Case No: E90MA335 NCN [2019] EWHC 3881 (QB)

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

Before HHJ Sephton QC, sitting as a Judge of the High Court

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Between :

Thomas Bradfield-Kay — Claimant

- and –

Marcus Cope — Defendant

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Mr Simon Cridland instructed by Leigh Day, Manchester for the Claimant

Mr Jonathan Holl-Allen QC instructed by Ryan Solicitors, Manchester, for the Defendant

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Judgment

1. In this action, Mr Bradfield-Kay alleges that Mr Cope was negligent in the performance of a left total hip replacement on 18 December 2009 and in connection with a consultation that took place on 9 August 2010. This was the trial on the issue of breach of duty pursuant to the order of DJ Stonier made on 10 April 2019.

Background

2. The defendant, Mr Cope, is a consultant orthopaedic surgeon specialising in lower limb arthroplasty. He practises at the Southport and Ormskirk NHS Trust and he has practising privileges at the Renacres Private Hospital in Ormskirk.

3. Mr Bradfield-Kay is an engineer. He had a complex history of back and leg pain. X rays taken in 2008 demonstrated that he had osteoarthritic changes in both hips. He was referred to Mr Cope at Renacres Hospital. Mr Cope performed a diagnostic right hip block which demonstrated that the pain in Mr Bradfield-Kay's right leg emanated from his right hip joint. Mr Cope performed a right total hip replacement on Mr Bradfield-Kay on 6 November 2009. Mr Bradfield-Kay made a rapid recovery and he was happy with the outcome of the operation.

4. At a consultation on 27 November 2009, it was decided to proceed to a left total hip replacement.

5. Mr Cope performed the left total hip replacement on 18 December 2009. Unfortunately, Mr Bradfield-Kay did not recover rapidly, as he had done when his right hip was treated. Mr Bradfield-Kay says that immediately after the operation, he developed serious pain in the thigh and groin. He had a consultation with Mr Cope on 9 August 2010. Mr Bradfield-Kay says that he reported his symptoms of thigh and groin pain to Mr Cope, but Mr Cope did not investigate it. There is a dispute about whether Mr Bradfield-Kay reported his complaints to Mr Cope and whether Mr Cope undertook any examination (and if so what) during this consultation.

6. Mr Cope saw Mr Bradfield-Kay again on 7 February 2011. Mr Cope recorded that the claimant was "doing not too well." He identified painful clicking "which probably relates to the psoas tendon catching over the anterior part of the cup." Mr Cope informed Mr Bradfield-Kay's general practitioner that if the clicking persisted, he would consider a psoas tendon release.

7. Mr Bradfield-Kay's GP referred him for a second opinion to Mr Hemmady, a consultant orthopaedic surgeon at Wrightington Hospital. On 15 March 2012, Mr Hemmady performed a left hip revision. His operation note recorded:

> "There was no evidence of trunnionosis. The cup was found to be retroverted and the anterium of the cup was prominent and was catching on the anterior structures. There were no signs to suggest wear of the head of the metal liner. The cup was well fixed and I removed it… The stem was found to be well fixed and therefore I elected to leave it in situ."

After Mr Hemmady's operation, Mr Bradfield-Kay's symptoms improved but did not resolve. In the event, Mr Bradfield-Kay underwent a further revision of the left hip on 23 May 2016.

8. In this action, Mr Bradfield-Kay complains that Mr Cope was negligent in the following respects:

   (a) When he performed the left total hip replacement on 18 December 2009, Mr Cope permitted the acetabular component of the prosthetic hip to be prominent, in such a position that the iliopsoas tendon caught on it, causing him to develop iliopsoas tendonitis (see paragraph 48(1)(i) – (iii) of the Particulars of Claim).

   (b) When he performed the left total hip replacement, Mr Cope used the incorrect femoral component (see paragraph 48(1)(iv) of the Particulars of Claim).

   (c) When he saw the claimant on 9 August 2010, he failed to record or investigate the claimant's groin pain (see paragraph 48(2) of the Particulars of Claim).

