Neutral Citation Number: [2020] EWHC 3306 (QB)

Case No: QB-2018-001157

IN THE HIGH COURT OF JUSTICE
QUEEN'S BENCH DIVISION

Royal Courts of Justice
Strand, London, WC2A 2LL

Date: 07/12/2020

Before :

MASTER COOK

- -

Between :

MR BRIAN HENRY	**Claimant**
- and -	
OXFORD UNIVERSITY HOSPITALS NHS FOUNDATION TRUST	**Defendant**

- -
- -

Helen Pooley (instructed by **Royds Withy King**) for the **Claimant**
Clare Hennessy (instructed by **DAC Beachcroft LLP**) for the **Defendant**

Hearing dates: 2nd, 3rd and 4th November 2020

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Approved Judgment

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

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Covid-19 Protocol: This judgment was handed down by the judge remotely by circulation to the parties' representatives by email and release to BAILII. The date and time for hand-down is deemed to be 7 December 2020 at 10:30 am

MASTER COOK:

1. This is the Claimant's claim for personal injury caused by alleged clinical negligence arising out of posterior instrumental fusion surgery which took place on 22 July 2010. In short, the Claimant alleges there was failure to recognise misplacement of the L5 pedicle screw, either intra-operatively, in the immediate post-operative period or longer term. No issue is taken with the placement of the pedicle screw. The Claimant's case was that he suffered impingement or irritation of the L5 nerve root caused by the pedicle screw from July 2010 until its removal in 2015.

2. At the CCMC which took place on 8 October 2019 the parties requested that the trial take place before one of the dedicated clinical negligence Masters, the alternative was to direct the claim be transferred to the County Court on the basis of the relatively modest value of the claim. I granted the request.

3. Due to Covid 19 restrictions the trial was conducted remotely by Microsoft Teams and I am grateful to all involved for their cooperation which enabled the trial to be completed within the three-day time estimate.

4. The essential background facts to this claim are as follows. The Claimant was a carpenter by trade who, in 1990 injured his lower back in the course of his employment. Thereafter he began to suffer pain in his lower back of increasing frequency and severity he also developed a left sided sciatica. All of this is well documented in the medical records, see by way of example, an assessment by the pain clinic at Northampton General Hospital on 22 May 2009 and in particular the pain manakin where the claimant has recorded the position of his pain at the base of his spine and radiating down his left leg. In August 2009 he was eventually referred to the Nuffield Orthopaedic Centre in Oxford where a diagnosis of chronic low back pain and chronic left leg sciatica L5 -S1 distribution was made. Following discography on 27 May 2010 the Claimant discussed treatment options with Mr Wilson McDonald. Mr Wilson McDonald's note of the consultation states;

> "*This gentleman continues to experience back pain. He is now on quite high doses of Morphine. With the Morphine, he copes reasonably well. However he is now not working because of the pain in his back. The pain is all at the lumbosacral junction without any significant referral into his legs and he has no neurological symptoms.*
>
> *On examination, he can only bend to touch knees. He has no inappropriate signs. His hips and knees and pulses are normal. Muscle power, sensation and reflexes are normal and there were no upper motor neuron signs. His pain is all at the lumbosacral junction on assessment and on palpation except for minor pain in the lower thoracic region. He felt we had a long talk about the benefits and risks of surgery and the alternatives. I explained that the functional restoration programme is probably equally good as spinal fusion in his case. However he is adamant he does not want to go down this line. He has had a variety of other treatments in the past. He has not had physiotherapy for eight years. He has had*

> *acupuncture, osteopathy and chiropractic. He was shown exercises but these were not particularly helpful.*
>
> *I think it is not unreasonable to offer him surgery. He and his wife, I think fully understand the discussion we have had. I have been over the benefits and risks of surgery and I have explained a 2% chance of nerve damage leading to pain, weakness or numbness in the legs. I have also discussed a 3% risk of infection requiring further surgery. We have explained I think there is a 60% chance of him doing better and a 5% chance of him being worse with surgery.*"

