlled analgesia (morphine) delivered after the operation by means other than an epidural.

T11/12: The level of the human spine indicated by the numbered vertebrae. "T" means thoracic.

The Issues

7. By the end of the trial there were only two remaining issues on breach of duty:

   7.1 did Doctor Rice obtain the Claimant's informed consent to carry out the attempted UEPIs, having already attempted and failed at 3 WEPIs?

   7.2 Did carrying out the last few of the 10 attempted epidural anaesthetics with the Trocar (there were 3 attempted WEPIs and 7 attempted UEPIs) amount to negligent treatment?

8. Whilst it was pleaded that the Defendant's consultant staff used a negligent technique or performed the technique negligently because one of them pushed the Trocar through the Claimant's spinal cord, that assertion fell away because it was not supported by the Claimant's anaesthetic expert, either in his report or in the joint report and in addition it was not supported by any other expert evidence.

9. Causation is also in issue. For the breach at para. 7.1 above, if I find (1) a lack of informed consent is proven and (2) that on the but for projection the Claimant would have refused consent to UEPI, then causation follows because the unchallenged evidence called and led by the Defendant from Doctor McLean, a neurologist, was that on the balance of probabilities the cord damage was caused during the attempted UEPIs not the WEPIs. The anaesthetic experts agreed with his analysis and the parties agreed that this was so in submissions. So, I find as a fact that the cord damage was caused during one of the attempted UEPIs. For the breach at para. 7.2 above the causation issue is much more complicated. It was agreed that the cord damage occurred at the T11/T12 level because the MRI scans showed the damage was there. However, it was not possible for the Claimant to prove which attempted UEPI caused the cord damage.

The Defendant's consultants did not set out in their notes or witness statements, for each of the 10 attempts, at which vertebral joint level the attempt was sited or how far in the Trocar went. Without knowing which attempt/s was (or were) at T11/T12, it might be difficult to prove which attempt did the damage, however the Defendant made an admission in the defence at para. 14 that Doctor Rice's 3 UEPI attempts were at the T11/12 and T12/L1 levels and 2 of those passed the bones and went towards the Dura. No admission was made about the levels of Doctor Michalou's 4 UEPI attempts.

Pleadings and chronology of the action

10. The Claimant's letter before action was dated 17th March 2020. The Claimant, through her solicitors, asserted that on the 2nd of July 2018 Doctor Rice assessed the Claimant before the bowel surgery and explained the risks of the POPR procedure and noted them in the anaesthetic record. However, it was asserted that Doctor Rice failed to set out the alternative options for POPR which should have included PCA using morphine. The letter went on to explain the Claimant's version of the three attempted WEPIs which became increasingly painful. The Claimant asserted that the third was so painful she said "stop". She asserted she did not consent to any more EPIs under anaesthetic (UEPIs). She alleged negligence by the Defendant including failing to consent the Claimant for the UEPIs; failing to provide her with POPR options; attempting too many (10) EPIs and carrying out one UEPI at the wrong place, namely L3/L4.

11. In the response letter dated September 2020, the Defendant denied breach and asserted that the options for POPR were discussed with the Claimant before the operation. The Defendant asserted that a leaflet had been given to the Claimant. The Defendant denied using negligent techniques and asserted that UEPI was used for patients who could not handle WEPI pain. The Defendant asserted that the Claimant had consented to the UEPIs.

12. The claim form was issued in June 2021 and in the original Particulars of Claim [PoC] the Claimant asserted that she did not give informed consent because she was not advised that there were alternative forms of POPR rather than just epidural. In relation to the facts, the Claimant asserted that after the third WEPI she asked Doctor Rice to stop and that she did not consent to any UEPIs. It was pleaded that Doctor Rice's post operative communications contained inaccuracies. In the particulars of negligence the Claimant asserted that, because Doctor Rice failed to discuss POPR options with her, she did not provide "informed" consent. In addition, the Claimant asserted that the 10 attempted EPIs were excessive in number and that the increased risk with the increased number of UEPIs implied a lack of skill and care. Further it was asserted that a negligent technique was used for the EPI which resulted in the cord damage.

13. On the 25th of October 2023, about 3 weeks before the trial commenced, the Claimant amended her PoC. Nothing was deleted but two paragraphs were added. In the first, the Claimant accepted that had she been given a reasonable explanation of the options for POPR she would probably have followed any clear recommendation from Doctor Rice

to have an epidural. In the second, it was pleaded that the Claimant had no discussion with Doctor Rice after the WEPIs in relation to treatment options and that had such a discussion taken place she would have refused to consent to UEPIs or any further EPIs at all and chosen PCA.

14. In the defence, dated 28th October 2021, the Defendant asserted that the Claimant had been consented for the bowel operation on the 28th of June 2018 and was consented for the EPIs on the 2nd of July 2018. It was asserted that on the 28th of June Nurse Barclay gave the Claimant a patient information leaflet on POPR options. This specifically set out not only EPI and PCA but other forms of pain relief post operatively. In addition, the Defendant asserted that on the 29th of June 2018, at an anaesthetic preoperative clinic, Doctor Henderson set out the "operative risks". The Defendant did not set out in the pleading whether the risks discussed were the risks of the bowel surgery or the risks the various POPR options. The Defendant asserted that on the 2nd of July 2018 Doctor Rice's notes showed that she explained the risks of EPI including permanent nerve damage and failure of the EPI. The Defendant asserted Doctor Rice discussed POPR alternatives including PCA and the risks of PCA, which included a higher nausea rate. It was asserted that the Claimant said she did not wish post operative pain, nausea or vomiting and accepted the recommendation for EPI. Specifically, it was pleaded that Doctor Rice told the Claimant that the risks of permanent neurological damage from EPI were between 1:30,000 and 1:10,000. The Defendant accepted that 10 attempted EPIs took place and that 4 involved the Trocar passing beyond subcutaneous tissue. The technique was explained. It was pleaded that WEPI penetrations 1 and 2 met bone and that penetration 3 went past the bone but that because Doctor Rice felt no "loss of resistance" she considered the Trocar was not in the correct position and abandoned the waking epidural attempts. It was asserted that the Claimant found the penetrations painful, despite local anaesthetic and was unable to remain slumped forwards whilst seated. The Defendant asserted that Doctor Rice discussed her plan to administer general anaesthetic and then to attempt UEPI and that the Claimant agreed with this course. It was pleaded that Doctor Rice administered general anaesthetic and attempted three UEPIs at T11/12 and T12/L1, so two levels. One hit bone but two passed through the subcutaneous tissue, however Doctor Rice felt no loss of resistance in the syringe plunger and so abandoned the procedures. She then asked Doctor Michalou, a fellow consultant, to assist, discussed the case with her and Doctor Michalou carried out 4 further UEPIs. Of those, three hit bone and one went through. The Defendant denied negligence and lack of consent. The Defendant relied on the information leaflet given on the 28th of June and the explanation with alternatives given by Doctor Rice on the 2nd of July. The Defendant pleaded that the PoC did not say what the Claimant would have done if alternatives had been explained (on the Claimant's case). The defence explained that it was reasonable to make multiple attempts because 6 of the 10 attempts had met bone and therefore presented no risk to the Claimant's spinal cord. Causation was denied.

15. Although the pleaded issues were many, by the time of trial certain issues had been agreed. It was agreed that the Claimant's cord was damaged at T11/T12 as a result of a Trocar being pushed from the back of the cord through to the front, during one of the attempted EPIs. In opening the Claimant's case was narrowed, excluding the assertion of negligent technique. The Claimant also abandoned the factual assertion that she said "stop" after the 3 WEPIs. Thus, the only two remaining real issues on breach were as set out in paragraph 7 above.

Evidence generally

16. When considering the evidence from lay and expert witnesses in this case I bear in mind that the Claimant carries the burden of proof for all facts and matters necessary to prove her claim. The standard of proof applying in civil claims is the balance of probabilities.

17. In relation to the evidence of the experts I bear in mind the requirements set out in the Civil Procedure Rules Part 35 and the practice direction thereto and the guidance in the judgment of Cresswell J in *the Ikarian Reefer: National Justice v Prudential Assurance* [1993] 2 Lloyd's Rep. 68, at para. 81:

> "The duties and responsibilities of expert witnesses in civil cases include the following:
> 1. Expert evidence presented to the Court should be, and should be seen to be, the independent product of the expert uninfluenced as to form or content by the exigencies of litigation: *Whitehouse v. Jordan* [1981] 1 W.L.R. 246 at 256, per Lord Wilberforce.
> 2. An expert witness should provide independent assistance to the Court by way of objective, unbiased opinion in relation to matters within his expertise: *Polivitte Ltd. v. Commercial Union Assurance Co. plc* [1987] 1 Lloyd's Rep. 379 at 386, Garland J. and *Re J* [1990] F.C.R. 193, Cazalet J. An expert witness in the High Court should never assume the role of an advocate.
> 3. An expert witness should state the facts or assumptions upon which his opinion is based. He should not omit to consider material facts which could detract from his concluded opinion (*Re J*, supra).
> 4. An expert witness should make it clear when a particular question or issue falls outside his expertise.
> 5. If an expert's opinion is not properly researched because he considers that insufficient data is available, then this must be stated with an indication that the opinion is no more than a provisional one (*Re J*, supra). In cases where an expert witness, who has prepared a report, could not assert that the report contained the truth, the whole truth and nothing but the truth without some qualification, that qualification should be stated in the report: *Derby & Co. Ltd. and others v. Weldon and others*, The Times, 9 November 1990, per Staughton L.J.

> 6. If, after exchange of reports, an expert witness changes his view on a material matter having read the other side's expert's report or for any other reason, such change of view should be communicated (through legal representatives) to the other side without delay and when appropriate to the Court.
> 7. Where expert evidence refers to photographs, plans, calculations, analyses, measurements, survey reports or other similar documents, these must be provided to the opposite party at the same time as the exchange of reports (see 15.5 of the Guide to Commercial Court Practice)."

18. Further, in relation to the expert evidence, I take into account the guidance in *Imperial Chemical v Merit Merrell* [2018] EWHC 1577, by Fraser J at para. 237:

> "237. The principles that govern expert evidence must be carefully adhered to, both by the experts themselves, and the legal advisers who instruct them. If experts are unaware of these principles, they must have them explained to them by their instructing solicitors. This applies regardless of the amounts at stake in any particular case, and is a foundation stone of expert evidence. There is a lengthy practice direction to CPR Part 35, Practice Direction 35. Every expert should read it. In order to emphasise this point to experts in future cases, the following points ought to be borne in mind. These do not dilute, or change, the approach in *The Ikarian Reefer*. They are examples of the application of those principles in practice.
> 1. Experts of like discipline should have access to the same material. No party should provide its own independent expert with material which is not made available to his or her opposite number.
> 2. Where there is an issue, or are issues, of fact which are relevant to the opinion of an independent expert on any particular matter upon which they will be giving their opinion, it is not the place of an independent expert to identify which version of the facts they prefer. That is a matter for the Court.
> 3. Experts should not take a partisan stance on interlocutory applications to the Court by a particular party (almost invariably the party who has instructed them). This is not to say that a party cannot apply for disclosure of documents which its expert has said he or she requires. However, the CPR provides a comprehensive code and it may be that disclosure is not ordered for reasons of disproportionality. However, if documents are considered to be necessary, and they are not available (for whatever reason), then an opinion in a report can be qualified to that extent.
> 4. The process of experts meeting under CPR Part 35.12, discussing the case and producing an agreement (where possible) is an important

> one. It is meant to be a constructive and co-operative process. It is governed by the CPR, which means that the Overriding Objective should be considered to apply. This requires the parties (and their experts) to save expense and deal with the case in a proportionate way.
> 5. Where late material emerges close to a trial, and if any expert considers that is going to lead to further analysis, consideration or testing, notice of this should be given to that expert's opposite number as soon as possible. Save in exceptional circumstances where it is unavoidable, no expert should produce a further report actually during a trial that takes the opposing party completely by surprise.
> 6. No expert should allow the necessary adherence to the principles in *The Ikarian Reefer* to be loosened.
> It is to be hoped that expert evidence such as that called by ICI in this case, and also in *Bank of Ireland v Watts Group plc*, does not become part of a worrying trend in this respect. There are some jurisdictions where partisan expert evidence is the norm. For the avoidance of any doubt, this jurisdiction is not one of them. Not only experts, but the legal advisers who instruct them, should take very careful note of the principles which govern expert evidence."

19. In relation to the non expert witness evidence I take into account what this Court said in *CNZ v Royal Bath* [2023] EWHC 19 (KB), at para. 51:

> "51. I acknowledge that it is inherent in all traumatic birth cases that some events become more illuminated in the minds of parents due to the trauma. I also take into account that memory, being a human talent or function, is not perfect nor is it made of concrete. On the contrary it may be degraded by time, enhanced by emotion, refined by repetitious discussion or lost or buried in part or in whole. In addition it may be innocently reconstructed in part or in whole by discussion, events, emotion (for instance anger or sorrow) and time."

20. When assessing the credibility of the written and oral witness evidence provided to this Court I take into account the following matters.

20.1 In clinical negligence claims where there are medical notes made by professionals acting under professional duties to make proper notes, those notes carry weight firstly, because they are contemporaneous records made at the time and secondly, because they are made under a professional obligation to be an accurate, frank and complete record of the medical process, what was done, by whom and when. To a greater or lesser extent the medical records are also a note of what was said by the Doctors to the patient and vice versa. Although the relevant written professional guidance from the Royal College of Physicians, the Royal College of Surgeons and the Professional Records Standards Body was not provided in evidence, this Court was provided with evidence by the

anaesthetic experts about the relevant standards of record taking for the key issues.

20.2 When claimants' and treating clinicians are asked to provide witness statements in clinical negligence claims long after the events which are the subject of the statements, they have available to them various sources to assist their recollection. The medical notes are the primary source. In addition, there may be available to them various secondary sources of semi-contemporaneous records for instance: post event medical notes made by the clinicians in the patients' records; hospital investigation statements; mortality meeting statements; duty of candour statements and complaint letters.

20.3 If the medical notes, the primary source records, do not contain any record of a relevant fact or matter, then secondary sources may be the only record to assist the treating clinician's recollection. If there are no documented secondary sources for the relevant facts and matters then the claimants and the clinicians are left to rely solely on their memories.

20.4 Memory is a human faculty which has been much studied by psychologists. It is the process by which we capture certain information through our senses (sight and hearing and touch) and store it, but the process inherently involves the leaving out or forgetting of certain details when the information is stored. Even with events from yesterday, or last week, only part of the details of the events will be retained, not every tiny detail. Furthermore, the recalling of memory involves retrieving the information from the memory and recording it in the claimant's or the clinician's witness statement through the written words. When memory is retrieved and put into a witness statement, to an extent the words written depend on the questions asked and the accuracy of the memory. Where the memory is vague or has gaps, certain manipulating factors may affect the written recollection, for instance: guessing; filling in the gaps with logic; conscious or unconscious bias; subsequent remorse or suffering; anger and resentment; suggestion by the questioner and self-preservation or guilt.