The witnesses

9. I heard from Mr Bradfield-Kay and from Mr Cope. I comment on their evidence later in this judgment.

10. I read and heard expert evidence from Mr Chatterji, a consultant orthopaedic surgeon instructed by the claimant. Mr Chatterji is an experienced orthopaedic surgeon, but he conceded that the primary focus of his practice is knee replacement surgery. He has undertaken total hip replacements; in particular he has performed metal-on-metal replacements using the same components as were in issue in the present case. He has previously given expert evidence on behalf of claimants in clinical negligence actions.

11. I read and heard expert evidence from Mr Manktelow, a consultant orthopaedic surgeon instructed by the defendant. The preponderance of Mr Manktelow's practice was primary and revision hip arthroplasties. In the course of revision arthroplasties, Mr Manktelow encounters the work of the surgeons who undertook the original surgery. Mr Manktelow is a past president of the British Hip Society and has published widely in relation to hip arthroplasty. I formed the impression that, because of his involvement in the British Hip Society and his experience Mr Manktelow was better able than Mr Chatterji to speak to the practice of hip specialists in England.

12. The expert witnesses were invited to discuss their reports and to produce a joint statement. The experts reached agreement on many of the issues in the case.

The acetabular component

13. In this case, Mr Cope elected to use an uncemented acetabular component, namely, a 54mm Pinnacle socket. During the evidence, the hemispherical acetabular component was variously described as "the cup," "the socket" and "the acetabular component." The report of Mr Chatterji explains how this is fixed:

> The acetabulum is deepened by using hemispherical graters which remove bone and cartilage. The acetabulum is under reamed normally by 1 or 2 mm from the outside dimension of what the definitive uncemented component is going to be. The definitive component is impacted into place. There is a frictional hold between the reamed bone and the acetabular component which gives primary stability…

Mr Chatterji explains that the component is designed to have a rough surface facing the pelvis so as to promote on/in growth of bone.

Common ground in relation to the acetabular component

14. It is convenient to identify the matters on which the experts agree in relation to the placing of the acetabular component.

15. Mr Cope, Mr Chatterji and Mr Manktelow all accepted that in total hip replacements, if the acetabular component is placed so that it catches the iliopsoas tendon as it passes over the exposed rim of the cup, the tendon can become irritated, inflamed and painful. I address later in this judgment what steps a surgeon could or should take to avoid this risk.

16. It is common ground that Mr Bradfield-Kay developed left iliopsoas tendonitis in the region of the hip joint. Mr Chatterji and Mr Manktelow explained to me that iliopsoas tendonitis is a recognised complication of total hip replacement which can occur for reasons other than the orientation of the acetabular component. However, they accept that in the present case, the most likely cause for irritation of Mr Bradfield-Kay's left iliopsoas tendon was a prominent anterior acetabular component.

17. In the Joint Statement, the experts agree that protrusion of the acetabular component beyond the anterior margin of the acetabulum is influenced by anatomical variation, the degree of anteversion and the depth to which the socket was implanted. In the present case, it has not been suggested that the depth of the socket is an issue. The focus of attention was upon the degree of version of the implant and any potential anatomical variations.

18. The experts agreed that the ideal orientation of the acetabular component in any given case is an ongoing challenge for hip surgeons. The ideal position may vary between individuals and (so it appeared in cross-examination) even between left and right sides in the same patient. The experts agreed that, generally speaking, the cup of the acetabular component should ideally be anteverted (i.e. face forward) between 15° and 25°. They agree that an acceptable range of anteversion is between 10° and 30°. They also agreed that it can be difficult for a surgeon to attain the ideal degree of anteversion when positioning the acetabular component. The decision about what version to accept is multifactorial and depends on the patient's anatomy, the bearing surface used and the anteversion of the femoral component to ensure that the combined anteversion gives a sound biomechanical reconstruction.