5. Following this consultation, the Claimant decided to undergo surgery. The Surgery was carried out on 27 July 2010 by Mr Packard under the supervision of Professor Lavy. The operation note states:

> "*Patient prone on Montreal mattress, bony prominences padded. Midline longitudinal incision centred over lower lumbar spine. Paravertebral musculature reflected laterally. Haemostasis throughout. Facet joints of L3/4, L4/5 and L5/S1 were identified and confirmed with II.*
>
> *Exposure was taken laterally to the transverse processes which were decorticated. Pedicle screws were inserted bilaterally into L4, L5 and S1. II showed good pedicle screw placement. These were secured with contoured rods (US to S2. The L3/4/ facet joint was otherwise preserved. The laminae were decorticated and local Autograft and Chronos bone substitute were placed posteriorly.*
>
> *Closure. Irrigated with normal saline. 1 Vicryl to fascia, 0 Vicryl to fact, 3/0 subcuticular PDS to skin. Steristrips. 20ml 0.5% Marcain.* "

6. Unfortunately, following his surgery the Claimant developed a wound infection and had to undergo a wound debridement and washout of the lumbar spine on 3 August 2010.

7. There are three relevant entries in the Claimant's nursing notes at this time. The first on 2 August 2010:

> "*/O tingling/tightness in L calf -O/E No tenderness to touch, no obvious swelling, hardness or pain. Advised to observe & report changes. Calf comfortable at rest*"

The second on 4 August 2010:

> "*Physio – consent gained V S,, Pt well. Has already mobilised this morning. o problems o- mobility. Report some lateral calf pain on L. ⁰ redness/tenderness on palpation. Pt mobilised ≈60m I + completed stairs I Pt reports slight foot drop on L –*

> *noticed 1st day post op following fusion. On ex - ↓eccentric control of DF. ⁰ indication for AFO. Advised active DF/PF exercises. P discharged from physio.*"

The third later that day:

> "*NURSING 4-8-10. 20.50 Care taken over at 13.30. Py given oxynorm for pain relief. Pt C/O pain in L of wound, s/b 202 Dr Muir, full power sensation and movement, pain is local to L side of wound and there is no visual cause. Pt to be reviewed by Spinal Team tomorrow. Pt mobilising Eating + drinking chs stable.* "

8. The Claimant was discharged and returned home. He was reviewed at the Oxford clinic by Mr Rout, specialist registrar on 13 December 2010;

> "*I have reviewed Mr Henry in clinic today. He is now four months from surgery. Unfortunately, he is complaining of back pain. He describes it as severe probably worse that it was preoperatively. He is requiring something in the region of 240 mg to 300 mg of OxyContin a day. This does appear to manage his pain. He also reports some pain around his left buttock and left thigh. He has no motor or sensory disturbances of his lower limb.*
>
> *On examination today, Mr Henry actually appeared quite comfortable. He walked in with good posture and moved from the chair to the examination couch without any obvious discomfort,*
>
> *He had a beautifully healed wound and there was no tenderness around his back. He had straight leg raises bilaterally of 80⁰ with no signs of neural tension. He had 5/5 power throughout all myotomes and there was no sensory deficit.*
>
> *I have taken radiographs today and these show satisfactory position of the metal work and there is no evidence of loosening. ...* "

9. The Claimant was then reviewed at the Oxford clinic by Mr Bowden, consultant orthopaedic surgeon, on 13 April 2011;

> "*Mr Henry continues to have back and lower limb symptoms. In June last year, he had posterior instrumented fusion from L4 to S1 because of persistent and severe low back pain. His postoperative course was complicated with an infection and in August last year the wound was debrided. He was treated on antibiotics and since completing the course of antibiotics there has been no evidence of infection.*