20.5 It is for these reasons, amongst others, that many clinicians' witness statements in clinical negligence claims set out what the clinician "would have done" or their "usual practice" because they cannot remember the facts and matters of what actually did happen. Likewise, the accounts of patients, made before seeing the medical records, often do not cover all of the facts and matters recorded in the medical records, so in many cases the patient's second witness statement, made after being shown the medical records, is more complete.

21. When approaching the credibility of witnesses Courts have developed certain well summarised factors which are taken into account. A witnesses' evidence may be assessed by reference to the following non exhaustive list of factors:

21.1 whether the witness had the medical notes before him/her when the statement was written;

21.2 the chronological consistency of the evidence;

21.3 the apparent truthfulness or honesty of the witness;

21.4 the internal logic of the evidence;
21.5 the external logic of the evidence by reference to the contemporaneous documents, events and other accounts;
21.6 the corroboration (if any) of the evidence by reference to the contemporaneous documents, events and other accounts;
21.7 the apparent or actual motivation of the witness;
21.8 the emotional, conscious or unconscious bias (if any) of the witness;
21.9 the independence of the witness;
21.10 the professional obligations which the witness was under when the events took place;
21.11 the demeanor of the witness when giving evidence.

22. I was assisted in submissions by reference to *Onassis v Vergottis* [1968] 2 Lloyd's Rep. 403 at 431 in which Lord Pearce gave this guidance:

> " "Credibility" involves wider problems than mere "demeanour" which is mostly concerned with whether the witness appears to be telling the truth as he now believes it to be. Credibility covers the following problems. First, is the witness a truthful or untruthful person? Secondly, is he, though a truthful person telling something less than the truth on this issue, or though an untruthful person, telling the truth on this issue? Witnesses, especially those who are emotional, who think they are morally in the right, tend very easily and unconsciously to conjure up legal rights that did not exist. It is a truism, often used in accident cases, that with every day that passes the memory becomes fainter and the imagination becomes more active. For that reason a witness, however honest, rarely persuades a judge that his present recollection is preferable to that which was taken down in writing immediately after the accident occurred. Therefore, contemporary documents are always of the utmost importance. And lastly, although the honest witness believes he heard or saw this or that, is it so improbable that it is on balance more likely that he was mistaken? On this point it is essential that the balance of probability is put correctly into the scales in weighing the credibility of the witness. And motive is one aspect of probability. All these problems compendiously are entailed when a judge assesses the credibility of a witness; they are all part of one judicial process. And in the process contemporary documents and admitted or incontrovertible facts and probabilities must play their proper part."

The lay witness evidence

23. I heard evidence from the following witnesses:
23.1 The Claimant.
23.2 Doctor Fiona Henderson.

23.3 Doctor Rice.
23.4 Doctor Michalou.

24. I read the evidence from Rochelle Edwards, the Claimant's daughter and Nurse Lesley Barclay.

The Claimant

25. The Claimant is 52 and lives in the Isle of Wight. Her surname was Furnell at the time of the relevant events. She has 3 children, a son and two daughters. She left school with 3 O-levels and worked in various fields. For many years she worked at Swinton Insurance, rising to manager by 2008 but she suffered bullying and emotional problems and left. After that she worked in a hotel rising up to head housekeeper. Later she changed to become a barmaid at the hotel. She was aiming to rise to bar manager. Healthwise, she had undergone two epidural anaesthetics for two caesarean sections for two of her children with no problems arising. In 2010 she fell down stairs and crushed a disc in her spine but this was resolved with physiotherapy. In 2011 she suffered stress incontinence. In 2012 she suffered carpal tunnel syndrome and had also a bone graft operation to one ear under general anaesthetic. She had suffered intermittent anxiety and depression in the past. In 2018 she suffered abdominal pain and vomiting and this led to the diagnosis of colon cancer in May or June 2018.

The chronology of events

26. In the section below I shall first set out each party's evidence on each of the three relevant dates and a summary of the medical notes for each event. Then I shall deal with the post operation events. By way of background in relation to consent, I should explain that the Defendant's case was that in 2018 surgical operations were consented in writing on a standard form, but anaesthetic procedures were consented verbally with no consent form to be signed by the patient.

28 June 2018 – the pre-operative assessment

27. On the 28th June 2018 the Claimant attended the Hospital for a pre-operative assessment. She met Nurse Barclay who could not recall the meeting by the time she came to write her witness statement. The medical notes recorded that Nurse Barclay assessed the Claimant's fitness, recorded her height, pulse, weight, BMI and ticked the box to show it was an anaesthetic appointment. She recorded next of kin and other general matters. She completed the control screening section and recorded the Claimant's two previous caesarean sections and her inner ear bone graft operation at Southampton General Hospital in 2012. A wider medical history was taken and a physical assessment was carried out. She recorded the Claimant's smoking and cannabis use. Various leaflets were given to the Claimant covering: the surgery, the consent form for surgery and pain relief. By the time of trial the "pain relief leaflet" had been identified and the parties agreed that it was the 2012 Hospital leaflet, which was out of date and had been improved and superseded by a newer, more informative leaflet issued in August 2017. The out of date leaflet was folded in two and printed on

both sides of one A4 sheet. It set out the options for POPR. These covered EPI and PCA (morphine) and others. No risks were set out in the leaflet. The EPI procedure was not described in any detail. On the same day the Claimant met Mr Nelson, the surgeon who was going to carry out the major bowel surgery to remove the section of bowel containing the cancer and to reconnect the two pieces of bowel remaining. A consent form was signed by Mr Nelson and dated 28.6.2018. In that he set out a written record that he told the Claimant of the risks of the bowel operation which were: bleeding; infections; anastomotic leak 5-10%; death 1-3% and anaesthetic complications. It was agreed by the time of trial that the warning as to anaesthetic complications related to the general anaesthetic not the POPR. Mr Nelson was not called by the Defendant. The Claimant's signature was not dated. The defence did not assert any discussion of risks of POPR taking place on this date. It was recorded on the PAAU clinic notes in Nurse Barclay's handwriting that the Claimant: "*Requires an Appt re major bowel 29.6.2018.*"

28. The events of 28.6.2018 were not mentioned in the Claimant's first witness statement (sworn 9 months after the events). No mention was made of any leaflet. The Claimant asserted that she was not told about any alternatives for POPR in July 2018. The events of 28.6.2018 were covered in the second witness statement (sworn 4 years and 3 months after the events) in which the Claimant accepted receiving a leaflet but asserted that there was no discussion about options or risks of POPR with Nurse Barclay. In cross examination the Claimant admitted that she did not read the leaflet. The Claimant also recalled signing the consent form on that date.

29 June 2018 PAAU (pre anaesthetic assessment unit)

29. In accordance with Nurse Barclay's appointment, the Claimant returned to the Hospital the next day for her PAAU visit. She met Doctor Henderson at the unit who was supposed to carry out the pre-anaesthetic assessment and provide her with information about the general anaesthetic for the major bowel surgery and general information about the options for POPR. Doctor Henderson was a witness who was plainly honest, kind and trying to assist the Court on the events of 29th June 2018. By the time of the trial she had retired. At the time of the events she was an associate specialist in anaesthetics. She had qualified in London in 1985 as a Doctor and in 1990 in anaesthetics. She worked at the Hospital from 1992 to 1997 and then took time off to travel. She took a degree in Architecture whilst doing intermittent locum work. Then she was a staff grade from 2000 to 2009 with various career breaks. From 2009 she was an associate specialist. In 2016 she suffered a nasty arm injury and returned part time, dropping down to the PAAU instead of front line anaesthetic work. She could not recall the meeting with the Claimant. Her witness statement was a recitation of her "usual procedure". The medical notes showed that Doctor Henderson took a short history from the Claimant of her previous anaesthetic events which were two caesarean sections, both of which involved regional anaesthetic (meaning EPIs) with no problems. Also, a previous general anaesthetic with no problems when she had an inner ear bone graft at Southampton General Hospital (SGH). She recorded no known drug allergies (NKDA – which was mis-written: NDKA). She recorded that the Claimant's exercise tolerance

was good and that she had 3-4 teeth crowns, which was a warning for the consultant anaesthetist who would intubate the Claimant. Doctor Henderson explained in her evidence (and I accept) that the PAAU meeting was not for taking consent from the patient for the choice of POPR because another anaesthetist would be the one to do that on the day of the operation, so the discussions she had with patients were always more general. In relation to the bowel surgery Doctor Henderson recorded that:

"Risks discussed + ACS risk score sheet given
Essentially I quoted:
Risk of anastomotic breakdown ~ 30%
Risk of death 3-4%
Risk of ileus <- 1in 5
Mrs Furnell understands these and wishes to proceed"

30. "ACS" was explained in evidence. It means the American College of Surgeons. The sheet was produced in evidence. In my judgment this was a wholly inappropriate thing for Doctor Henderson to have done at that time. Mr Nelson had consented the Claimant already the day before and had given the risks to the Claimant. His summary was different to the risks quoted by Doctor Henderson. For instance, he estimated the risk of death at 1-3%. There was no need for Doctor Henderson to go through all this with the Claimant again using different figures.

31. What Doctor Henderson did not note was any discussion of the POPR alternatives or the benefits and risks of each alternative: EPI and PCA. She had a half page in which to do so but wrote nothing on it. Nor did she note giving any risks involved in general anaesthetic. In her witness statement Doctor Henderson set out her "usual practice". She usually would discuss the need for POPR and mention EPI. She asserted that she *"might*" mention PCA as an alternative. She usually would explain the risks of EPI including a 15% failure rate; headache in 1% of patients; nerve damage which is temporary of 1:1,000 and permanent of 1:10,000; of which 1:50,000 would be debilitating, with haematoma at the same rate. In cross examination Doctor Henderson sought to persuade the Court that after she wrote her witness statement (October 2022) she did recover some memory of her meeting with the Claimant. I found that evidence to be unlikely. She asserted recalling discussing epidurals with her and because there was a note of the previous epidurals, I accept this was likely. Doctor Henderson admitted that she probably did not know that Mr Nelson had consented the Claimant the day before so that all of the risk information she had given to the Claimant was irrelevant and potentially confusing (because it was different). She gave evidence that the Hospital's out of date leaflet was updated in August 2017 and she accepted in cross examination that she had assumed that the Claimant had been given the correct leaflet: the updated one. Looking at the updated leaflet it clearly sets out that the Hospital understood how stressful and challenging it is for patients to be given a lot of information on the day of an operation, so it tries to provide the information in the days or weeks before the operation so the patient has to time to digest and decide without

rush. The relevant parts of the updated leaflet are set out in the Appendix to this judgment. I remind myself firstly that the updated leaflet was not given to the Claimant despite Doctor Henderson thinking that it had been given. In my judgment, because it is full of a lot of information, most members of the public would wish and need it to be explained to them in a more easy to understand, focussed and sympathetic way. In any event, Doctor Henderson accepted that the paragraphs in this leaflet on consent made it clear that consent to anaesthetic treatment was required separately from consent to surgery. That much was agreed by the Defendant. She also accepted that the updated leaflet was confusing because it implied that consent to anaesthetic was to be in writing, whereas at the Hospital it was always taken verbally. But none of this was relevant to the Claimant because she was never given the updated leaflet. It is relevant only to the extent that Doctor Henderson thought the Claimant had been given it. Doctor Henderson accepted in cross examination that she should have had a conversation with the Claimant on POPR and the relative risks and benefits of EPI and PCA and should have recorded that. She did not record any such discussion. I consider that her failure to make a record of any discussion with the Claimant about the risks and advantages of the alternative options for POPR was not good clinical practice. This is relevant to but not determinative of the decisions I shall make below on whether any such discussion did actually occur.

32. The Claimant made no mention of 29th June PAAU visit in her first witness statement. However, in her second (probably after being shown the full medical records), the Claimant mistook Doctor Henderson for a man, multiple times. The Claimant accepted that the risks of surgery and the need for POPR were discussed. EPIs were discussed and she was asked if she had had headaches from the EPIs in the past. She disclosed she had suffered nightmares and hallucinations after one EPI. The Claimant asserted that the alternative of PCA was not mentioned, so no options for POPR were raised. In cross examination the Claimant accepted that she had little clear recollection of this meeting. Her explanation for getting Doctor Henderson's gender wrong was fanciful.

33. Taking into account the assessment of the witnesses below, all of the evidence put before me and the factors about witness credibility set out above, I find as a fact that Doctor Henderson did discuss POPR with the Claimant, because she asked about her earlier EPIs and whether she had suffered any problems with them and noted that. I accept, as the Claimant did, that that headaches were discussed as potential side effects of EPIs. I do not accept that alternative forms of POPR were mentioned by Doctor Henderson or that any of the relative benefits or detailed risks of PCA or EPIs were discussed, because no note was made of such a discussion. I reject Doctor Henderson's assertion that she went through the risks of temporary or permanent nerve damage from EPIs with the Claimant.

2nd July 2018 – the consenting process at the Hospital

34. By the time that the Claimant met Doctor Rice on the morning of 2nd July 2018, she was facing major bowel surgery with a risk of death of 1-3% (or 3-4% if she recalled

and believed what Doctor Henderson had told her). I find that she was scared and stressed. She had been given the out of date POPR leaflet, which she had not read, which provided the options for POPR but none of the risks involved with EPI or PCA. She had been involved in a brief discussion of EPI for POPR with Doctor Henderson.

35. The Claimant recalled (in her first witness statement) that in the morning of the day *before* the operation (1.7.2018) Doctor Rice came to her bedside on the ward. Doctor Rice gave evidence in her witness statement that she met the Claimant on the morning of the day *of* the operation (2.7.2018). In the Claimant's second witness statement she accepted that the meeting occurred on 2.7.2018. The operation took place at around 3.00 pm in the afternoon. The conversation which took place on the ward is the core issue in this case. No nursing record was made. No other witness was called to give evidence. The notes were made by Doctor Rice on the Anaesthetic Record, which is a single sheet, two sided and folded down the middle. It has a front page for the consultant to record "*consent and explanations*" which has some very useful boxes to record what the consultant anaesthetist should record, namely: "*epidural*"; "Spinal"; "*Headache*"; "f*ailure of technique"*; "*pain relief*"; "in cannula"; "*PCA*"; etc and "*comments"*. As the experts agreed and explained, Doctor Rice was under a professional obligation not only to explain the POPR options (EPI, PCA and others) but to set out the relative benefits and risks, to obtain informed consent from the Claimant and to record this. In breach of those obligations, the front sheet of the Anaesthetic Record was left blank by Doctor Rice.