19. Three reasons emerged in the course of the evidence as to why it is important to achieve appropriate version of the acetabular component (there may be other reasons, but the following have potential relevance):

    (a) The orientation of the acetabular component affects the stability of the joint.

    (b) When using metal on metal components (as in this case) appropriate version of the acetabular component minimises metal wear. As I understand it, metal on metal prostheses can produce detrimental metal ions and the problem may be exacerbated if the positioning of the cup causes edge loading.

    (c) If the acetabular component is placed in version congruent with the reamed acetabulum, it fits flush. If the acetabular component is retroverted, the edge of the component extends beyond the anterior margin of the native bone.

20. It is common ground that Mr Bradfield-Kay's left hip did not dislocate, nor was there any instability or subluxation in it between December 2009 and March 2012. The stability of the joint is not an issue in this case.

21. Likewise, no abnormal wear of the components was detected. The soft tissues were not stained by the metal components. No trunnionosis was found and the cobalt and chromium readings were only slightly elevated, as expected with new implants.

22. The issue in the present case was protrusion of the cup beyond the acetabular rim.

Evidence about the acetabular component placed by Mr Cope

23. There is surprisingly little reliable evidence about the orientation of the socket placed by Mr Cope and the extent to which it stood proud of the acetabular rim.

24. The experts have considered the radiographic images of the hips. They agree that there is a difference in version in the right and left hips; they agree that the left acetabular component is beyond the confines of the native acetabulum and they agree that it is very difficult to assess anteversion from the films available in this case. They agree that the amount of anteversion or retroversion is small. I understand this to mean that the cup was in a neutral position (approximately 0°) rather than the ideal range of between 15° and 25°. Mr Manktelow believes that the imaging does not clearly demonstrate the relationship between the anterior rim of the socket and the acetabular margin.

25. The revision surgery was undertaken by Mr Hemmady, who was undertaking the surgery at Wrightington, a tertiary referral centre. In the Joint Statement, the experts agreed that Mr Hemmady's findings were reliable. He noted that the cup was "retroverted" and said that the "anterium of the cup was prominent and was catching on the anterior structures". Mr Manktelow expressed surprise that Mr Hemmady's description was not much fuller than this, and in particular, that he did not seek to describe the damage to the iliopsoas tendon or the extent to which the cup protruded beyond the acetabular rim. He pointed out that Mr Hemmady may have meant that the cup was retroverted relative to the ideal position, rather than retroverted in absolute terms (i.e. with the cup facing backwards rather than forwards). He pointed out that the "anterior structure" closest to the cup would have been the capsule, though he conceded that the iliopsoas tendon lay immediately adjacent to the capsule.

26. In considering Mr Hemmady's remarks, I bear in mind that he was undertaking revision surgery a relatively short time after the original surgery. I assume that his comments were intended to explain the difference between what he would have expected to find in competently performed recent arthroplasty and what he found in fact.

27. I conclude that:

(a) The prominence of acetabular component justified a remark from Mr Hemmady. I infer that the prominence was more than negligible. The acetabular cup was not placed within the confines of the native acetabulum.

(b) The version of the socket was less than expected, such as to justify a remark from Mr Hemmady. I infer that the variation from the ideal was significant; even if the socket was not retroverted in absolute terms. I conclude that Mr Hemmady's use of the word "retroverted" connotes a significant version. This conclusion is consistent with the experts' views on the version of the socket. The cup was not placed at an appropriate degree of anteversion.

(c) The version of the socket was such as to cause the acetabular component to be prominent. (I draw this inference from the previous two findings.)

(d) I accept Mr Hemmady's account and the evidence of the experts that the prominence of the acetabular component was sufficient to cause irritation of the anterior structures, specifically, the left iliopsoas tendon.

In my judgment, the evidence does not support more detailed findings.

The approach to avoiding a prominent acetabular component

28. I heard evidence about whether a surgeon should take steps, and if so what steps, to avoid a prominent acetabular component.