> *Mr Henry has mechanical low back pain, but also has symptoms to suggest a left L5 radiculopathy. His symptoms fluctuate, but on balance it is his back pain is limiting his activities most. He has marked paravertebral muscle spasm and reduced movements, but he has no focal neurological deficits.*
>
> *Mr Henry's symptoms may still improve. I have explained to him that this may take anything up to a year and to maximise the chances of recovery he needs to do the exercises he has been taught by his physiotherapist on a regular basis. He should also increase the level of his aerobic activity and even if he is experiencing pain try to return to normal daily activities. Unless he does his symptoms are unlikely to resolve. He is concerned that any increase in activities may damage his spine, but I have reassured him that this is extremely unlikely.*
>
> *I have arranged to see Mr Henry again in six months and if indicated I will arrange a CT scan to establish if the bone graft has incorporated and if there has been any changes around the instrumentation that could be related to the postoperative infection.* "

10. The Claimant continued to experience pain in his lower back for which he took large quantities of pain killers and attended the pain clinic at Bedford General Hospital. On 26 October 2011 he was once more reviewed at the Oxford clinic by Mr Batista, spinal fellow, who wrote to the Claimant's GP requesting that a CT scan be arranged locally in Bedford. It seems the original copy of this letter may not have reached the Claimant's GP.

11. Mr Henry was last seen at the Oxford clinic on 8 July 2013 when he was still reporting severe lower back pain. In October 2013 Mr Henry's GP referred him to the Royal National Orthopaedic Hospital in Stanmore:

> "*Thank you for your help with this 51 year old man who would like to see you regarding his chronic back problem.*
>
> *He has been a patient of ours for the last four years but has had back pain for the last twenty years. This has proved quite difficult to manage over the years. Eventually in November 2020 he had an L4 to S1 spinal fusion carried out at the Nuffield Orthopaedic Centre in Oxford. However he is still having problems with pain. He was last seen in their clinic in August and we were asked to arrange an MRI scan locally. I enclose a copy of the result which we have been sent. Although I am sure you will be able to obtain the images from the Bedford Hospital. You will see that there are no specific disc bulges at all but some general degenerative change it would seem. Mr Henry is still having pain radiating down his left leg in his lower back and also now in his upper back. He says that*

> *he has lost faith with the Nuffield Hospital and would appreciate a second opinion …*"

12. Unfortunately, the Royal National Orthopaedic Hospital did not consider the Claimant's case to be complex enough and so his GP made a further referral to Addenbrookes Hospital in Cambridge. He was initially seen on 6 February 2014 by Dr Abhishek, a consultant rheumatologist on 11 February 2015 who noted;

> "*Presently his back pain and mid thoracic pain are worse. He gets constant left leg and buttock pain. There is no history of paraesthesia or weakness*"

13. The Claimant was referred to the Cambridge pain clinic and reviewed again by Dr Abhishek on 24th April 2014 when a nerve block of the L5 root was arranged. On this occasion it was noted;

> "*… His low back pain continues as before. He has got left sided sciatica for the last 8 years which is worse after surgery. The pain is typically in the left L5 S1 distribution. …* "

14. The Claimant was only afforded temporary relief by the nerve block. He was then referred to the neurosurgeons and on 23 September 2014 saw Mr Richard Mannion who discussed the removal of the metal work. Mr Mannion reported as follows;

> "*he had an MRI scan in July and has had some CT scans previously. The MRI is difficult to interpret entirely given the artifact from the screws, but the CT does show the that the left L5 screw is breaching the cortex medially and entering the lateral recess. One cannot be certain as to whether this is irritating the nerve root but if it was then this could explain at least some of the pain radiating down the leg.*
>
> *On examination he seems to have full power on dorsiflexion and no loss of power which suggests that the L5 root is working at present.*
>
> *We discussed in detail the pros and cons of hardware removal. He is aware that while this can be done there is no guarantee that it will improve his symptoms, either in the leg or back. In fact it is very unlikely to improve the back pain but could possibly improve the leg pain. Equally there is a risk that the surgery could make the leg pain worse. If the screw is touching the root and has been doing so for four years then, should there be any adherence, removing the screw was carry a significant risk of damaging the root, leaving him with a foot drop and even worse a pain in the leg. There are other risks such as infection and CSF leak. All in all I have quoted the likelihood of any improvement at no greater than 50% with a 50% chance of either the same or worse as a consequence of surgery."*