36. In the middle of the folded Anaesthetic Record sheet is a chart setting out the procedures which Doctor Rice carried out. I shall return to that below. One the back the form are named boxes to be filled in and Doctor Rice filled in some of the spaces there. She recorded the Claimant's height and weight (transposed from the records made by Nurse Barclay). She recorded the Claimant's previous anaesthesia, exercise tolerance, allergies, smoking and cannabis use and teeth crowns. Under "examination" records were made of the Claimant's blood pressure and respiration. Under the heading "Investigations check list" she wrote nothing. Under the heading "Results" she wrote:

> *"Ren*" (this meant Remafentinil)
> "- *Epidural"*
> *"- A line"*
> *"- CATH* (Doctor Rice explained that meant catheter)
> *"- CVC"*

In evidence Doctor Rice explained that this was a list of the tubes which the Claimant would encounter when emerging from the general anaesthetic. Remafentinil is a pain killing substance used for local anaesthesia. Beside and to the right of that column, still under the heading "Results", Doctor Rice wrote:

> "*HA*" (meaning headache)

"PND (1 in 30k)" (meaning permanent nerve damage, 1 in 30,000)
"failure"
"↓ *BP"* (meaning reduced blood pressure).

These notes clearly related to the risks of EPI.

Discussion of the risks of EPI

37. In her first witness statement (9 months post event) the Claimant asserted that Doctor Rice explained that she would be giving the Claimant a "spinal block", for pain relief and informed her of the possible risks. She had been given EPIs before her caesarean sections and she knew what was involved. In her second witness statement (4 years post event) the Claimant changed her evidence and denied that Doctor Rice discussed the risks with her at all and "certainly not statistics". I do not accept that this change in evidence was an accurate recollection of the conversation because Doctor Rice wrote down the risks including statistics and gave evidence that she probably did explain the risks and in the Claimant's first witness statement she had recalled being told of the risks and this was accepted in the letter before action too, so I reject the Claimant's later evidence on this fact and accept and find that she was told of the risks of epidural.

Discussion of the technique of EPI

38. The Claimant asserted in her second witness statement that Doctor Rice did not discuss the technique of EPI when taking consent. In cross examination she admitted that Doctor Rice did do so. She explained the reason why she had changed her evidence was that she had become confused when writing the witness statement. I find as a fact that Doctor Rice explained the technique of EPI.

Discussion of the alternatives to EPI for POPR

39. The Claimant asserted in both witness statements that she was not provided by Doctor Rice with any options for POPR other than EPI, so, for instance, PCA (morphine) was not suggested as an alternative. Doctor Rice gave evidence in her witness statement (made 2-4 years after the events) that she recalled that she did discuss and explain the alternatives, especially PCA and asserted that she explained that in young women it sometimes induced nausea and vomiting. She asserted that she recalled that the Claimant said that she did not want pain, nausea or vomiting so she consented the Claimant for EPI, stressing that she did not "have" to have it. The Claimant denies this discussion.

40. There was no medical note made to support Doctor Rice's assertion. The relevant spaces on the Anaesthetic Record for noting the consent for the EPI are blank. The box for Doctor Rice to tick to show she had discussed PCA as an alternative POPR is blank. So, the notes support the Claimant's evidence. I take into account that in her evidence Doctor Rice accepted that she should have noted the fact that she had obtained consent from the Claimant and should have noted a summary of the alternatives offered for

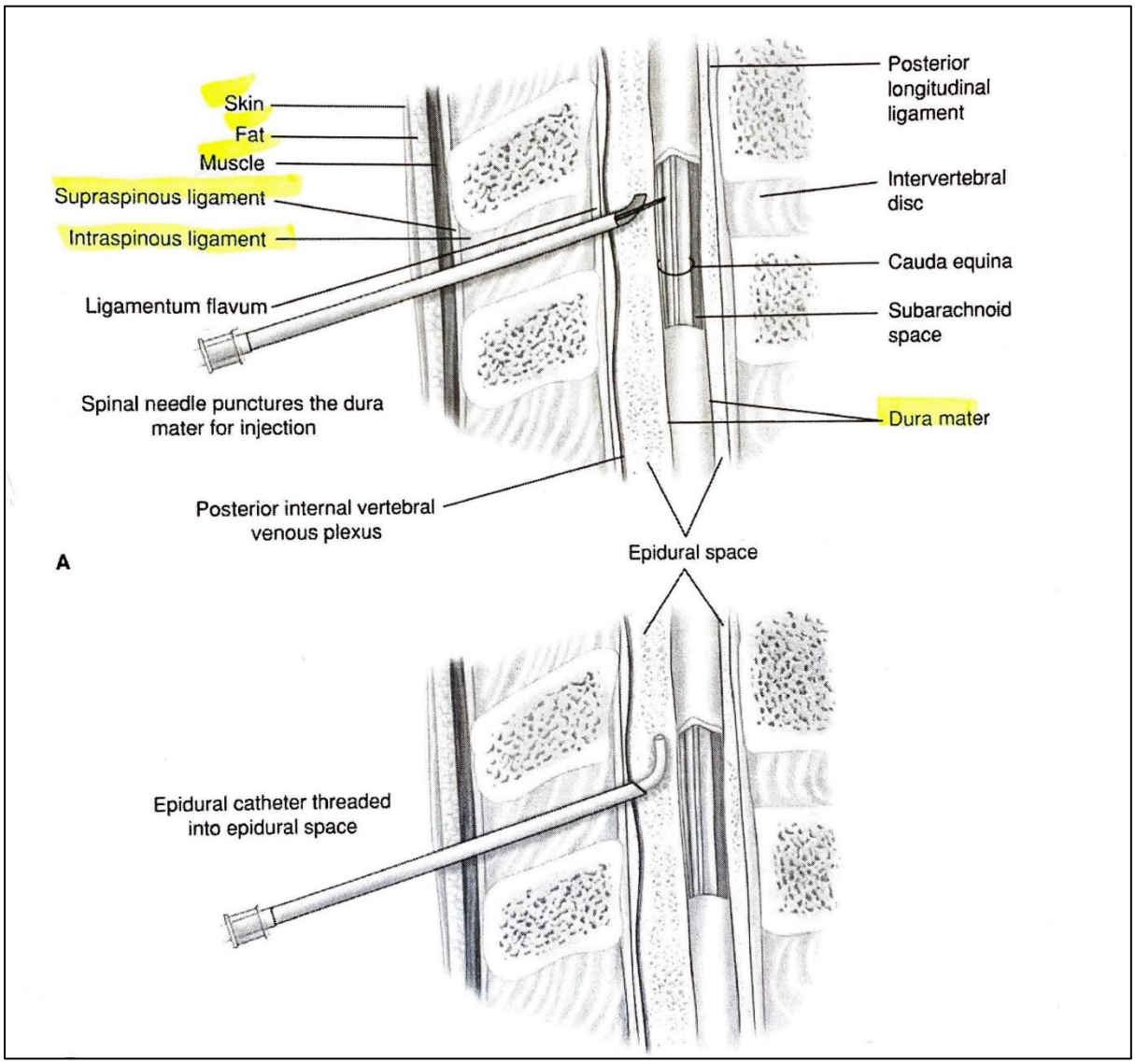
POPR. So, I wonder why she did not if the conversation did actually take place? The conversation should have taken place on the ward. There was no apparent rush. The operation was listed for the afternoon. Perhaps she thought that Doctor Henderson had already explained all the options? To assist in the decision over this factual issue I have looked for answers in the post operation events. The bowel operation went well but the epidural did not. Doctor Rice could not place the epidural and nor could Doctor Michalou, despite 10 attempts in total. Neurological damage became apparent in the late afternoon as soon as the Claimant came round. Doctor Rice explained in evidence that she was very worried and sought an urgent MRI from Southampton General Hospital (SGH) to exclude epidural haematoma caused by the epidural attempts. Surely at this stage, or in the following ten days before the Claimant's discharge, she would or should have looked at her own anaesthetic notes, seen there was no note of consent and added in the details of the consent, clearly marked as her post event recollection, dated and signed. Yet she did not. Nor did she write a written record when the case was discussed at the Hospital morbidity and mortality meeting or the Wessex area morbidity and mortality meeting, both of which she attended and both of which examined this case. I conclude that despite Doctor Rice's protestations in the witness box that she was careful and fastidious in taking notes, she was not fastidious on this occasion. She did not note that she discussed any alternative forms of POPR or that consent was given for EPI. Furthermore, I do not accept the accuracy of Doctor Rice's recollection of the words said (of discussing the alternative of PCA to the Claimant) which she first recorded four years and 2 months after the events. The date of her witness statement was 23rd September 2022. In evidence Doctor Rice stated that she had first been asked to recall events after the letter of claim (March 2020) to assist in the letter of response (September 2020), so that was around 2 years after the events. In the period when the Claimant was in Hospital she made no record in the medical notes of consent or alternatives being discussed. In a duty of candour letter dated 13.7.2018 she made no record of either consent or discussing POPR alternatives. In the intervening period since discharge she made no record of the alleged conversation. She made no written record for the morbidity and mortality meetings. I consider that her recollection of the conversation in the witness statement has been manipulated by her need to explain a gap in the notes, motivated by a desire to assuage her guilt and embarrassment at what happened. A feeling of guilt, an element of secrecy and of embarrassment were apparent in Doctor Rice's post event communications, to which I shall return below.

41. In the second witness statement the Claimant asserted that had she been offered PCA initially she would have chosen morphine, however in the amended PoC she abandoned this assertion and accepted that if Doctor Rice had recommended EPI she would have chosen EPI. I end this section by remembering that the Claimant's case on causation cannot succeed on a failure to obtain informed consent before the WEPIs were undertaken because the Claimant accepted, in her amended pleading, that she would have taken Doctor Rice's advice for an EPI for POPR and would have consented to WEPI even if PCA had been explained to her The Claimant explained that this was

because, at that stage, she had no fear of EPI and respected Doctor Rice's advice and expertise and trusted her.

2nd July 2018 – the failed epidurals

42. At around 3pm in the afternoon of 2.7.2018 Doctor Rice started the process of giving the Claimant WEPI in the anaesthetic room. Set out below is a diagram helpfully provided by the parties of what is involved in an epidural with a Trocar:



43. The medical notes made by Doctor Rice were on the inside folded page of the Anaesthetic Record. Under the heading: "Epidural", which was clearly for Doctor Rice to make notes of the details of the epidural, the following headings were set out beside which there were spaces for her to write in:

"Needle/Type
Size
Position
Awake Y/N

LA Soln % Opiate
Amount
Local anaesthetic Y/N
Catheter in situ Y/N
Height of block
Left Right
Upper Lower"

Not one of these sections was filled in by Doctor Rice.

44. In her first witness statement (9 months after the event) the Claimant gave evidence that a medical student was in the room and Doctor Rice was explaining the procedure to him as she went along. The first attempt was more painful than the EPIs she had undergone before. She wrote that it did not feel right. The second attempt was two fingers down and was even more painful. Doctor Rice did not manage to get in it. The Claimant described Doctor Rice as "*determined*" and she said "*your back is not playing ball*". The third WEPI was a bit lower and the Claimant said it was too painful and she asked Doctor Rice to "stop". Doctor Rice agreed to stop on the Claimant's recollection, because it was obviously distressing the Claimant. She did not say she would try again. The operation went ahead with the Claimant under GA. In her second witness statement the Claimant changed that account somewhat. Four years and three months after the events the Claimant recalled that *two* medical students were in the room. Doctor Rice asked if she minded the students watching and then explained the EPI procedure to the students. The description of the 3 WEPI attempts is very similar to the first statement save that Doctor Rice is described as becoming "*annoyed"*. The Claimant was crying by the third attempt. In this witness statement the Claimant omitted to assert that she had asked Doctor Rice to "stop". In opening, the Claimant's counsel stated that the Claimant did not rely on the pleaded assertion that the Claimant asked Doctor Rice to "stop". The Claimant was in Court listening. Later, in evidence under cross examination, the Claimant again asserted that she had asked Doctor Rice to "stop". On this asserted fact I do not accept the evidence of the Claimant. I find as a fact that she did not ask Doctor Rice to stop. A served witness statement is an important piece of evidence and it was made with legal advice. On the balance of probabilities, I find that the assertion of saying "stop" was omitted intentionally. In any event the Claimant abandoned the point in opening. In the second witness statement the Claimant added that after the 3 failed WEPI attempts, *had* Doctor Rice asked whether she could continue with UEPIs "*there is no way I would have let her"*. In her evidence in cross examination the Claimant explained that she had lost trust in Doctor Rice by then and that she was scared.

45. Doctor Rice's recollection in her witness statement (2-4 years after the event) was that she used a 16 Gauge Trocar on the end of a syringe filled with saline. She identified T11/T12 by using the scapula as a guide to find T8/9 and working down. She met bone

on the first two passes. This matches the Claimant's recollection, so I accept this evidence and find as a fact that this occurred. On her third attempt she got the Trocar past the bone but was unable to find any "loss of resistance". This was the phrase she used to explain getting through the Ligamentum Flavum into the epidural space when resistance to the Trocar end is suddenly much reduced. She asserted that she did not see cerebro-spinal fluid (CSF) "*in the needle"*. I note here that the needle I was shown was made of metal and was not see-through, so I do not understand how she could ever see CSF in the needle. She described the extent of the Claimant's pain complaints in her witness statement as follows: "*very painful and distressing. She was unable to maintain the slumped position (curled, chin down, shoulders dropped) sitting position.*" She asserted that she stopped and discussed the situation with the Claimant. She explained that she would put the Claimant to sleep and then attempt the EPI again and she asserted that the Claimant agreed. She asserted that she made 3 further UEPI attempts at T11/T12 and T12/L1, one attempt met bone and two others passed the bone but "*again I couldn't identify any ligamentous resistance and did not see CSF in the epidural needle. I abandoned the procedure."* So, this time Doctor Rice seems to be suggesting that she could not find the Ligamentum Flavum. She then discussed the case with Doctor Michalou who, she asserted, agreed that post operative pain relief could be "*a significant problem*". This is a part of Doctor Rice's evidence which I find was illogical. PCA is a well recognised POPR procedure which was widely used at the time, as the experts informed the Court, and Doctor Rice asserted she had told the Claimant as much before the operation. It carried no risk of permanent nerve damage. In the event PCA was used for the Claimant's POPR after the bowel surgery with no issues. EPI had a 15% failure rate. Yet Doctor Rice was very keen to stress in her evidence how concerned she was to avoid using PCA and to continue to attempt UEPI instead. I note that Doctor Rice made no record of the level of each attempted UEPI or the depth of the insertion of the Trocar into the Claimant's body on the Anaesthetic Record. Doctor Rice invited Doctor Michalou in and asserted that she had a discussion with her and she attempted 4 more UEPIs, but Doctor Rice denied that carrying out 10 separate attempts at epidural was beyond reasonable.