29. In their joint statement, Mr Chatterji and Mr Manktelow said this:

> Both experts agree that surgeons should ensure the acetabular component is not placed in a position that could interfere with the iliopsoas tendon such as beyond the acetabular margin of the native acetabulum.

30. Mr Manktelow's evidence was consistent with this passage. He said that typically, once the socket has been positioned, the surgeon will run a finger or surgical instrument over the anterior aspect of the socket to ensure that is seated deep to the natural bony acetabulum. He said that running a finger or an instrument over the edge of the cup would not necessarily prevent the prominence of the anterior aspect of the cup.

31. Mr Manktelow explained to me that he undertook many hip revision arthroplasties i.e. revising a hip arthroplasty that had already been operated on, usually by another surgeon. He referred to his National Joint Registry data which shows that he undertook 103 revision arthroplasties in the period April 2015 – March 2018. He told me that in the course of his revision practice, he had seen prominent acetabular components "quite frequently;" on "a number of occasions." He told me that "a number of surgeons make this error because surgeons are not as careful as they should be to ensure that the socket is deep to the anterior bone." He also said that he thought that surgeons were less aware of this than they should have been. What I derive from those pieces of evidence is that

(a) Some surgeons undertaking arthroplasties allow the acetabular component to stand prominent from the native bone. I draw the inference that there is a body of surgeons undertaking total hip replacements who do not ensure that the acetabular component is not placed in a position that could interfere with the iliopsoas tendon.

(b) Mr Manktelow is critical of their conduct (as demonstrated by the use of "error" and "not as careful as they should be").

32. Mr Cope told me that he underwent 3 separate training sessions when he was taught how to undertake total hip replacement. He was not taught to check that the cup did not protrude beyond the acetabular rim. He was taught that the critical – and perhaps the only – issue (so far as placement of the cup is concerned) was whether the joint would be stable after reconstruction. I accept his evidence that this is what he was taught. I find that when he placed the acetabular component into Mr Bradfield-Kay's acetabulum, Mr Cope did not ensure the acetabular component was not placed in a position that could interfere with the iliopsoas tendon because he had never been trained to do so and it did not cross his mind.

33. Mr Chatterji gave evidence that it is easy for a surgeon to note whether the anterior aspect of the cup is prominent and may potentially catch on anterior structures. He told me that the acetabular component can be visualised by the surgeon because the area is exposed by the use of retractors. He told me that his practice is to run his finger, or an instrument, around the rim of the acetabulum, so as to check that it is flush with the native bone. Mr Chatterji was unable to refer to any textbook or handout from any presentation to demonstrate that his practice was accepted throughout the profession as standard either in 2009 or at present.

34. Mr Chatterji stated that it was a straightforward procedure to remove the cup and re-orientate it intraoperatively if it was found to be prominent. His evidence on this point was not challenged.

35. The experts explained that there are circumstances when it is not possible to ensure that the socket is not prominent. The anatomy of the patient may be such that it is necessary to allow the socket to stand proud of the acetabular rim. By way of example, Mr Cope told me that once the claimant had brought this claim, he had changed his practice to ensure that the cup was not prominent. Very recently, he had re-positioned the cup because it was prominent; the result was that the joint was no longer stable. However, Mr Chatterji asserted, and Mr Manktelow conceded (in the Joint Statement and in evidence) that there was no surgical or anatomical necessity in the present case to leave the cup proud anteriorly.

36. On the ultimate issue, Mr Chatterji believed that the acetabular component was proud of the native acetabulum and was catching on the anterior structures, namely the iliopsoas tendon, which is a known complication of a prominent acetabular component. His opinion was that this known avoidable complication constitutes a breach of duty. In the present case there

were no anatomical peculiarities or surgical necessity to leave the acetabular component proud anteriorly.