15. The Claimant opted to have the metal work removed. He underwent successful surgery at Addenbrookes in February 2015. Following surgery, the Claimant reported that he was pain free, however within a month he was reporting both lower back pain and sciatic to his GP. These symptoms have continued and if anything, have got worse over time. There is a progress note from Mr Abrahams on 12 October 2015;

> "*although this helped initially his pain levels returned to the pre surgery levels and he continues to suffer from back pain and left leg pain*."

The Parties Positions

The Claimant

16. The allegations of negligence set out in the particulars of claim fall into three categories:

    i) Allegations of negligence during the surgery. A failure to use AP imaging and a radiolucent operating table and a failure to recognise the misplaced screw. (para 20i & iii)

    ii) Allegations of negligence in the days after surgery. A failure to act upon the Claimant's complaint of symptoms and organise a further CT scan. (para 20 ii, iv, v & vi)

    iii) Allegations concerning subsequent scans and missed opportunities to identify that the misplaced screw was causing the Claimant problems. A failure in May 2011 to identify a left sided radiculopathy could be related to the misplaced screw and failure to ensure the CT scan recommended in November 2011 was carried out and reported effectively and without delay. (para 20 viii, ix, x & xi)

The Defendant

17. The Defendant initially admitted that a radiolucent operating table and AP imaging had not been used. These admissions had been made in response to Part 18 questions raised by the Claimant's solicitor. However, on 8 September 2020 Deputy Master Stephens gave the Defendant permission to resile from this admission and serve additional witness evidence from Professor Christopher Lavy, the surgeon who supervised the claimant's operation.

18. At trial the Defendant denied all aspects of the Claimant's case. Breach of duty, causation and quantum were all in issue.

19. The parties were however agreed upon the issues which it was necessary for the court to decide, largely as a result of the common ground reached on a number of matters between the expert witnesses.

20. The Parties had been given permission to rely upon expert evidence from a consultant spinal surgeon and a consultant radiologist. The Claimant served reports

from Mr Jonathan Spilsbury and Dr Hartley Euinton and the Defendant served reports from Mr J B Williamson and Dr James Rankine.

The spinal surgeons' joint reports

21. The spinal surgeons Mr Jonathan Spilsbury and Mr J B Williamson produced a joint report dated 25 October 2020 and were agreed that the Claimant had a history of low back pain and right sciatica and that the posterior instrumental fusion surgery carried out in July 2010 was an attempt to address the Claimant's persistent low back pain. The spinal surgeons acknowledged that the question of whether AP imaging was taken and whether or not a radiolucent table was used was a matter of fact for the court but were agreed that a failure to take AP imaging during the insertion of pedicle screws would be a breach of duty.

22. The spinal surgeons were agreed that L5 pedicle screw was misplaced, since there was breach of the inferomedial cortex, however the degree of intrusion into the neural canal was not great. They were agreed that such pedicle screw misplacements are common and that the AP x-rays taken after surgery were not interpreted as showing a misplaced screw.

23. The spinal surgeons were agreed that the indication for removal of the misplaced screw is not the fact that it was misplaced as most screws with this degree of misplacement will not have any adverse effect. However, if the screw was having an adverse effect, by causing new radicular leg pain, or a neurological defect, then there was an indication for further investigation and possible removal.