46. In her oral evidence Doctor Rice stated that the Trocar had a diameter of 1.65 millimetres. She then demonstrated on the 3D skeleton with the Trocar the method she used to attempt the epidural penetrations. I watched carefully. She explained that the Ligamentum Flavum is very tough and that an anaesthetist can feel the Trocar against it and then push through it and then there is a "loss of resistance" on the syringe plunger when the end of the Trocar enters the epidural space. Doctor Rice showed the Court the Trocar and the markings on it. Under searching professional cross examination by Mr. De Bono, Doctor Rice gave evidence that on average the epidural space is 3 to 5 centimetres beneath the skin. She asserted that every anaesthetist has, at some stage, breached the Dura and this causes a flood of CSF into the syringe and causes the anaesthetist to stop. She asserted that she did not know how wide the average spinal cord is at T11/T12. I found that a remarkable answer considering how many MRI scans she, as a consultant anaesthetist, had to view each year. She accepted that if she had

pushed the Trocar fully into the Claimant's body then there would be a high chance of the Trocar going through the spinal cord. Doctor Rice asserted that the Claimant showed "*high anxiety*" and "*hypersensitivity to pain"* as a result of the 3 WEPIs.

47. When asked whether there was any neurological pain or were any neurological symptoms displayed by the Claimant during the WEPIs and whether the spinal cord was innervated she responded that she did not know whether an awake patient would suffer or complain of immediate neurological symptoms if the cord was damaged by a Trocar and asserted there was some teaching that the cord had no innervation. This evidence directly contradicted the evidence of Doctor McLean, the Defendant's neurologist and of both expert anaesthetists. All of the experts agreed that pushing a 1.65mm diameter Trocar into the spinal cord at T11/T12 of an awake patient would cause immediate pain and neurological symptoms. Indeed, that was the reason why Doctor Alice Manson later recorded that the Claimant had made no complaint of "*neurological symptoms*" during the first three attempted epidurals. This information can only have been given to her by Doctor Rice. That is why the experts all agreed that the damage to the Claimant's cord was not caused during the WEPIs carried out by Doctor Rice. I find on the evidence that, on the balance of probabilities, the cord damage was caused during the UEPIs not the WEPIs because the Claimant did not suffer cord damage neurological symptoms when she was awake. I found Doctor Rice's evidence about the lack of innervation in the spinal cord troubling.

48. Doctor Rice accepted that her record keeping was inadequate. She failed to record the type of epidural needle used and the other matters expressly set out as required to be noted on the Anaesthetic Record. She stated that this was a "*deviation"* from her normal practice and gave the explanation that she was "*distracted"* by her failed attempts at epidural. She asserted that she always recorded every needle pass. I consider that this was important and telling evidence because, if her consistent practice was to record every needle pass then her explanation for why she completely failed to record any of the positions of the attempted epidurals on this Claimant may have been fundamental to her state of mind at the time. I take into account the presence of one or two students which may have been a factor at that time in promoting embarrassment and perhaps determination.

Events after the operation

49. The medical notes show that at about 5:30 in the afternoon of 2.7.2018, after the operation, the Claimant was recovering and was able to speak to Doctor Rice in the recovery room. The notes that she made show that the patient disclosed pain ++ (plus plus) in her right leg, especially behind the knee. On examination the right leg had increased tone and the Claimant was unable to straight leg raise or carry out other manoeuvres at all. Paraesthesia was also found over parts of the thigh and leg. Doctor Rice devised a plan to ask Doctor Isobel Rice, who had expertise in pain management, to review and decided to discuss the case immediately with the neurology section at SGH. Doctor Rice's evidence was that in the recovery room after the accident she

reminded the Claimant that the UEPIs were carried out and Doctor Rice asserted that she was "*surprised*" that the Claimant did not remember ever giving consent for them. The Claimant asserts that no such conversation ever took place. Doctor Rice made no note of this surprise. This is yet another example of Doctor Rice giving evidence in relation to consent which was not recorded in the notes.

50. After talking to SGH, the medical records show that Doctor Rice noted that MRI was the investigation of choice but that SGH had warned it would not be possible immediately after surgery because of safety issues. The second best option was a soft tissue sequence CT scan to exclude epidural haematoma "*given multiple epidural attempts*". Doctor Rice later wrote a referral letter to SGH in which she wrote "*this follows multiple pre-op attempts at citing an epidural at T11/T12. … Fine resolution CT was unable to exclude an epidural haematoma.*" The Claimant was airlifted to SGH and reviewed by a specialist registrar in neurosurgery (named Hall) at 11:00 PM. He noted right leg weakness and the query was whether this was due to epidural haematoma. He noted "*multiple epidural attempts at T8/9, T10/11, and L 3/4*". He can only have written these levels from his own observations. The radiology report from the MRI scan was provided by a junior radiologist called Doctor Vedwan (an St5) and he noted the clinical history as being that an epidural was sited after multiple attempts *at T11/12.* I find that this last note about where the EPIs were sited must have come from Doctor Rice's referral letter. He made an error recording that the left leg suffered altered sensation and weakness when in fact it was the right. He commented on the MRI as showing normal vertebral alignment and normal marrow signal. Disc height and signal were preserved. He found a "*capacious spinal canal"*. He identified no haematoma. However, soon thereafter a consultant radiologist called Doctor King reviewed the same scan and concluded as follows:

> "Intermediate signal is present within the thecal sac around the roots of the cauda equina from the level of the T12/L1 disc down to the level of the L3/4 disc centrally and on the right side probably representing haematoma from epidural needle puncture. No epidural haematoma demonstrated. The distal thoracic cord also demonstrates T2 intermediate signal change which is of equivocal significance and may be spurious. Imaging of the thoracic cord under the care of a neuroradiologist should be considered."

51. The Claimant was transferred back to the Hospital by ferry and reviewed on the 5th of July 2018 by Doctor Alice Manson (a neurologist) and Doctor Rice. Doctor Manson noted the failed epidurals preoperatively "*but no symptoms of note during procedure other than local back pain."* As I set out above this was an important and relevant note and the information must have come from Doctor Rice. It rather undermines her protestations in live evidence of the Claimant being *"outstandingly distressed"* and "*extraordinarily distressed*" and "*abnormally anxious and distressed*". Doctor Manson

wrote a letter after that clinic which was typed on the 6th of July 2018 but probably not sent out until the 10th. The letter summarised matters but included a "PS":

> "I have subsequently had the opportunity to review the scans with our neuro radiology team who have in fact noted a significant amount of blood around the nerve roots (actually reported in a later review by the musculoskeletal radiologists) which I think likely to explain her symptoms and presumably secondary to the epidural attempts. There is also a question as to the signal change in the cord and I would therefore recommend repeat MR thoracic and lumbar spine with contrast."

She also made a handwritten note recording that in the spinal canal there was evidence of "*approach at T12/L1*" with "*signal change*" in the cord "*at the limit of T11/T12 and the area at T11/T12 and in the thecal sac*". Logically, in my judgment, this would suggest that the damage at T11/T12 could have been caused by a Trocar approach from the level T12/L1 or T11/T12.

52. On the 9th of July at about 20.18 hours the notes show that Doctor Rice reviewed the Claimant on the ward. She noted that she discussed Doctor Manson's letter setting out that there was blood around the *"nerve roots down to L4/L5"* and that this was probably an epidural complication. She examined the Claimant and noted continuing pain in the right leg and paraesthesia, but also improvement. She discussed that the cause was probably the bleeding due to the epidural. She apologised. She noted that she said this was a recognised but uncommon complication and this was her first ever complication from regional anaesthesia. She explained to the Claimant that a further MRI was to be carried out.

53. In her first witness statement the Claimant's record of this review meeting is at para. 18 and roughly matches the note. In her second witness statement the Claimant asserted that Doctor Rice visited her twice after the operation. On the first visit, four days after the operation, she was with Ian Golding and Mr Nelson. Doctor Rice disclosed that she was upset because she had had to put her dog down that morning.

54. On the 10th of July 2018 a further MRI scan was carried out and reported on by Doctor Voigt. Again, the vertebral bodies were reported as normal in height and alignment and had normal lumbar lordosis. However, there was a right anterolateral 5 millimetre sub-acute epidural haematoma at L1-L3 displacing adjacent cauda equina fibres. There was also a suspicion for subtle oedematous changes of the spinal cord at the level of T11/T12 possibly in keeping with post traumatic changes.

55. On the 11th of July 2018 Doctor Rice again reviewed the Claimant on the ward and made notes. The Claimant's pain was improving. She recorded no bladder and bowel symptoms (in contradiction to the Claimant's asserted injuries). She noted

that she would write a separate letter to the Claimant's GP to explain the epidural haematoma.

56. In relation to the second visit, the Claimant recalled that it was six days after the operation (roughly correct) and was in the presence of the Claimant's two daughters. The Claimant recalled Doctor Rice saying: *"I suppose I am Public Enemy number one now am I?"* In evidence Doctor Rice agreed that she may have said that but in a different context. This allegedly made the Claimant's daughters furious. Then Doctor Rice informed the Claimant of *three* attempts at epidural while she was unconscious. This shocked the Claimant. Doctor Rice did not disclose that Doctor Michalou had carried out four additional UEPIs. Doctor Rice made no reference to the events in this review in her witness statement, only the date. In her live evidence the Claimant explained that this was the first time she was told that epidural had been done whilst she was unconscious. I find that this recollection of the Claimant's was correct. This was the first time.

57. The Claimant's discharge summary, sent to her GP, included reference to a follow up appointment with Doctor Rice and stated that there *"were multiple epidural attempts at T8/9, T10/11 and L3/4*". I assume that Doctor Rice did not write this. In her evidence Doctor Rice disputed attempting epidural at L3/L4 but she never sought to correct the reference to L3/L4 in the discharge summary or to write any note of the correct sites for the EPIs which she did.

58. On the 11th of July 2018 Doctor Rice dictated a duty of candour letter addressed to the Claimant at the Claimant's home address. It was typed on 13.7.2018. In this she wrote as follows:

> "I am writing this letter so that you have a written account of what happened to you around the time of your operation.
> You will remember that we had several goes at trying to place an epidural in your back before the operation and **also had a further three attempts while you were asleep** before the operation started. When you woke up your right leg was very painful and you could barely move it. **One of the causes of this might have been a blood clot** around the bottom of the spinal cord pressing on the spinal cord. This can sometimes happen when the epidural **needle hits blood vessel** and the blood clot starts to press on the spinal cord. To rule this out we sent you by helicopter to Southampton to have a scan and the original scan showed that you did not have any blood around the bottom of the spinal cord or the nerves as they came out of the spinal cord. I then asked the neurologists to see you and she was still unclear as to what has caused this but we started you on some unusual pain medicines Amitriptyline and Gabapentin. The paralysis of your leg appears to be slowly improving and I hope you will get the full

> function of it back. The repeat scan we did just before you went home showed that in fact there was a small amount of blood at the bottom of the spinal cord. This was not visible on the first scan we did. This blood was not pressing on any of the nerves and was not a big enough volume of blood to press on the spinal cord itself. We spoke to the neurosurgeons and asked for their opinion as to whether you needed an operation on your back and they were very clear that would not be necessary. I have sent you home today with the Amitriptyline and Gabapentin that we spoke about. I have also given you some guidance how to increase those medicines to use them at their maximum effect without developing serious side effects.
>
> I must once again apologise that this complication happened to you. I know we talked about it as a potential risk before the operation but again I am very sorry for any pain or anxiety that this has caused you.
>
> I am going to send you an appointment to see me in an outpatient clinic in the next few weeks so that you can go over what we have talked about and I can answer any questions you might have. In the meantime please contact me through the hospital if you need to speak to me before the outpatient appointment." (My emphasis).

59. In this letter it is clear that Doctor Rice failed to provide the Claimant with an accurate account of what was done to her when she was unconscious. In the second paragraph it was untrue to say that there were only three further attempts whilst the Claimant was unconscious. There were seven. In addition, Doctor Rice failed to mention that it was Doctor Michalou who carried out four of those. When cross examined on this point Doctor Rice gave what, in my judgment, was unimpressive evidence, she attempted to explain the inaccurate numbers by suggesting that she was not referring to the 10 attempted epidurals at 10 different sites but rather only referring to those epidurals which did not hit bone and so were capable of passing close to or through the Dura. Under further cross examination she accepted that the Claimant would not have understood that meaning from the words she used. She could not explain why she did not reveal that Doctor Michalou had carried out 4 attempts. In the third paragraph Doctor Rice blamed the symptoms on the blood around the bottom of the spinal cord and yet made no mention of the suspected damage to the cord itself as disclosed by the MRI scan the day before. Doctor Rice did set out a confirmation that she had discussed the risks with the Claimant before the operation. Interestingly what she did not do is assert that she had obtained the patient's consent before carrying out the UEPIs or had discussed the option of PCA as an alternative.

60. Doctor Rice was questioned on her duty of candour letter. At first, she sought to disavow that the purpose of the letter was to explain what had happened to the Claimant, until it was pointed out to her that the first paragraph stated that the purpose of the letter was to explain what had happened. She asserted that she was a meticulous anaesthetic record keeper and yet could not explain why she had not accurately

informed the Claimant that there were 10 attempts at epidural and she had in effect stated in the letter that there were only 6. Nor could she explain why she omitted to mention that Doctor Michalou had carried out four of them. When pressed on why she had failed to disclose Doctor Michalou's involvement, Doctor Rice admitted that a patient would want to know which Doctors had carried out procedures on her body. She accepted that she was wrong to fail to mention it.

61. During the course of the trial Doctor Rice admitted that this case was discussed not only at a Hospital morbidity and mortality meeting but also at a Wessex area morbidity and mortality meeting and also in her annual appraisal. No documents were disclosed from the morbidity and mortality meetings. Her appraisal record was disclosed. It was dated the 13th of March 2019. In this Doctor Rice disclosed her feelings of guilt and responsibility and stated that previously she had taken consent carefully but that since the case she was being "even more explicit as to what consent might mean for the patient personally". Looking at that in the context of the actual medical notes made by Doctor Rice it is apparent that she was minimising her failings. Had she been frank with her appraiser she would have admitted that she made no note evidencing any verbal consent on the Anaesthetic Record for the original WEPIs and furthermore she made no note of any verbal consent for the UEPIs. In addition, she made no record of advising on alternative forms of POPR and made no record of the sites of the 10 attempted epidurals.