37. Mr Manktelow, though critical of the orientation of the acetabular component, would not describe that in its own right as constituting a breach of duty on the part of the treating surgeon. I felt that Mr Manktelow did not explain satisfactorily why what Mr Cope did was not in breach of duty. He, Mr Manktelow, plainly thought that a surgeon ought to avoid prominence of the acetabular component. Although he gave evidence that there were surgeons who did not ensure that the acetabular component was not prominent, he clearly disapproved of their views, as I have pointed out earlier in this judgment. Mr Manktelow did not offer a justification or rationale for neglecting to ensure that the acetabular component was not prominent. I was left with the impression that Mr Maktelow's justification for asserting that there was no breach of duty was because he said so.

Acetabular component: discussion

38. There is fortunately no disagreement about the law in this case.

39. The starting point is the well-known jury direction of McKinnon J in *Bolam v. Friern Hospital Management Committee* [1957] 1 W.L.R. 583, 587:

> 'I myself would prefer to put it this way, that he is not guilty of negligence if he has acted in accordance with a practice accepted as proper by a responsible body of medical men skilled in that particular art . . . Putting it the other way round, a man is not negligent, if he is acting in accordance with such a practice, merely because there is a body of opinion who would take a contrary view.'

40. This statement of the law was expounded upon by Lord Browne-Wilkinson in *Bolitho v City and Hackney HA* [1998] AC 232, 241:

> "… in my view, the court is not bound to hold that a defendant doctor escapes liability for negligent treatment or diagnosis just because he leads evidence from a number of medical experts who are genuinely of opinion that the defendant's treatment or diagnosis accorded with sound medical practice. 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 case* [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."

41. On the evidence before me, there is plainly a body of surgeons undertaking hip arthroplasties that holds the opinion that surgeons should ensure that (so far as possible) the acetabular component is not placed in a position that could interfere with the iliopsoas tendon such as beyond the acetabular margin of the native acetabulum. Both Mr Chatterji and Mr Manktelow subscribe to this view. The following points appear to me to be important:

(a) In the present case, Mr Cope would have been able to visualise the acetabular component to ensure that it was not prominent. It would have been possible for him to ensure that the acetabular component was not prominent by testing with a finger or an instrument.

(b) In the present case, there was no surgical or anatomical reason why the acetabular component could not be placed so as to avoid prominence carrying with it a risk of irritating the iliopsoas tendon.

(c) As Mr Chatterji pointed out, if the acetabular component was placed where it might interfere with the iliopsoas tendon, it was a straightforward matter to remove the component and replace it.

42. In my view, the evidence justifies a finding that there is a body of surgeons that does not hold that opinion. At the time of the operation in question, Mr Cope was one such. Mr Manktelow's experience of undertaking revision arthroplasties demonstrates that there are other surgeons who appear to adopt the same practice.

43. Mr Holl-Allen QC submits that Mr Maktelow's evidence provides Mr Cope with a *Bolam* defence and that the claimant is driven to rely upon *Bolitho.* I do not accept that submission. In my view, both *Bolam* and *Bolitho* require the court to examine the different schools of thought and to ask itself whether the school of thought relied upon by the defendant can demonstrate that its exponents' opinion has a logical basis.

44. I reach the conclusion that there was no logical basis for neglecting to ensure that the acetabular component was not placed in a position that could interfere with the iliopsoas tendon. No good reason has been advanced for not taking this precaution. It has not been shown that the two views show that there is a nice balancing of different risks about which surgeons could reasonably disagree. The risk of impingement on the iliopsoas tendon was a well-recognised risk which could easily have been identified by visualisation and/or by palpation or running an instrument around the acetabular rim. If there was any risk in the placement of the cup, it was

a relatively simple matter to remove the cup and replace it. There was no surgical or anatomical reason for running the risk in this case.

45. It follows that I find the allegations in paragraph 48(1)(i), (ii) and (iii) made out.

46. I acknowledge that Mr Cope is being held to a standard of which he was unaware at the time. For the reasons I have sought to explain in this judgment, the evidence establishes that this is the standard that Mr Bradfield-Kay was entitled to expect from a competent hip surgeon in 2009.