24. The spinal surgeons did not agree on causation but noted this was in part due to their differing interpretation of the evidence. They were agreed that should the court find that the leg pain of which the Claimant complained was a continuation of his pre-operative pain then no symptoms were due to the misplaced L5 screw. In the event the court were to find that the Claimant complained of a new leg pain Mr Spilsbury's view was that the misplaced screw irritated the L5 nerve root causing pain for 3 to 5 years. Mr Williamson did not believe that the degree of pedicle breach, where the screw was not impinging or compressing the nerve root, was sufficient to cause a problem and points to the fact that following removal of the screw the Claimant's pain had returned and reached pre-operation levels.

The radiologists' joint reports

25. Dr Hartley Euinton and Dr James Rankine produced joint reports dated 21 October 2020 based upon separate agendas prepared by the solicitors. Based on a CT scan dated 5 April 2012 the radiologists agree the L5 nerve root appears to be very close to the screw but does not appear to be compressed or deviated and that the inevitable artefact associated with CT makes assessment problematic. Dr Euinton's opinion was that this should have been reported by a responsible body of radiologists. Dr Rankine's opinion was that it would only be necessary to report if the nerve root had been compressed or displaced.

26. Following removal of the screws, Dr Euinton's opinion was the post-operative imaging showed the L5 nerve root to be a little swollen. Dr Rankine did not agree Dr Euinton's interpretation his view was that the root was normal and that it was not

appropriate to compare the section through the L5 root with others because they exited the spinal canal at differing angles.

27. The agreed issues were:

i) Whether during surgery on 22 July 2010 the pedicle screw was misplaced;

ii) Whether AP imaging and a radiolucent table were used during the operation;

iii) Whether the Claimant developed new radicular leg pain or a neurological deficit in the immediate post-operative period? If the Court concludes that the claimant did, the experts were agreed that this would be a reason to investigate by way of a CT scan or consider whether the pedicle screw was the cause of any new radicular leg pain or a neurological deficit symptoms if such symptoms were reported by the Claimant;

iv) Was the left L5 pedicle screw touching the nerve root? Did the screw cause compression or deviation of the nerve?

v) Was the left L5 pedicle screw the cause of the Claimant's symptoms?

vi) Did removal of the pedicle screw and metal work remedy the Claimant's pain and if so for how long? Does the fact his leg pain returned mean that the pedicle screw was not the reason for his pain?

The relevant legal principles

28. The relevant legal principles were not in dispute. To amount to medical negligence, any alleged error in treatment or investigation or omission to provide adequate treatment must be shown to derive from a failure to attain the required degree of skill and competence of a reasonable practitioner. "*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 a competent man exercising that particular art.*" (Bolam v Friern Hospital Management Committee [1957] 1 WLR 582, at 586 per McNair J.)

29. The practice relied on has to be respectable, responsible and reasonable and has to have a logical basis; and where it involved weighing comparative risks, it had to be shown that those advocating it had directed their minds to the relevant matters and reached a defensible conclusion: Bolitho v Hackney HA [1998] AC 232, at 241H-242A per Lord Browne-Wilkinson.

30. In the context of this case, the Claimant must establish that the Defendants' assessment and treatment of the Claimant fell below the standard reasonably to be expected. Alternatively that any decisions made lacked a logical and rational basis.

The Evidence

31. I heard the following non-expert evidence. For the Claimant, from the Claimant and his mother. For the Defendant, from Professor Lavy and Mr William Bowden.

32. I also heard expert evidence from each of the spinal surgeons and radiologists.

The Claimant

33. The Claimant gave evidence in accordance with his witness statements dated 12 October 2016 and 29 October 2019. My view of the Claimant is that he was doing his best to recall events but he was a very poor historian. This is not really surprising given his long history of back pain and the large amount of pain killers he has taken at various times to combat his pain. One very obvious example, which emerged in the course of cross examination, was that he could not remember he had suffered a wound infection and required further surgery following his spinal fusion in July 2010. Another example was the assertion, made in his second witness statement, that his interview with Mr Williamson on 28 April 2020 only lasted 10 to 15 minutes. When Mr Williamson's telephone records were put to him he accepted that that the interview had in fact lasted over 30 minutes. There were many other instances which I need not recite.