62. Further in cross examination, in relation to Doctor Rice's assertion that she had informed the Claimant in the recovery room about the 10 attempts and reminded her of her consent, Doctor Rice accepted that patients rarely recall what happens in the recovery room after a major operation under anaesthetic. Doctor Rice also admitted that she was surprised that she had not recorded the levels at which she had carried out her epidural attempts. In relation to the presence of students in the anaesthetic room Doctor Rice could not recall but stated that the adults present could have been departmental support and assistance. Turning to the Claimant's reaction to the WEPIs I was struck by how Doctor Rice kept stressing the Claimant's high level of pain. She described the Claimant as "*outstandingly distressed*" and "*extraordinarily distressed*" and "*abnormally anxious and distressed*". Yet she made no clinical note of these asserted recollections. Doctor Rice rejected the evidence from the notes made by the surgical registrar in neurosurgery at SGH that her epidural attempts were at T8/9, T10/11 and L3/4. She also rejected the evidence of the Claimant's daughter, Rochelle Edwards, that the attempts caused bruising down her mother's spine to the bottom of it. She asserted that the bruising at the bottom could have been due to surgical tracking because the Claimant was on blood thinners during the operation. She accepted that attempting an epidural at L3/L4 was "less than optimal", a phrase which rather manipulated the reality. The experts considered such an attempt would have been inappropriate because it would not have afforded proper pain relief. She accepted that the information given to Doctor Manson would have been from her and that Doctor Manson recorded only 3 failed epidural attempts, when in fact there were 10. Doctor

Rice rejected the assertion that she was attempting to downplay the number of epidural attempts she had made. In relation to the conversation had with the Claimant on review when the Claimant's daughters were present, she accepted that it was possible that she had said that she may appear to be "public enemy number one" and explained this was so because she was concerned that the Claimant might wish to see another anaesthetist rather than her. In relation to consent, Doctor Rice asserted that she had placed over 1100 epidurals during her professional career before this event. She agreed that the surgical consent form was separate from anaesthetic consent. She consented verbally. Doctor Rice accepted that by the day of the operation the Claimant would have been likely to be stressed because this was big surgery. She accepted that patients in such a condition might miss the minutiae of the discussions with the anaesthetists. She accepted that there might be a flaw in the Hospital's system by the provision of the wrong leaflet and by Doctor Henderson deferring to the "on the day" anaesthetist rather than describing the options for POPR in some detail. She accepted that patients did get bombarded with information. She maintained that she had a specific recollection of advising the Claimant about PCA and the risk of nausea and vomiting and the Claimant not wishing that to occur. She asserted that young women are "*notoriously difficult"* in relation to pain management. Under further cross examination Doctor Rice accepted that she had not recorded any of the POPR options other than epidural in the notes. She also accepted that she had not filled in any of the consent area of the Anaesthetic Record form and had written the risks in the wrong area. She asserted that after the first three waking attempts the Claimant was very upset and couldn't maintain a correct position because she was moving and crying. She rejected counsel's assertion that she had failed to discuss the options with the Claimant in that state but had simply told her she would "put her to sleep". She could not explain why she did not make any note of consent in relation to the initial waking EPIs or the later unconscious EPIs. She accepted that she had time to make a note before or during the operation but had not done so. She had also had three to four hours to make notes between the morning consent conversation on the ward and the start of the epidural at around 3:00 in the afternoon.

63. When counsel suggested that it was Doctor Rice's *determination to succeed* which pushed her to attempt 10 epidurals, Doctor Rice stated that the risks were small but with hindsight were awful and that her practice is now different. In an unguarded moment she stated that others would "*have had a go at 3 levels*". When asked what that phrase meant Doctor Rice explained that 3 levels would be the maximum. I had the impression when this evidence was given by Doctor Rice that she herself considered that she was practising right on the edge of what was acceptable by the phrase have a go at 3 levels.

64. On the 11th of September 2018 Doctor Rice wrote to Mr Kenney a consultant gynaecologist about the Claimant stating:

> "*unfortunately during her anaesthesia for her hemicolectomy **I caused an epidural haematoma whilst trying to insert an epidural** intended for post operative pain relief."* (My emboldening).

65. Stopping here, I do not see why Doctor Rice would write to a colleague taking responsibility for causing a neurological injury if she did not think that she had caused it herself.

Doctor Michalou

66. This Doctor made no notes at all and did not sign the Anaesthetic Record. Furthermore, she made no post event notes (which would have been signed and dated accurately) despite becoming aware of the neurological injury to the Claimant which she herself might have caused. She provided no duty of candour letter about her involvement in the Claimant's treatment and her involvement was kept secret from the Claimant by Doctor Rice in her duty of candour letter. This is all rather disturbing. Doctor Michalou provided her statement 2 - 4 years after the events and purported to recall in detail that Doctor Rice told her that the Claimant had a "*chronic pain history"*. In my judgment this was a telltale about the accuracy of her recollection when there was no such record in the Claimant's pre-event medical notes because the Claimant did not have a chronic pain history. She purported to recall that Doctor Rice informed her that she had consented the Claimant after the first 3 failed WEPIs. Again, considering that this was not written anywhere in the notes by Doctor Rice, I found this asserted memory remarkable. She asserted that: "*after a full discussion"* she agreed that an EPI would be the best option for POPR considering that *"Mrs Parsons was very sensitive to pain".* She identified T10/T11 and T11/T12 and carried out 4 attempts. She recalled that on her first 3 she met bone. On her last she considered that she was in the epidural space (loss of pressure feeling) and threaded in the catheter but was unable to get the catheter through the needle. She became aware of the neurological injury after the operation on review with Doctor Rice but I note she made no effort to put the detail of her involvement on the Anaesthetic Records or anywhere in the Claimant's notes. She remained effectively a treatment ghost who was unknown to the very patient on whom she carried out invasive treatment which may have damaged the Claimant's spinal cord.

67. In cross examination Doctor Michalou asserted that she could remember the case but she admitted that she had discussed it with Doctor Rice after receipt of the letter of claim. In relation to the events, she accepted that she did not ask Doctor Rice how many failed attempts she had made. She gave evidence that she had never seen cord damage occur from an EPI before. She asserted that she did not stick the Trocar in further than 5 cm on the final attempt.

Expert Evidence

Professor Jonathan Hardman

68. The Professor was instructed by the Claimant's solicitors to report on breach of duty and causation. His served report was dated December 2022. He is head of anaesthesia

and critical care at the University of Nottingham Hospitals NHS Trust. His abbreviated CV shows huge experience since commencing practise in 1992. He has been a Professor since 2012. He has administered more than 6,000 regional anaesthetics including epidurals, spinals and nerve blocks. One half of his working time involves administering anaesthesia and the other half is spent in teaching, journal editing, textbook writing and medico-legal practice. He has performed more than 2,000 thoracic and lumbar epidurals. He has published more than 280 scholarly articles and made presentations at more than 150 international meetings. He is an editor of the British Journal of Anaesthesia and has been since 2007. He is a senior FCA examiner and has been since 2012. In his evidence in chief in his report he set out the patient's history and a summary of the medical notes together with a summary of the allegations and responses in the pleadings. In his opinion it was a reasonable plan to use thoracic epidural for POPR. In relation to the process of consent he advised that there are several acceptable alternatives to epidural and that it was the patient's right to choose which treatment to undergo and to be told of the risks involved. He stated that minimally Doctor Rice should have disclosed that there were several acceptable options for POPR and should have listed them and disclosed their risks and benefits. It would have been reasonable for Doctor Rice to recommend thoracic epidural but it was mandatory to make the Claimant aware that this was not the only available option. He set out a typical approach which an anaesthetist would take for obtaining consent on page 8 of his report. He advised that a failure to disclose suitable alternatives would indicate that informed consent was not given and would be a breach of duty. He also advised that he believed that Doctor Rice should have communicated the increased risk in persisting in attempts to place the epidural, especially in an unconscious patient.

69. His opinion on the number of attempts to place the epidural was that having failed in her first three attempts it would have been reasonable to switch plan to provide PCA with morphine and other pain killing pills. As for the Defendant's total number of 10 attempts, he advised that it was likely to under-represent the number of needle advancements performed because needle "redirections" are typically not counted as attempts. He advised that each needle advancement brought an accumulating risk of injury to nearby structures including the spinal nerve roots and the spinal cord. He advised that excessive attempts to place an epidural are associated with complications. Having found epidural placement impossible whilst the Claimant was conscious and able to position herself optimally, he advised that it was unlikely that re-attempting placement whilst she was unconscious in the lateral position would be successful. He advised that the risk of injury was increased due to the loss of the Claimant's ability to inform Doctor Rice of pain and neurological symptoms that might indicate needle contact with neural tissue in the nerve roots or spinal cord. In addition, knowing that the anatomy was not as anticipated and the epidural space was difficult to locate, the risk of injury was increased by attempting placement in an unconscious patient. He advised the Court that:

> "Therefore, I feel that it was inappropriate to proceed to attempts at epidural placement after induction of anaesthesia, having failed to place the epidural while Ms Parsons remained conscious. It was unnecessary, brought an unacceptable risk of injury, and was a breach of duty, in my opinion. This breach of duty appears to have led to neurological injury (but please note that I defer to the expert opinion of a neurologist in the matter of causation)."

70. In relation to the siting of the epidural and the note taking, Professor Hardman advised that Doctor Rice failed to specify the vertebral levels and that was substandard record keeping. He accepted that it was reasonable practice to attempt epidural placement at a new level if placement is initially unsuccessful. He advised that placement between T7 and T12 would provide useful analgesia but that attempting EPI at L3/L4 would be a breach of duty. He deferred to the neurologists and their evidence about foot drop as evidence of injury at that level.

71. Professor Hardman advised that it seemed to be likely that there had been injury to the nerve roots, cauda equina or spinal cord during needling rather than injury occurring later due to compression by haematoma but deferred to the neurologists. He considered it entirely credible that there had been neural injury caused directly by needling at several vertebral levels. He advised that it was credible in view of the admission of needling at T11/T12 and the MRI findings that the Trocar entered the spinal cord at this level.

72. At the end of his report he summarised the witness statements of the Claimant and the Defendant's witnesses. He left the determination of facts to the Court where the witnesses disagreed.

Joint statement by the anaesthetists

73. In the joint statement made by Professor Hardman and Doctor McCrirrick in August 2023 they agreed on the balance of probabilities that the Claimant suffered a spinal cord injury as a result of trauma caused by the Trocar. Both referred to the expert neurology evidence in support of this conclusion. They agreed that cord trauma caused by a Trocar during epidural attempts was a recognised but exceedingly rare complication and the incidence was in the order of a handful of cases per 100,000 attempts. As to the question whether there was any medical record of the Claimant being offered alternative POPR Doctor McCrirrick avoided the question and Professor Hardman advised that there was none. Both experts advised that they would have expected Doctor Henderson to have discussed the POPR options with the Claimant and to have documented that discussion. When asked about the medical records made, Doctor McCrirrick avoided the question of whether the notes indicated at what vertebral level the attempts were made. Instead, he simply recited what Doctor Rice said in her witness statement. He did not consider that it was a requirement to document the exact number of times Trocar placement was attempted. Professor Hardman advised that he would expect a competent anaesthetist

to set out how many attempts were made and at what level the attempts were made in the medical notes. The only record of the levels of the attempts available was made at SGH, not by Doctor Rice. In response to question 7, about the lack of contemporaneous records to support Doctor Rice's recollection of the detail of her first two attempts, the experts noted there was no record of the details. The same applied to Doctor Rice's attempts under anaesthetic: there was no record of the details. The same applied to Doctor Michalou's attempted epidurals under anaesthetic: there was no record of the details. The only record was the number of attempts made by each consultant. Both experts noted the factual inaccuracy in relation to the number of attempts made to place the Trocar in the duty of candour letter written by Doctor Rice. In relation to causation the experts were asked whether it was more likely that trauma occurred to the cord before or after general anaesthetic and whether it was possible to say which of the attempted epidurals caused the cord damage. Doctor McCrirrick considered it was not possible to state with any certainty when the injury occurred even if it was prior to general anaesthesia. In his opinion he stated that the issue of when the injury occurred was irrelevant. Stopping there, in my judgment, Doctor McCrirrick was being unhelpful and was wrong about the relevance of this issue. It was directly relevant to causation on the Claimant's case on consent and that too many attempts were made. In addition, in his live evidence to the Court he resiled from this position and accepted that cord trauma probably did not occur whilst the Claimant was awake because neurological symptoms would have been reported. Professor Hardman advised that Trocar needling of the spinal cord would have been painful and would have been apparent. Given that there was no evidence of sudden severe pain it was more likely that the neurological injury occurred whilst the Claimant was unconscious. He agreed it was not possible to state which attempted penetration was the cause of the injury. As I shall set out below, by the end of the evidence it was agreed that had the injury occurred when the Claimant was awake neurological symptoms would have been reported as well as cord pain and so Doctor McCrirrick 's opinion on this issue fell. When considering the attempts which hit bone Doctor McCrirrick advised that those attempts did not exclude the possibility of cord trauma and Professor Hardman explained that the far side bone could have been hit after the Trocar passed through the spinal cord. The issue of whether making multiple attempts increased the overall risk of injury Doctor McCrirrick accepted there was a theoretical risk of increasing neurological injury however he pointed out the overall incidence was extremely small even with multiple attempts. Professor Hardman advised that it was unarguable to deny that repeated attempts must bring greater risk of injury because the risk is cumulative. Both experts advised there were no guidelines on the maximum number of epidural attempts. Both agreed that it was a matter of clinical judgment when to stop. That judgment involved balancing the expected benefits against the risk of injury and complications. However, Professor Hardman disagreed with Doctor McCrirrick on the choice made and advised that:

> "I feel that the potential benefits of an epidural in the Claimant (particularly when placed at sub optimal intervertebral levels and in the context of other acceptably effective analgesics) did not outweigh the

> predictable risk of serious injury bought by persistence in the face of anatomical difficulty and in an unconscious patient."

74. On the question of whether informed consent was given Doctor McCrirrick relied upon the evidence of Doctor Rice and ignored the evidence of the Claimant. Both he and Professor Hardman advised that the Claimant should have been informed of the alternatives and the benefits and risks of each. In relation to the discussion at the PAAU clinic the experts agreed that the Claimant should have been told of the options for POPR broadly and the advantages and disadvantages and associated risks of each should have been outlined in simple terms. The Claimant should have been told that the choice was hers and that she would have a further discussion on the operation day with the anaesthetist. The experts agreed that the Claimant should not have been told that epidural was mandatory. However, there was no evidence to support that assertion. I do not include here their advice on the assertion that Doctor Rice failed to set out the risks of epidural because, on my findings of fact, she did provide that advice. The experts advised on the issue of whether epidural in an unconscious patient is more risky than epidural in a conscious patient. Both agreed that there was a debate within the anaesthetic world about the relative risks of these two options. In simplest terms the debate on one side against unconscious epidural involved the lack of the safety net of the patient being able to complain of pain at the time of neurological injury to the spinal cord. The alternative argument is that unconscious epidural is more comfortable and involves less risk because the patient will remain absolutely still. Both agreed that a considerable body of anaesthetists supported unconscious placement, particularly in patients unable to tolerate the pain of waking epidural. Professor Hardman stressed that the debate concentrated generally on the first attempted epidural penetration. In this case the issue was not the first attempt, it was continuing after three failed attempts and Professor Hardman advised that there were very clear additional risks brought by continuing attempts with the Claimant unconscious, having failed while she was conscious, because of the known anatomical or technical difficulty that had become apparent. The experts agreed there was no literature in relation to cord injury with unconscious epidural compared to conscious epidural. Both accepted that a responsible body of anaesthetists in July 2018 would have considered it appropriate to attempt unconscious epidural where waking epidurals had been unsuccessful, but Professor Hardman warned that informed consent was required and the unconscious epidural attempts should have been limited to a reasonable number at the appropriate intervertebral level. Stopping there, it seems to me that this agreement by Professor Hardman rather undermined the opinion he gave in his report that it was a breach to carry out any UEPIs in the Claimant.