The femoral component

47. The report of Mr Chatterji explains the procedure relating to the femoral component:

> "… an entry is made into the top end of the femur, with the entry point being important for the orientation of the femoral component… The femur is then broached to compact the cancellous bone (spongy) and when rotational stability is achieved with a trial broach then it is reasonable to stop broaching in this particular system.
>
> With the trial broach in place and either the definitive liner inserted into the cup or a trial liner, a trial is performed to assess for leg length, offset and stability. When the surgeon is satisfied that the trial is satisfactory, a definitive stem is inserted and normally a further trial is performed. The appropriate head is then secured to the femoral component"

48. One of the factors to be considered by a surgeon undertaking a total hip replacement is the hip offset. The hip offset is the perpendicular distance from the centre of the femoral head to a line running down the middle of the shaft of the femur. It was common ground that a surgeon will generally attempt to achieve a hip offset that corresponds to that which existed before the surgery.

49. Mr Chatterji explained to me that a surgeon will generally try to place the stem of the femoral component so that it goes down the middle of the femoral shaft. If the broach – and later, the stem – are placed at an angle, the result is suboptimal.

Common ground in relation to the femoral component

50. It is now common ground that when Mr Cope undertook the right total hip replacement on 6 November 2009, he used a KLA9 Corail stem as part of the femoral component; when he performed the left total hip replacement on 18 December 2009 he used a KA8 Corail stem.

51. The experts agree that, using these components, the hip offset, if the stem were in perfect alignment, would have been 45.6mm on the right side and 38.3mm on the left side. The actual hip offset is likely to have been different, because perfect alignment was not achieved.

52. The experts agree that the femoral components on both left and right sides are undersized relative to the patient's femur and are sub optimally positioned in varus alignment.

53. The experts agree that looking at the right side should have alerted Mr Cope to the fact that he ought to introduce his size 8 broach in a more lateral position and in more accurate alignment on the left side. This would have enabled him to put a larger stem in with more appropriate offset.

Mr Cope's explanation

54. Mr Cope's witness statement says this:

> In the right THR a size 9 KA component was required to obtain the correct fit. On the left I needed to use a size 8 KA component which is a difference of just 0.5mm. It is quite common for patients to require slightly different sizes of stem and does not cause any concern or difficulty.

I infer from this evidence that Mr Cope's choice of stem for the left leg was founded on the belief that the stem used on the right hand side was a 9 KA, and that he intended to achieve a similar offset in both legs. In a patient with reasonably regular limbs, I am not surprised that he used the successful results on the right hand side to guide his performance on the left hand side.

55. Before he came to give oral evidence, Mr Cope realised that his witness statement was in error. He accepted that he had used a 9 KLA stem on the right hand side, and not a 9 KA stem. He told me that it was a typographical error. I could not understand his explanation about the typographical error that he had made.

56. Mr Cope explained that he used an 8ST broach on the left side, and he appeared to get a "tight" fit. He did not try any larger broach for fear of causing an intraoperative periprosthetic fracture.

Findings

57. I find that Mr Cope tried the 8ST broach on the left side because he believed that a 9ST broach and a 9 KA stem had been used on the right side. I am fortified in this finding by the observation that his witness statement suggests that he used a 9 KA stem, even though he was aware when he made his statement that the claimant was alleging that the difference in offset between right and left was 7.3mm.

58. Having used the 8ST broach, he Mr Cope obtained a "tight" fit. The reason he achieved a "tight" fit was that the broach had been not placed sufficiently laterally or in good alignment

with the femoral canal. I accept that he did not try a larger broach for fear of causing a fracture. He then used an 8KA stem in the left femur.

59. In my opinion, when he undertook the left total hip replacement, Mr Cope did not check properly in the operation notes to see what stem he had used in the right leg. Had he done so, he would have recognised that he had used a size 9 KLA stem, which gave rise to a materially different offset from a 9 KA. I regard this as an elementary blunder which bespeaks negligence on his part. Because of his error, he believed that the difference in offset between left and right was 0.5mm whereas in fact it was approximately 7mm. Had Mr Cope realised that he had used a 9 KLA stem on the right side, when he made a comparison (such as the experts suggest that he ought to have done) between left and right sides he would have realised that there was a problem which would have led him to consider introducing his size 8 broach more laterally and in better alignment.