34. Over all the Claimant accepted in cross-examination that the entries in his medical records were likely to be more accurate than his own recollection. Where there is a difference between the Claimant's recollection and entries contained in his medical records I have no hesitation in preferring the medical records.

35. It is clear that the medical records and in particular those from the Northampton Pain Clinic in 2009 demonstrate that the Claimant suffered from significant left sciatic pain before his surgery. This is in complete distinction to what he told Mr Spilsbury in October 2017;

> "Prior to surgery Mr Henry tells me that he had little in the way of leg pain. He had occasional pain radiating down his left leg, but the majority of the pain was back pain. …"

36. I cannot accept the Claimant's account, set out at paragraph 7 of his witness statement, that he developed a left sided foot drop which recovered several weeks later or the sciatica which he reported was somehow different in nature to that which he had previously reported. The *"slight footdrop"* reported by the Claimant and referred to in the nursing note quoted at paragraph 7 above is not consistent with the development of a true footdrop. If there had been a true footdrop this would have been mentioned in the notes. As it is the notes record that he was able to mobilise up and down stairs and was discharged from physiotherapy. No neurological deficit was recorded. The medical records demonstrate the numbers of various doctors, nurses and physiotherapists who saw the Claimant in his post-operative period. In my judgment it is unlikely that none of them would have noted increased constant leg pain, numbness and a foot drop.

37. I accept that from 2013 there was a shift in the type of pain being experienced by the Claimant as evidenced by the notes set out at paragraphs 11 and 12 above. However and importantly his reports of pain are of the same type of pain, namely severe lower back pain radiating into his left leg.

38. As can be seen from Mr Mannion's note at paragraph 14 above the decision to proceed to surgery was a matter for the Claimant and risks and benefits were clearly

explained to him at length, partly because Mr Mannion could not be certain that the Claimant's problems were being caused by the L5 pedicle screw.

39. The Claimant accepted that following removal of the metal work his pain has returned.

Mrs Christina Henry

40. Mrs Henry gave evidence in accordance with her witness statement. I accept that she was doing her best to assist the court, however there were obvious limitations on the scope of the evidence she could give and her evidence was primarily directed to the amount care she provided to her son. Mrs Henry is a retired nurse now aged 82. Following his separation from his wife the Claimant now lives with his mother and she provides him with approximately 5 hours of care per week.

41. Mrs Henry also told me that she tended to accompany her son to all his recent DWP and medical appointments and makes notes in a note book as the Claimant's medication makes him drowsy and liable to forget important information.

Professor Christopher Lavy

42. Professor Lavy gave evidence in accordance with his witness statement. I found him to be a highly impressive witness with an equally impressive CV. I accept his evidence without hesitation. From 2007 he was employed as an honorary Consultant Orthopaedic and Spinal Surgeon at the Oxford University Hospital trust and his specialist areas are micro-discectomy and decompression of the lumbar spine.

43. As one might expect, due to the passage of time, Professor Lavy cannot recall the detail of his involvement in the Claimant's care but relies upon his usual practice and his experience of the usual practices at the Nuffield Orthopaedic Centre together with the entries in the Claimant's electronic and paper medical records.

44. He told me that the operation was performed in operating theatre 6 at the Nuffield Orthopaedic Centre and that the operation was performed by Mr Richard Pickard under his supervision. He said that for each for each of the screws that were being inserted to provide the instrumentation fixation points along both sides of the spine at each vertebral level, the satisfactory screw placement of each screw would have been checked using the theatre image intensifier viewing both lateral and anterior posterior ("A-P") x-ray views to identify and confirm satisfactory screw placement in respect of level, depth, alignment and angulation. He said that it was his practice to check screw position on x-ray imaging in theatre sequentially before we proceeding to the next level or stage. It was not the practice at the Nuffield to retain every single image for this stage of the operation. The usual practice was to check on the imaging the positioning of all of the implanted screws, using both lateral and A-P x-ray views, at the end of the surgery and for these "final implant position" images to be saved.