75. Both experts agreed it was mandatory for Doctor Rice to obtain further consent to the unconscious epidurals after carrying out the failed waking epidurals. However, Doctor McCrirrick could not resist descending into advising the Court about how unlikely it would have been that Doctor Rice would have failed to obtain consent. He went so far as to say: *"it is extremely unlikely in my view Doctor Rice would have made further*

attempts at epidural placement had the Claimant specifically withdrawn consent." This was a trespass on the Court's function as the determiner of facts and Doctor McCrirrick, being an experienced medico legal expert, should have been well aware that he was trespassing. At this stage, in my judgment, he was arguing the Defendant's case as an advocate rather than maintaining his professional discipline within his own field of expertise.

76. Both experts agreed that it was mandatory to obtain further informed consent from the Claimant with an explanation that UEPI was optional and there were alternatives including PCA and that UEPI carried further risks of injury. In relation to Doctor Rice's decision to involve Doctor Michalou, both experts agreed it was reasonable to invite her to make an attempt but Professor Hardman did not consider that four attempts was reasonable. Doctor McCrirrick advised that a reasonable body of anaesthetists, indeed in his view the majority, would have proceeded in the same way. As to the position of the epidural attempts, both experts agreed that bruising was not uncommon at each site though Doctor McCrirrick avoided dealing with the specific question which related to the evidence of the Claimant's daughter, that there were bruises down to the base of the spine. Professor Hardman did grapple with that evidence and advised that bruises indicating epidural attempts from the mid back to the sacrum would indicate grossly excessive attempts and attempts at levels which would bring no useful analgesic effect. Questions 30 and 31 dealt with the total number of attempts. Doctor McCrirrick advised that 10 attempts in total would be at the upper limit of what "*one might generally consider reasonable*" and Professor Hardman advised that 10 was "excessive".

77. In his live evidence in chief Professor Hardman restated his opinion that 10 skin passes in addition to Trocar re-directions was unreasonable taking into account the risk benefit analysis. He advised that the angle of the injection of the needle was relevant to the risk and that the needle could be at between 20 to 30° or up to 45° away from the coronal plane (being an imaginary line perpendicular to the back cutting straight through the body from back to front). He advised that there wasn't much variability organically between patients and that the cord is typically the thickness of a little finger, so over a centimetre in the diameter but not as much as two centimetres. The MRI of the Claimant's spine showed that her vertebral bodies and spaces were normal. He advised that the epidural space was approximately 5 millimetres and that the distance from the epidural space to the bone on the far side of the cord might be approximately 2 centimetres in total. However the distance from the skin surface to the epidural space varied greatly between patients and involved the fat in the body, the bend of the spine and the angle of insertion of the trocar. He advised that if the needle was angled at 45° from the coronal plane then it would travel only half the distance inwards, this being a matter of trigonometry.

78. In cross examination Professor Hardman was taken through his report and it was suggested to him paragraph by paragraph that he had failed to set out the Defendant's witnesses' factual versions of events. What he had done in his report was to summarise

the Defendant's witness statements at the end. I do not consider the way he laid out his report to be perfect but it was not inappropriate. He gave evidence that he was invited to report first on the notes and the Claimant's evidence and only after exchange of witness statements was he invited to update his report to finalise it. He had approximately 2 months in which to do that and he did so. Whilst he did not interleaf at each section each of the pieces of evidence from the Defendant's witnesses, I do not consider that that was necessary for his report to be of assistance to the Court. I reject the Defendant's submission that Professor Hardman "tacked on" a summary of the Defendant's witnesses' evidence. He apologised for not having updated his chronology by interleaving the Defendant's factual assertions. When pressed in relation to his recitation of the Claimant's assertion that she had said "stop" after the third attempted epidural, he recalled that this was probably in an earlier witness statement she had given. The Court adjourned for that earlier witness statement to be produced (voluntarily) and it was produced and it supported his recollection. I was impressed by the care with which he answered the questions. He was pressed on his use of the phrase *"able to position herself optimally"* but he stood firm on his view that waking patients and this Claimant, are able to position themselves optimally. As to the factual dispute about the Claimant's pain and distress and Doctor Rice's assertion that she was unable to maintain a sitting position, that was a matter for the Court. Professor Hardman accepted that crying and distress and pain would make it more difficult to maintain an optimal position for epidural but he had taken that into account. He frankly accepted that he had failed to summarise two points from Doctor Rice's evidence, one in relation to consent and another in relation to the levels at which she asserted she had carried out epidurals. He apologised for those errors. When questioned on his evidence about UEPIs he explained that epidurals whilst the patient is sleeping are acceptable and have some advantages, particularly lack of distress and less hurry, but these were small gains in relation to the loss of the safety net of notification of neural injury by a waking patient. He considered that the positioning of the unconscious patient lying on the cushion was less good than a waking patient's being slumped over forwards with the use of gravity to improve the slump. He advised that it was slightly more difficult to identify the midline and there was a loss of symmetry as the unconscious patient sank into the bed on her side, so it was more difficult to place the epidural. However, he accepted that if the patient could not maintain the appropriate position whilst awake, then sleeping epidural was a reasonable option. At the end of his evidence he advised that after removal of the Trocar it is usual to put an adhesive plaster over the hole but this did not always happen.

Doctor McCrirrick

79. Doctor McCrirrick was the anaesthetist instructed by the Defendant who reported in December 2022. He retired from NHS practice at the Gloucestershire Royal Hospital in 2021, having practised there since 1994. He was clinical director of anaesthesia for two years from 2008. He spent two years in Bermuda from 2004. In the past he had published extensively on many aspects of anaesthesia and had been on the editorial board of a journal called Anaesthesia and Intensive Care Medicine. In his report he set

out the medical notes and the evidence of the witnesses. To a certain extent he interleaved the Claimant's witness evidence in the chronology, but he focused substantially on Doctor Rice's evidence. So for instance he wrote at paragraph 5.7:

> *"Doctor Rice subsequently induced general anaesthesia in a standard fashion, having sought verbal consent to attempt to site an epidural catheter after induction of general anaesthesia."*

This approach rather disclosed Doctor McCrirrick's thought process because it did not identify the issue, which was a factual one for the Court, namely whether any consent had in fact been obtained for the UEPI. Instead, he presumed to determine that issue by accepting Doctor Rice's account despite her making no medical record. I refer back to the expert's duties set out above in the *Ikarian Reefer*.

80. In his opinion, in relation to the assertion that the alternatives for POPR had not been provided to the Claimant, he relied on the leaflet given to the Claimant but advised that it was mandatory for Doctor Rice to explain that epidural anaesthesia was optional and there were alternative modes of POPR and that it would be insufficient for Doctor Rice just to discuss the potential complications of EPI. Having given that advice he then recited the medical notes which referred to the risks being provided to the Claimant but he failed to point out that none of the options were noted. That little oversight was again quite telling. Doctor McCrirrick did then consider, in his opinion section, that the Claimant denied the existence of the consent discussion and advised that if there was no such discussion that would be a breach of duty. In relation to allegation (b) in the PoC, the alleged failure to provide alternatives after the WEPIs had failed, Doctor McCrirrick advised that it would not be routine practice to abandon EPI after one attempt and the majority of anaesthetists would not consider suggesting alternatives after one failure. This of course wholly missed the point which was that there had been three attempts and three failures and the Claimant was distressed and crying. He went on to advise that the decision to attempt UEPIs was reasonable but did not answer the question of whether a further consent was needed before they commenced. As I have set out above, this was dealt with in the joint report and he impliedly accepted that further consent was required in that report (in his answers to questions 26 and 27). Doctor McCrirrick advised that UEPIs were a reasonable choice by Doctor Rice. In relation to the number of attempts he advised that it was reasonable for Doctor Rice to ask Doctor Michalou to attempt epidural after her 6 failed attempts. He advised that 10 attempts would be supported by a reasonable body of practitioners but accepted that the increasing number of attempts theoretically bore some relation to an increasing risk of neurological injury. However, he advised the incidence was negligible. In answer to the allegation of negligent technique Doctor McCrirrick advised that nerve injury does not in itself imply negligent care and asserted that "*the Claimant has provided no evidence to indicate it was a consequence of a failure to exercise reasonable care."* I find this a remarkable approach by an expert who was being asked to advise *the Court* on the evidence and the medical notes about whether there has been a breach of duty in relation

to the technical standard required by professionals when carrying out epidurals. It is not Doctor McCrirrick's job to assess whether to the Claimant and her team had provided sufficient evidence of negligent technique. It was Doctor McCrirrick's responsibility to look at all of the evidence, including the medical notes and the neurological evidence and to advise on whether in his opinion there was a breach of duty on technique.

81. In his report summary Doctor McCrirrick advised on consent. He stated that if the Claimant's evidence is accepted there was a breach of duty by failing to consent. On Doctor Rice's evidence there was no such breach. He advised it was reasonable to attempt WEPI & UEPI with verbal consent and that although 10 attempts might be at *"the upper limit of what one might generally consider reasonable"* he did not consider the number in itself indicative of negligent care.

82. He also advised that the standard of documentation of the hospital was reasonable and qualified that by saying in any event it had no direct bearing on the standard of care in relation to the technical skill of Doctor Rice. In the light of the evidence of the failure by Doctor Henderson to make any medical note that she had provided information about the alternatives for POPR and the risks and benefits and Doctor Rice's failure to make any note of obtaining consent or to explain the alternatives for POPR, and of Doctor Michalou's failure to write any notes, I reject Doctor McCrirrick's advice that the standard of note taking in this case was reasonable. I find that it was not.

83. In his evidence in chief Doctor McCrirrick advised that he had probably carried out between 1000 and 1100 epidurals in his career. He advised that there were advantages to epidural over PCA. He advised that he found it easier to administer epidurals with the patient asleep. In cross examination Doctor McCrirrick was questioned about the structure of his report. He accepted that he did not know whether he had read Doctor McLean's neurology report at the time of writing his report. He did not think that the neurological details would affect his opinion on breach. I found that answer slightly troubling because he did refer to a report by Doctor Halpin in the joint statement in relation to cord damage. He asserted, in answer to the question that Doctor McLean advised that the needle went straight through the cord and caused an acute injury emerging the other side and creating a hematoma anterior to the cord and lateral (to the right), that this information had "*no direct bearing on breach of duty*". I do not consider that he was right about that. He asserted he had assumed that had occurred. However, he accepted that he did not say this in his report. In answer to questions from the Court about whether the questions: "how far the needle went in?" and "at what angle it went in?" were relevant to breach, he disseminated about the epidural space being a variable distance beneath the skin. He said that a clinician should try to find it by slow insertion of the Trocar needle with continuous pressure on the syringe, looking for a subtle give when the Trocar goes through the Ligamentum Flavum. He stated that if the Dura was breached spinal fluid would come back and then it would be possible to hit the cord beyond that and go straight through the cord. He advised that the depth of the needle was not a guide in relation to the epidural space. In relation to paragraph 5.7 of his

report, when asked why he assumed that Doctor Rice's evidence was correct, he apologised for stepping outside his field of expertise and adopting the judicial function.

84. In relation to consent he accepted it was mandatory to explain the POPR options and alternatives. He accepted that Doctor Henderson should have discussed options. When it was pointed out to him that she had failed to document any such discussion, he accepted she should have. This was contrary to the opinion he had given in his report that the standard of medical notetaking was satisfactory. He agreed that it was better to provide information before the day of the operation, so the patient had time to consider it. He agreed that the wording of the updated leaflet (August 2017) in relation to consent was "*completely misleading"*. It suggested written consent for both the surgery and the anaesthetic but the practice was verbal consent on the day. He agreed that it was sub-optimal to provide the patient with the alternatives and risks and benefits of POPR only on the day of operation. He agreed that Doctor Rice should have given a choice of POPR and documented doing so. He agreed there was no document evidencing any such conversation. He also agreed that at the second stage, after the WEPIs, Doctor Rice should have kept the patient informed, because it was possible she might have refused further epidurals and he agreed that Doctor Rice had failed to record any further consent being obtained. He explained away the failure by saying that custom and practice determined how much was needed in the notes and Doctors do not record all matters. Despite Doctor Rice accepting she should have recorded any consent she obtained from the Claimant before the WEPIs and before the UEPIs, Doctor McCrirrick stated he had seen a failure to record numerous times and he asserted that it was acceptable custom and practice to fail to record the consent. However, a little later in his evidence he accepted that he would expect a note of the conversation between Doctor Rice and Doctor Michalou in which they allegedly carefully balanced the risks and the benefits of further UEPIs. He was not prepared to accept that Doctor Michalou should have asked Doctor Rice how many attempts she had already made before herself deciding to make further attempts. In relation to the number of attempts he stated that there is no defined number demarcating what is a reasonable number from an unreasonable number. He thought 20 would be too many and 10 was about the time to stop. He stated that 10 was uncommon but not grossly unusual. He stated that a registrar might do three to five attempts and then a consultant might do two to three more (that would make 8). As to the incidence of the risk of nerve damage, he stated that a handful, perhaps 15 per 100,000 was the rate. He stated he did not know whether the risk increased cumulatively. He accepted there was no data set on whether the risk of multiple attempts was higher. He did not accept that the repeated failures indicated a patient factor was the cause, but considered there may have been a doctor factor creating the failure and suggested for instance that Doctor Rice might have become "*psychologically freaked*". He stated that if a single doctor had carried out 12 attempts he would have been less supportive than he was for Doctor Rice who had called in a colleague. He then accepted that, taking into account the fact that two anaesthetists had both failed, it was more likely to have been a patient factor. He also expressly accepted that the more attempts that were made the greater the risk of hitting the cord, but

qualified this by saying that the risk was still vanishingly small. In further cross examination he accepted that a patient would cry out if the anaesthetist hit the cord with the Trocar. He disagreed with Professor Hardman that there was an increased risk involved in UEPI generally, but he accepted that epidurals are tricky. In re-examination he stressed that cord damage was a rare complication and that he did not know why it had occurred. He postulated that perhaps some patients are more susceptible than others and the Claimant might have had a small epidural space.