60. I accept Mr Maktelow's view that "the choice of the KA8 component would not, in its own right, constitute breach of duty." The breach of duty in this case lies in the fact that the KA8 component was not chosen "in its own right" but because of an easily avoidable misunderstanding about what prosthesis had been used on the contralateral side.

61. It follows that I find the allegation at paragraph 48(1)(iv) of the Particulars of Claim made out. Whether such breach of duty gave rise to any loss is an issue for another day.

The consultation on 9 August 2010

62. Mr Bradfield-Kay's case is that after Mr Cope had performed the left total hip replacement, he suffered immediate, constant, excruciating pain in the left groin and thigh. He alleges that he complained about the pain in particular at the consultation he had with Mr Cope on 9 August 2010, and he alleges that Mr Cope is negligent for failing to record his complaint of persistent groin pain or to take steps to investigate such complaint. Mr Cope denies that Mr Bradfield-Kay complained of persistent groin pain, which is why it was not recorded.

Mr Bradfield-Kay's evidence

63. The evidence in Mr Bradfield-Kay's witness statement about the consultation on 9 August 2010 is laconic. He says, "I told him that I was still in a great deal of pain especially in my groin." In cross-examination, Mr Bradfield-Kay elaborated this account a little. He told me that he had informed Mr Cope about the pain in the groin and thigh and identified the groin as the most significant component of the pain. He denied that Mr Cope had examined him during the consultation.

64. Mr Cridland submitted that Mr Bradfield-Kay's medical records show that he had complained to other practitioners about groin pain. He relied upon the following:

(a) A letter dated 20 July 2010 from Denise Prescott, a senior physiotherapist, to Dr Evans, Mr Bradfield-Kay's general practitioner which refers to "intense constant pain in the left groin."

(b) A referral dated 18 August 2011 from Dr Ryan, Mr Bradfield-Kay's general practitioner to Mr Hemmady. Dr Ryan states, "he says has had a different sort of pain as soon as he came round from the anaesthetic and has never been right since. It has been painful, it clicks…"

(c) A letter dated 2 November 2011 from Dr Hemmady to Dr Ryan, which states, "following the operation the same day he was in excruciating pain in the left hip which never really settled."

Mr Cridland submitted that this evidence supported the claimant's account that he had reported his persistent, serious pain in the groin and thigh to Mr Cope on 9 August 2010.

65. I bear in mind that it is now common ground that Mr Bradfield-Kay developed left iliopsoas tendonitis. Given this diagnosis, it would not be surprising if Mr Bradfield-Kay were suffering pain in the left groin in August 2010.

66. In my judgment, Mr Bradfield-Kay was not a reliable or consistent historian for the following reasons:

67. Mr Bradfield-Kay gave me an account of groin pain he had suffered in the 1980s. He told me variously that this pain lasted "for several months" and "a few years."

68. Of more direct relevance, I note that although Mr Bradfield-Kay now complains of immediate, constant, excruciating pain following the operation on 18 December 2009, the contemporaneous records do not support the allegation. A nursing note at 17:15 records the claimant as being "wide awake and comfortable." A note made at 23:00 records the claimant complaining not of acute pain but itching. The analgesic record shows that oramorph was stopped quite soon after the operation. Notes taken by Mr Cope on 19th and 21st December do not indicate any complaint of serious pain. Mr Bradfield-Kay told me that his pain was so bad that a doctor had to administer an injection, but the medical notes do not show that fact, as I am sure they would have done, had an injection been given.

69. In a physiotherapy session on 11 January 2010, there is no mention of the pain complained of. In a session on 1 February 2010, it is recorded that he complains of "discomfort." On 15

March, the physiotherapist records "has been painful at left groin," but by 23 March he was "much better."