45. Professor Lavy told me he could see no reason for himself or Mr Pickard to depart from the usual practice with this operation. He said that no surgeon with a functioning image intensifier would simply not use it to obtain imaging from the required angles. He therefore, confirmed without doubt the Claimant's

instrumentation would have been imaged, and for some reason the radiographer did not store those A-P images. He also confirmed that all operating theatres at the Nuffield were equipped with radiolucent operating tables.

46. In cross examination Professor Lavy said that at the time it was not unusual for images not to be saved by the radiologist and that the equipment used had a limited memory which could account for the loss of the AP images. He was also very clear that he could not have referred to "*II"* in the operation note, set out at paragraph 5 above, if an image intensifier had not been used.

Mr William Bowden

47. Mr Bowden gave evidence in accordance with his witness statement. I found him to be an impressive witness and I accept his evidence without qualification. Mr Bowden is a Consultant Orthopaedic Surgeon at Oxford University Hospitals NHS Foundation Trust and has been in post since April 2000. His professional qualifications are MB BCh 1986 F08 Orth (SA) 1994.

48. Mr Bowden told me that when he examined the Claimant on 13 April 2011 and made the note set out at paragraph 9 above, Mr Henry had pain radiating down his left lower limb suggestive of a left L5 radiculopathy but demonstrated no objective signs of a radiculopathy. His main problem was that of severe backpain. He had no neurological deficits and without objective signs of nerve root compression the clinical focus was on his back pain and there was no compelling evidence of nerve root compression by a screw or by any other structure.

49. In cross-examination Mr Bowden told me he took a holistic approach. He recognised the Claimant had had an awful time of it and was obviously in terrible trouble. He readily accepted that had the Claimant demonstrated any neurological defect he would have referred him for an urgent CT scan. He was very clear that the Claimant had no foot drop symptoms and that he had carried out a full neurological examination and found no neurological deficit. In the circumstances he was entirely satisfied that it was appropriate to take a conservative approach and see the Claimant again in six months' time.

The expert radiologists

50. I heard evidence from both Dr Hartley Euinton and Dr James Rankine. Dr Euinton is a general radiologist with an interest in the muscular skeleton who has been a consultant radiologist at Chesterfield General Hospital for the past ten years. Dr Rankine is a consultant radiologist with a special interest in spinal imaging at the Leeds General Infirmary, a large NHS teaching hospital.

51. I have set out, at paragraphs 25 and 26 above, the issues on which they both agree. Dr Euinton's criticism of the reporting of the imaging was a criticism which was not set out in his report but emerged in the course of the joint meeting. I do not think it is strictly necessary for me to resolve this issue, however I think both experts' view can be supported. The difficulty with Dr Euinton's approach was that he only considered the issue from his own point of view. Dr Rankine explained that in large teaching hospital, where the radiologists work closely with the spinal surgeons, he would not report a very minor breach of the spinal cortex by a pedicle screw in

circumstances where there was no impingement or deviation of the nerve. He agreed, when I put the point to him, that it might be appropriate to report such a breach of the spinal cortex in circumstances where the radiologist was reporting from a local hospital. In the circumstances I accept Dr Rankine's evidence that a responsible body of radiologists would not have reported the breach of the spinal cortex in the circumstances of this case.

The expert spinal surgeons

52. I heard evidence from both Mr Jonathan Spilsbury and Mr J B Williamson. Mr Spilsbury is a spinal consultant at the Royal Orthopaedic Hospital in Birmingham and has been in practice since 1987. Mr Williamson is a consultant orthopaedic surgeon at the Spire Manchester Hospital and has been in practice since 1984, he has been a consultant since 1996.