Neurologist's evidence

Doctor McLean

85. Doctor McLean reported for the Defendant on the neurology in December 2022. He did not give live evidence. In his opinion there was undoubtedly a neurological injury to the Claimant's spinal cord, most likely during epidurals carried out under anaesthetic. Although the Claimant felt pain during the WEPIs, there were no neurological symptoms reported. He advised that the Claimant would immediately have reported such had the Trocar gouged (my word) through her spinal cord. He advised that most probably the Trocar caused acute cord injury and went through from the back of the cord to the front causing the haematoma at the front of the cord on the right hand side. He recorded the incidence of neurological injury with spinal and epidural at 0.07%, citing references for that advice. His second report was on condition and prognosis and the joint report with Doctor Manford dated August 2023 contained the same advice.

Doctor Manford

86. Doctor Manford's first report was dated April 2021, his second and third were dated December 2022. In summary he advised that the Trocar passed through the cord and out the other side, as indicated by the injury to the cord on the 10.7.2018 MRI and the blood on the far side of the cord. He explained that the motor deficits indicated spinal cord damage instead of haematoma irritating the nerve roots as the cause.

The Law

The standard of care

87. Doctors owe a professional duty of care to their patients. When considering breach of duty and the standard of care in this case I have applied the principles in *Bolam v Frien Hospital* [1957] 1 WLR 582. McNair J was addressing a jury and ruled thus:

> "Before I turn to that, I must tell you what in law we mean by "negligence." In the ordinary case which does not involve any special skill, negligence in law means a failure to do some act which a reasonable man in the circumstances would do, or the doing of some act which a reasonable man in the circumstances would not do; and if that failure or the doing of that act results in injury, then there is a cause of action. How do you test whether this act or failure is negligent? In an ordinary case it is generally said you judge it by the action of the man in the street. He is the ordinary man. In one case it

> has been said you judge it by the conduct of the man on the top of a Clapham omnibus. He is the ordinary man. But where you get a situation which involves the use of some special skill or competence, then the test as to whether there has been negligence or not is not the test of the man on the top of a Clapham omnibus, because he has not got this special skill. The test is the standard of the ordinary skilled man exercising and professing to have that special skill. A man need not possess the highest expert skill; it is well established law that it is sufficient if he exercises the ordinary skill of an ordinary competent man exercising that particular art."

And

> "A man need not possess the highest expert skill; it is well established law that it is sufficient if he exercises the ordinary skill of an ordinary competent man exercising that particular art … in the case of a medical man, negligence means failure to act in accordance with the standards of reasonably competent medical men at the time."

88. I also have taken into account the ruling of Lord Browne-Wilkinson in *Bolitho v City and Hackney HA* [1998] AC 232:

> "In the *Bolam* case itself, McNair J. [1957] 1 W.L.R. 583, 587 stated that the Defendant had to have acted in accordance with the practice accepted as proper by a 'responsible body of medical men.' Later, at p. 588, he referred to 'a standard of practice recognised as proper by a competent reasonable body of opinion.' Again, in the passage which I have cited from *Maynard's c*ase [1984] 1 W.L.R. 634 , 639, Lord Scarman refers to a 'respectable' body of professional opinion. The use of these adjectives - responsible, reasonable and respectable - all show that the Court has to be satisfied that the exponents of the body of opinion relied upon can demonstrate that such opinion has a logical basis. In particular in cases involving, as they so often do, the weighing of risks against benefits, the judge before accepting a body of opinion as being responsible, reasonable or respectable, will need to be satisfied that, in forming their views, the experts have directed their minds to the question of comparative risks and benefits and have reached a defensible conclusion on the matter."

Consent

89. I refer to my judgment in *CNZ v Royal Bath* [2023] EWHC 19 (KB), at paras. 260 et seq:

> "**Informed consent and reasonable treatment options**

260. The Supreme Court ruled on the legal requirements governing consent in clinical practice in *Montgomery v Lanarkshire* [2015] AC 143. The relevant facts were as follows. In 1999 the mother was pregnant and the pregnancy was regarded as high risk because she was diabetic, small of stature and because she was carrying a large baby. She raised her concerns about NVD. She was not told that her baby faced a 9-10% risk during NVD of shoulder dystocia (stuck shoulder) which could result in severe arm disabilities despite medical procedures designed to resolve the dystocia. The Doctor considered that if mothers were told of the risks most women would have chosen CS which was not in their best interests. The mother's case was that she should have been told and she would have chosen CS had she been told. The baby did get stuck in the birth canal and did suffer severe arm disabilities. The first instance Judge dismissed the claim holding there was no breach of duty during the consent process and even if the mother had been informed of the risk she would not have chosen CS. The mother's first appeal was dismissed. On second appeal to a seven judge Supreme Court the appeal was granted. In summary the Court ruled that the consent process was inadequate and the mother should have been warned of the risks so her consent was not "informed" consent.

261. The judgment of six of the seven Lords was provided by Lord Kerr and Lord Reed together. The ratio in relation to consent is set out at paragraphs 74-93. The Court analysed the tension between (1) the older historic paternalistic approach to medicine in which the Doctor knows best and (2) the individual's right to choose based on the full information needed for the patient's exercise of that right to choose. The Court noted:

261.0 the changes in society and the changes in medical practice which reflected the greater autonomy of patients and greater access to information by patients from the internet and other sources.
261.1 The GMC Guidance (1998, 2008 and 2013) on consent acknowledging the patients' rights to reach informed decisions about their treatment.
261.2 The steps forwards in the development of the law on Human Rights taken by the *Human Rights Act 1998* which reflected fundamental values relating to personal autonomy over one's own body and what happens to it.

262. The ruling was as follows:

> "81. The social and legal developments which we have mentioned point away from a model of the relationship between the Doctor

and the patient based on medical paternalism. They also point away from a model based on a view of the patient as being entirely dependent on information provided by the Doctor. What they point towards is an approach to the law which, instead of treating patients as placing themselves in the hands of their Doctors (and then being prone to sue their Doctors in the event of a disappointing outcome), treats them so far as possible as adults who are capable of understanding that medical treatment is uncertain of success and may involve risks, accepting responsibility for the taking of risks affecting their own lives, and living with the consequences of their choices.

82. In the law of negligence, this approach entails a duty on the part of Doctors to take reasonable care to ensure that a patient is aware of material risks of injury that are inherent in treatment. This can be understood, within the traditional framework of negligence, as a duty of care to avoid exposing a person to a risk of injury which she would otherwise have avoided, but it is also the counterpart of the patient's entitlement to decide whether or not to incur that risk. The existence of that entitlement, and the fact that its exercise does not depend exclusively on medical considerations, are important. They point to a fundamental distinction between, on the one hand, the Doctor's role when considering possible investigatory or treatment options and, on the other, her role in discussing with the patient any recommended treatment and possible alternatives, and the risks of injury which may be involved.

83. The former role is an exercise of professional skill and judgment: what risks of injury are involved in an operation, for example, is a matter falling within the expertise of members of the medical profession. But it is a non sequitur to conclude that the question whether a risk of injury, or the availability of an alternative form of treatment, ought to be discussed with the patient is also a matter of purely professional judgment. The Doctor's advisory role cannot be regarded as solely an exercise of medical skill without leaving out of account the patient's entitlement to decide on the risks to her health which she is willing to run (a decision which may be influenced by non-medical considerations). Responsibility for determining the nature and extent of a person's rights rests with the Courts, not with the medical professions.

84. Furthermore, because the extent to which a Doctor may be inclined to discuss risks with a patient is not determined by medical learning or experience, the application of the Bolam test to this question is liable to result in the sanctioning of differences

> in practice which are attributable not to divergent schools of thought in medical science, but merely to divergent attitudes among Doctors as to the degree of respect owed to their patients."
> …
> "87. The correct position, in relation to the risks of injury involved in treatment, can now be seen to be substantially that adopted in Sidaway by Lord Scarman, and by Lord Woolf MR in *Pearce* [1999] PIQR P53, subject to the refinement made by the High Court of Australia in *Rogers v Whitaker* 175 CLR 479, which we have discussed at paras 77-73. An adult person of sound mind is entitled to decide which, if any, of the available forms of treatment to undergo, and her consent must be obtained before treatment interfering with her bodily integrity is undertaken. The Doctor is therefore under a duty to take reasonable care to ensure that the patient is aware of any material risks involved in any recommended treatment, and of any reasonable alternative or variant treatments. The test of materiality is whether, in the circumstances of the particular case, a reasonable person in the patient's position would be likely to attach significance to the risk, or the Doctor is or should reasonably be aware that the particular patient would be likely to attach significance to it."
>
> 263. The Court also gave guidance that the role of the Doctor does not require reducing risks to mere percentages and that the information to be given needs to be tailored to the patient's own characteristics in a dialogue to ensure informed understanding by both the Doctor and the patient."

Assessment of the expert witnesses

90. I consider that both expert anaesthetists were doing their best in the witness box to assist the Court. The reports both contained layout issues in relation to integrating the witness statement evidence of the other party after the first draft based solely on the instructing party's evidence. Neither report layout was sufficiently poor so as to undermine my approach to the credibility of either expert. Professor Hardman had a greater and more impressive academic record and is still in NHS practice. He had carried out more epidurals and reached a more prestigious teaching level than Doctor McCrirrick. I also found him to be more independent and more detailed in his approach. Doctor McCrirrick fell into the trap of advocating for the Defendant's witness evidence to be accepted by the Court, which was inappropriate and showed that he struggled to escape from some unconscious bias towards the NHS. His opinion evidence about the standard of medical record taking being satisfactory was shown to be plainly incorrect and I reject it. His opinion on the need for further consenting for the UEPIs was contradictory and I do not rely upon it. Doctor McCrirrick's failure to report the neurological evidence that cord damage from Trocar penetration was the cause of the injury was a

disappointment. His view that it did not affect his assessment of breach was illogical and I reject that opinion. In contrast Professor Hardman stayed within the boundaries of his expertise, was neutral on the factual issues for this Court to determine and was firm and consistent in his evidence. I consider that he was not undermined by cross examination. So overall I prefer the evidence of Professor Hardman on most matters where his evidence is at odds with Doctor McCrirrick. However, that does not mean that I accept all of his evidence and reject all of Doctor McCrirrick's evidence.

91. There is one issue on which Professor Hardman's evidence was not sufficient. The issue of multiple attempts. On page 9 of his report he opined that *"I feel that it was inappropriate to proceed to attempts at epidural placement after induction of anaesthesia … This breach of duty appears to have led to neurological injury"*. The test for breach is not what the Professor "feels", it is the test set out in *Bolam*. In the joint report he asserted that the last few of Doctor Michalou's further 4 attempts at widespread levels were not reasonable. Both in relation to the carrying out of UEPIs and to the 10 attempts I accept the evidence of Doctor McCrirrick. Both experts advised that there is a clear debate in the anaesthetic world about UEPI versus WEPI which is unresolved. In addition, both agreed that there is no guidance on the maximum number, it is a matter of clinical judgment and whilst Doctor McCrirrick advised that 10 was at around the limit of what was reasonable it was not beyond that limit. He was experienced in epidural procedure. He disagreed with Professor Hardman and under cross examination no defect in his thinking became apparent. The risks from multiple penetrations obviously increases but it is small for permanent nerve damage for each attempt (1:10,000). At most after 10 attempts it would be 10:10,000, which is 1:1,000. This is still very small. However, the figures may be based on neurological damage in some patients who had multiple attempts so cumulative counting may be completely flawed. I consider that Doctor McCrirrick accurately represents the view of what is probably a small but reasonable body of anaesthetists on the issues of both the decision to move to UEPIs and the number of attempts made in total. Applying the *Bolam* test I consider that Doctor Rice's decisions were not unreasonable professionally on those two issues.

Assessment of lay witnesses

92. Doctor Henderson did not recall the examination of the Claimant. She noted that she provided detailed surgical risks when there was no need to do so because the Claimant had been consented already by Mr Nelson. She made notes of doing what was not needed, and made no notes of doing what she was required to do, namely to discuss the POPR options. She made an assumption that the Claimant had received the up-to-date POPR leaflet when the Claimant had not and failed to ask to be sure. In those circumstances I prefer to rely on the medical notes as being more credible than the verbal evidence of Doctor Henderson's usual practice. I have already found that she discussed EPI for POPR with the Claimant but not the alternatives.

93. I found the Claimant to be honest and doing her best, but she was also carrying anger at Doctor Rice which coloured her evidence somewhat. More of a challenge to her recollection was that her first recorded account of the events was not contemporaneous. She sent no letter of complaint. So, 9 months afterwards, when she signed her first witness statement, she was recalling details long after the events. I was helpfully informed that some but not all of the medical notes were available then. The Anaesthetic Record was "incomplete" and some of the post operative review notes were not yet disclosed. Despite this her recollection was pretty good on the post operative reviews when they were provided and she redrafted her witness statement to provide the served version. Under skilful cross examination by Mr Mumford the contradictions in the Claimant's evidence were revealed. Her evidence on whether she said "stop" after the first 3 WEPIs was overtly contradictory and I have already rejected it above. Her explanation for other errors in her evidence, for instance that she had been given no risk warnings about EPIs, was unconvincing and illogical because she had asserted receiving a risk warning in her first witness statement. But, at the heart of her evidence was the consistent core complaint that she did not agree to UEPI after the 3 failed WEPI attempts. I found that evidence to be logical, consistent and corroborated by the absence of medical notes saying anything about her giving consent. It flowed from her loss of trust in Doctor Rice after the painful WEPIs and her firm impression that Doctor Rice was "*determined"* to succeed. I find that the Claimant clearly did agree to WEPI because she was awake when each was done. I find that she did so after the risks of EPI had been explained to her on the ward by Doctor Rice. Doctor Rice corroborated her pain and distress caused during the WEPIs. Both agreed that the Claimant cried at the time of the third WEPI. Her evidence of the two reviews by Doctor Rice after the operation was partly accepted by Doctor Rice and one roughly matched her first witness statement recollection. Further the account she gave of her shock when she first found out about the further UEPIs some days after the operation rang true to me. So, as I shall set out below, I do accept the core of the Claimant's evidence, in particular where the medical notes corroborate her evidence, but I reject many of the details she put forward which do not gain corroboration from the medical notes.

94. I do not find that Doctor Michalou was at all dishonest but I was not persuaded that she was wholly independent. In my judgment Doctor Michalou's evidence was manipulated by unconscious bias towards protecting her colleague. Her failure to write any note of her involvement in this spinal cord damage case was unimpressive. Her assertion that she recalled the minutiae of a very short and unrecorded conversation with Doctor Rice about the allegedly careful balancing of risks against reward of further UEPIs set against the option of PCA, without ever reading the patient's notes, without asking Doctor Rice how may attempts she had already made and without making any note herself, is in my judgment unlikely to be accurate given, it was provided 2-4 years after the event for a consultant who carries out scores of EPIs per annum. Her demeanour and her evidence in the witness box was too firm, too resolute and too certain set against that background. She admitted she had spoken to Doctor Rice before she wrote her witness statement.