70. Mr Bradfield-Kay saw Mr Cope on 8th February 2010. Mr Cope's letter of that date records that he was "doing well" although "he still gets the odd twinge in his groin and he has also got some left thigh pain." I note that Mr Cope's account of the complaints on 8th February fits in with the history recorded by the physiotherapist.

71. Although Mr Bradfield-Kay saw his general practitioner on several occasions in early 2010, there is no record that he complained of pain in the groin and thigh. In April, the general practitioner eventually referred Mr Bradfield-Kay to Ms Prescott. Ms Prescott wrote the letter I refer to above.

72. Mr Bradfield-Kay has not convinced me that he suffered disabling pain in his groin commencing immediately after the operation on 18 December 2009. I accept that he developed groin pain some time later. For the reasons set out below, I reject his evidence that he complained to Mr Cope about his groin symptoms on 9 August 2009.

Mr Cope's evidence

73. Mr Cope wrote a letter dated 9th August 2010 to Dr Ryan. It emerged in evidence that this was the only record Mr Cope made of the consultation: there are no clinical notes that supplement the letter. In the letter, he refers to the claimant's "slight Trendelenburg gait." He continues, "This is no doubt making his back pain worse and he states that the pain down his left leg is slightly worse than it was previously. The pain radiates from his buttock down to his knee…" The letter does not state that Mr Cope undertook a formal examination of the claimant.

74. Mr Cope's witness statement says that Mr Bradfield-Kay complained about pain in the buttocks and left leg. He says that he undertook an examination. He acknowledges that he advised Mr Bradfield-Kay to return in 6 months to see if the discomfort had resolved. Mr Cridland put to Mr Cope in cross-examination that Mr Bradfield-Kay had complained about the persistent, disabling pain in his groin. Mr Cope replied ruefully that he wished that Mr Bradfield-Kay had indeed complained in August 2010, so that the problem could have been addressed as early as possible. He pointed out that when Mr Bradfield-Kay complained about pain in the groin at the next consultation on 7th February 2011, he recorded clicking in the left hip which he suggested might be caused by the psoas tendon. He also recommended that further imaging be undertaken.

75. I reject Mr Cope's evidence that he undertook an examination of Mr Bradfield-Kay. I am confident that, had Mr Cope undertaken a competent examination, he would have recorded, either in his letter to Dr Ryan or in his clinical notes, what he found on examination. Such findings would have included, for example, the range of movement in the affected hips. There is no record consistent with such an examination. I acquit Mr Cope of deliberately misleading the court: in my view, he mis-remembered when he made his statement in 2019 what had occurred many years previously.

Findings

76. I find that Mr Cope's letter of 9th August 2010 accurately records what occurred in the consultation. It is a contemporaneous record. I regard it as improbable that Mr Cope would have recorded that the claimant was complaining of pain radiating from his buttock to the knee if the claimant was in fact complaining of pain in the groin and thigh. Though I have been critical of some aspects of Mr Cope's care in the course of this judgment, I believe that he wanted the best for his patient. I do not believe that he would simply have ignored a complaint that the patient was suffering from constant, debilitating pain in the groin. I am fortified in this finding by the observation that when Mr Bradfield-Kay complained to him in February 2011 about groin pain, Mr Cope identified possible a psoas tendon problem and suggested undertaking a repeat MRI. Insofar as the accounts of Mr Bradfield-Kay and Mr Cope differ from the account given in the letter of 9th August, I reject them.

77. It follows from this finding that I reject the allegation at paragraph 48(2) of the Particulars of Claim. Mr Cope did not record Mr Bradfield-Kay's complaints because Mr Bradfield-Kay did not make the complaint to him. He cannot be criticised for failing to investigate something that he did not know about.

Conclusion

78. I find the allegations of breach of duty at paragraph 48(1) of the Particulars of Claim have been made out. The allegation at paragraph 48(2) of the Particulars of Claim has not been established.