53. I have set out at paragraphs 21 to 24 above the issues on which they both agreed. The major issue remaining in dispute between the Mr Spilsbury and Mr Williamson concerned causation. Ms Hennessy made a number of criticisms of Mr Spilsbury's evidence. First, that he placed undue emphasis on the Claimant's account given to him during his interview for the purpose of preparing the condition and prognosis report. Second, that he had failed to recognise that that Mr Bowden had recorded *"no focal neurological deficits"* and had therefore not diagnosed a radiculopathy. Third, that he had not adequately considered the Claimant's wider medical records. In my judgment these criticisms are well made. Overall my impression is that Mr Spilsbury's approach has been partisan, rather than taking an objective view of the evidence contained in the medical records, he has attempted to select medical records which fitted in with his view of the case. In cross examination Mr Spilsbury was forced to concede that his report failed to properly consider evidence that was contrary to the Claimant's position as it should have done. By contrast Mr Williamson's report was very thorough and his opinion which covered 12 pages provided analysis and his view depending on the various conclusions the court might reach on the facts.

54. In the joint statement Mr Spilsbury suggested, for the first time, that the Claimant's L5 nerve root may have been intermittently irritated. In coming to this conclusion he relied upon his interpretation of the physiotherapy note set out at paragraph 7 above. I prefer the evidence of Mr Williamson on this issue. Mr Williamson interpreted the note as a report of a subjective feeling of foot drop and noted there was no objective weakness on examination, which would be necessary to make such a diagnosis. He also said that had the physiotherapist been concerned about the Claimant's ability to dorsiflex his foot it is unlikely that she would have failed to inform other medical staff and she would not have discharged him from physiotherapy care.

55. Mr Williamson's clear view was that the degree of pedicle breach, where by the screw was close to, but not moving or compressing the nerve root would not be sufficient to cause either radicular pain or a neurological deficit. In his view it was hard to understand why if the screw caused the Claimant's leg pain between insertion and removal the pain would not be permanently abolished by the screw's removal.

My conclusions

56. Issue (i), *whether during surgery on 22 July 2010 the pedicle screw was misplaced?* I conclude the pedicle screw was misplaced to the extent there was a minor breach of the inferomedial cortex. The degree of intrusion into the neural canal was not great and such misplacements are common. There was no breach of duty.

57. Issue (ii), *whether AP imaging and a radiolucent table were used during the operation?* I conclude that AP imaging and a radiolucent table were used.

58. Issue (iii), *whether the Claimant developed new radicular leg pain or a neurological deficit in the immediate post-operative period?* I conclude that the Claimant did not develop a new radicular leg pain or neurological deficit. I find that he reported the same pain albeit at different intensities. That is sufficient to dispose of this issue, Mr Bowden was not required to refer the Claimant for an immediate CT scan.

59. Issue (iv*), was the left L5 pedicle screw touching the nerve root? Did the screw cause compression or deviation of the nerve?* I conclude that the L5 pedicle screw was not touching the nerve root at any point and that there was no compression or deviation of the nerve.

60. Issue (v), *was the left L5 pedicle screw the cause of the Claimant's symptoms?* I conclude that it was not for the reasons given by Mr Williamson.

61. Issue (vi), *did removal of the pedicle screw and metal work remedy the Claimant's pain and if so for how long? Does the fact his leg pain returned mean that the pedicle screw was not the reason for his pain?* I conclude that the Claimant did report less pain following the removal of the metal work for a matter of two or three weeks however the fact his pain returned meant the pedicle screw was not the cause of his pain.

62. In the circumstances the claim fails both in relation to breach of duty and causation. There must be judgment for the Defendant.

63. I would like to conclude by stating that one cannot help but have the greatest sympathy for the Claimant, he has clearly suffered greatly from his pain and will continue to do so. It is perhaps unfortunate he was led to believe that the minimally misplaced pedicle screw was the cause of or contributed to his pain, however I hope he can now move forward and with the help of the pain specialists obtain some measure relief.