Doctor Rice

95. I found Doctor Rice to be a conscientious and well qualified anaesthetist who was honestly doing her best to explain an event that has deeply troubled her and made her feel guilty. Certain revealing aspects of her evidence are set out above. Her admission to the gynaecologist that she caused the damage. Her admission that despite priding herself in her accurate and detailed note taking she wholly failed to live up to her own standards in this case. Her admission that having "a go at 3 levels" was the maximum that she thought would be appropriate and her seeking to downplay what she had done by her post event communications. She under quoted the number of attempted EPIs to Doctor Manson and to the Claimant; she failed to reveal to the Claimant that Doctor Michalou had undertaken 4 attempts and she failed to reveal to the Claimant the suspicion of cord damage at T11/T12 shown on the 10th July 2018 MRI, choosing instead to assert that a blood vessel had been punctured rather than the cord damaged itself. I am troubled by Doctor Rice's failure to go back to the notes in the days after the events and to set out a full record of what she did with the proper date and time showing that these were post event entries. I am further troubled that no written record has been disclosed and hence I assume no written record was made for the internal morbidity and mortality meetings or the Wessex morbidity and mortality meeting. Finally, the appraisal form made less than a year after the event shows the complete lack of insight into the inadequate note taking by Doctor Rice which is further downplaying her responsibility. I was troubled by her assertion that the spinal cord lacks feeling and that a Trocar could be pushed through it without an awake patient complaining of any neurological symptoms, which was clearly incorrect on the expert evidence. I consider that during the passage of time between the events and her first being asked to recall them, which was around 2 years, her feelings of responsibility and guilt and the absence of medical notes on all of the key factual issues has degraded and undermined the accuracy of her memory.

96. Thus, I have come to the conclusion that where Doctor Rice's evidence of what was said is not supported by the medical notes and is contradicted by the Claimant, I should treat Doctor Rice's evidence with limited weight.

Findings of fact and rulings on the law

97. I have already made some findings of fact on disputed issues in paragraphs 9, 33, 34, 37, 38, 40, 45, 47, 49, 50, 52, 56, 82 and 90-93 above. On the balance of probabilities, on the evidence before me, I also make the following findings of fact and rulings.

98. On 28th June 2018 Nurse Barclay did not discuss the POPR options with the Claimant but did give her an out of date leaflet setting the options out. The Claimant did not read it. She should have but she had a lot of other leaflets about her bowel surgery to read as well. The Claimant also met Mr Nelson who set out the risks of bowel surgery and noted them properly and consented her in writing for the major bowel surgery. She was given an appointment to come back the next day to the PAAU and did so. I have

carefully considered whether the leaflet provided sufficient information of the alternatives for there to be no need to provide verbal information. I reject that approach because: the Defendant did not make that submission; the experts did not support that approach but instead advised that verbal discussion of the risk and benefits of each option was mandatory and because the leaflet did not set out any risks. It simply listed the following pain relief options: oral medications; injections; local anaesthetic; patient controlled anaesthesia (PCA); epidurals. Furthermore, it expressly stated:

> "There are many treatments which can be successful in helping to prevent and control pain. You, your doctors and nurses will decide which ones are right for you. Many people combine two or more methods to get relief. Your pain is personal to you; the amount you feel may not be the same as others feel, even those who have had the same operation, so the medical staff will need your help in determining the best plan for you."

99. In the afternoon of the 29th June 2018 the Claimant met Doctor Henderson who assessed her and who unnecessarily set out the risks of bowel surgery again using different figures for the risk of death. Doctor Henderson should have, but failed, to advise the Claimant of her alternative options for POPR. She only mentioned epidural anaesthesia and she did not set out the risks.

100. On the 2nd of July 2018 when Doctor Rice was consenting the Claimant verbally in the morning on the ward she failed to mention the alternative options for POPR. She should have included PCA and other options and set out the risks and benefits. Instead, she concentrated on WEPI and the risks thereof. She noted the risks which were discussed on the Anaesthetic Record. The Claimant gave verbal consent which was not "informed consent" and so was invalid because she was not informed of the relative risks and benefits of other options including PCA. Doctor Rice failed to fill in the spaces specifically designed for recording informed consent and for noting discussion of the alternatives to WEPI, specifically including PCA, on the Anaesthetic Record sheet.

101. In the afternoon Doctor Rice had a least one student present when she carried out 3 WEPIs on the Claimant, none of which were successful and each of which caused the Claimant more pain, despite the local anaesthetic provided to her. During those failed attempts in front of the student/s, Doctor Rice became distracted by her inability to succeed and the Claimant's crying and distress.

102. Doctor Rice then became determined to put the Claimant to sleep and to continue with UEPIs, however she failed to explain to the Claimant that she would continue with UEPIs and she failed to set out the alternatives (specifically PCA) so that the Claimant could choose. Her professional responsibility at that stage was to gain the Claimant's informed consent to the way forwards but she did not do so. As a result, she did not make any notes on the Anaesthetic Record of informing the Claimant of her POPR

options or of any verbal consent to more attempted epidurals. This was a further breach of her professional consenting and note taking obligations. On the "but for" facts, I accept and prefer the Claimant's evidence that she would have refused further epidurals had she been asked and offered PCA as an alternative and would have rejected Doctor Rice's advice to have further epidurals whilst she was unconscious. I find that the Claimant would have chosen PCA instead. She was scared and had lost trust in Doctor Rice's ability to succeed with the epidurals.

103. Thus, the attempted UEPIs were, in law, a battery to the Claimant's body, to which she had not consented. The three further attempts which were made by Doctor Rice to site the Trocar in the epidural space whilst the Claimant was in the lateral position unconscious failed. As she herself described it, Doctor Rice decided to "go for three levels". On her evidence perhaps two were deep enough to clear the bony vertebrae behind the spinal cord and approach or puncture the Dura and the cord. By her own admission one or more of these were at level T11/T12. She then called in Doctor Michalou. Scant discussion took place and I do not accept that there was a detailed discussion of the risk and benefits of PCA over EPI. Doctor Michalou did not read the Anaesthetic Record or the Claimant's medical notes. She then made 4 attempted epidurals, at least one of which cleared the vertebral bones behind the spinal cord and led Doctor Michalou to try to feed the catheter into the Trocar, but it would not go through. There is no evidence of which levels these attempts were at. Then they both gave up. Doctor Rice failed to record the levels at which she had made her 6 attempts and Doctor Michalou left the room without making any medical notes of her own 4 attempts and without reading any medical notes. I make no further finding on the contents of the conversations between Doctor Rice and Doctor Michalou which I do not accept they could have recalled accurately 2-4 years after the event without any medical notes.

104. The Defendant admits that some of the attempts which were made by Doctor Rice were at the T11/T12 level. This was the level at which, on one attempt, the Trocar was pushed through the Ligamentum Flavum, through the epidural space, through the Dura, through the spinal cord rear to front and out the other side. Doctor Rice did not record how far in each Trocar attempt went in. I take into account that the needle was 8cm long and clearly marked up along its length and the average depth of the epidural space is 3-5 cms. I take into account that the cord is around 1-2 cm in diagonal at this area and that the MRI scan showed that the Claimant had a normal spine. I do not find that Doctor Rice attempted epidural at L3/L4. The evidence from SGH pointed towards that but without hearing from SPR Hall I am not prepared to make that finding and the evidence of the Claimant's daughter was from a lay person.

105. After the Claimant came round in the recovery room and her symptoms became apparent Doctor Rice felt worried and guilty. I find that she decided not to mention the involvement of Doctor Michalou to the Claimant and so never did. I find that she did not mention the UEPIs at that time either. The first time that the Claimant became aware

of the UEPI attempts was many days after the operation when, at a review meeting, Doctor Rice admitted they had been done. The Claimant was shocked by this. In her letter to Doctor Kenney (11.9.2018) Doctor Rice admitted that she had caused the epidural haematoma. In her letter to the Claimant (dictated 11.7.2018, typed 13.7.2018) she failed to disclose the high number of attempts made after the Claimant was put to sleep and kept the involvement of Doctor Michalou secret.

106. In relation to the claim that the wrong technique was used by Doctor Rice, there is insufficient evidence to support that assertion. Professor Hardman did not so assert and Doctor McCrirrick completely ducked the issue.

107. In relation to the pleaded case that 10 attempts at siting the epidural anaesthetic by using a 16 Gauge Trocar were too many, I consider that it was at the outer limit of what a small but reasonable body of anaesthetists would do, but I do not find that it was a breach of the standard of care imposed on Doctors Rice and Michalou. When coming to this conclusion I accept the evidence of Doctor McCrirrick, which on this issue I considered to be sufficiently logical to be within the *Bolitho* test. Although the risks did accumulate with every attempt, they were still very small. I also accept the thrust of the evidence of Professor Hardman, when he wrote that he "feels" that this was too many. However, the *Bolam* test is not based on feelings, it is based on what a reasonable body of anaesthetic professionals would not do.

108. I do not need to consider the tricky causation issues within the second issue on this case (the 10 attempts issue) because of the findings which I have made above.

Breach

109. I find that informed consent was not obtained from the Claimant on 2nd July 2018 in the morning or that afternoon for either the waking or the unconscious epidural attempts made by Doctor Rice and Doctor Michalou.

110. If there had been consent to the unconscious epidural attempts, I find that the number of unconscious attempted Trocar penetrations (7) to set up epidural anaesthesia which were subsequent to 3 waking Trocar penetrations, was at the outer limit of what acceptable professional practice would permit but was not negligent.

Causation

111. The failure properly to consent the Claimant for the WEPIs did not lead to any injury because the Claimant accepts in her pleadings that if she had been properly consented on the ward, or at any time before the WEPIs were performed, she would have accepted Doctor Rice's advice to have a waking epidural.

112. The failure to obtain the Claimant's informed consent before putting her to sleep and starting 7 more epidural attempts was causative of the cord injury at T11/T12 and the haematoma running down the spine from there to around L3. On the medical evidence

I have found that the Claimant's neurological symptoms were caused by the attempts made after the Claimant was put to sleep. Hence 100% of the agreed damages were caused by the lack of consent.

Judgment

113. Judgment shall be entered for the Claimant. The agreed damages are £1.3 million. The consequentials should be agreed, if possible, between the parties before this judgment is handed down.

Appendix (which is included in the judgment)

The August 2017 Leaflet which was not given to the Claimant.

This leaflet included the following information.

"**Regional anaesthesia (RA)**

This is when local anaesthetic is injected near major nerves. The area of the body affected becomes numb and you can tolerate surgery without being unconscious. The most common forms are Spinal and Epidural anaesthesia where local anaesthetic is injected close to nerves in the spine. Spinal or Epidural anaesthesia is effective for operations on the lower body, such as Caesarean section, bladder operations, or replacing a hip or knee. Other forms of RA involve an injection around nerves in an arm or leg, called a 'nerve or nerve plexus block'. Nerve blocks are also useful for pain relief after the operation, as the area will stay numb for a number of hours. For more information, see the leaflet on nerve blocks for shoulder-, arm- or hand-operations (www.rcoa.ac.uk/document-store/nerve-blocks-surgery-the-shoulder-arm-or- hand).

Some advantages of RA include:

• Staying awake and breathing on your own.
• Maintaining your natural airway reflexes.
• Lower risk of sickness and vomiting.
• Being exposed to fewer different anaesthetic drugs.
• Less or no drowsiness/confusion and quicker recovery of full consciousness after surgery.
• Often better pain control after surgery with lower doses or lower strength pain killers.

Some disadvantages are:

• Numbness and weakness of limbs delaying you from getting up and walking/using your arm/hand for several hours after surgery
• Sometimes a temporary bladder catheter is required for a few hours.
• Injection around nerves or into the spine can be unpleasant.

• Sometimes there is failure to achieve good numbness in the desired region. A GA maybe required if this happens.
• Rare risks of nerve damage, which can lead persisting numbness, weakness, pain, paralysis and/or incontinence.
…
Prolonging the effect via use of catheters has some disadvantages such as reducing your ability to move around while having one, as well as catheter displacement and infection risks."
…
"**Your consent**
In order to treat we need your formal consent to do so, and we usually ask to give this in writing, by signing a form. You will be asked to give consent separately to the surgery and to the anaesthetic. To be able to give well informed consent you should understand the different options available to you, with their advantages, disadvantages and risks of complications. This leaflet should help you to understand this better and give you time before your operation to consider. Your anaesthetist will try and understand things from your perspective so he or she can best advise as to which type of anaesthetic would be best for you. However, please note that the amount of time that you will have with your anaesthetist on the day of surgery will be limited. A long and detailed discussion is usually not possible on that occasion. If you feel that you need more time to understand and consider the options, or ask a number of questions that are important to you we recommend that you to book a separate appointment with an anaesthetist well before your planned operation, by contacting 552210 on weekdays between 10AM to 4PM." (My emphasis).
…
"People vary in how they interpret words and numbers. This scale is provided to help.

Very common	Common	Uncommon	**Rare**	Very rare
1 in 10	1 in 100	1 in 1000	**1 in 10,000**	1 in 100,000

Side effects and complications
RA: This may occur with a regional anaesthetic or local anaesthetic.
GA: This may occur with a general anaesthetic.

Very common and common side effects
RA GA Feeling sick and vomiting after surgery.
…
Dizziness, blurred vision. Headaches. Itching. Aches, pains and backache. Pain during injection of drugs. Bruising and soreness. … Pain after surgery. Failure of RA. Chest infection after the operation, (particularly if you have Asthma, COPD or other serious lung disease)"

…

Uncommon side effects and complications

RA GA Bladder problems, bladder infection, kidney infection.

…

RA GA Slow breathing (depressed respiration).

…

RA GA An existing medical condition getting worse.

RA GA Temporary organ failure. (chest, heart, kidney) requiring treatment on an Intensive Care Unit

RA Accidental injection of local anaesthetic into blood vessels.

RA GA Deep vein thrombosis; pulmonary embolism.

RA GA Bladder catheter: Injury of urethra/bladder or other abdominal organs."

"Rare or very rare complications

…

RA GA Serious allergy to drugs

RA GA Nerve damage which can lead to persisting numbness, weakness, paralysis, incontinence. (My emphasis)

RA GA Pneumothorax (collapse or a lung, requiring a chest drain to be sited between the ribs)

RA Generalised seizure. Meningitis or abscess in the spine/spinal cord

RA GA Death

RA GA Equipment failure

RA GA Rare injuries from monitoring equipment, such as skin burns or pressure-induced bruises."

END