Case No: HQ13X04774

Neutral Citation Number: [2016] EWHC 1729 (QB)
**IN THE HIGH COURT OF JUSTICE**
**QUEEN'S BENCH DIVISION**

Royal Courts of Justice
Strand, London, WC2A 2LL

Date: 13/07/2016

**Before** :

**Mrs Justice Whipple**

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**Between :**

| | |
|---|---|
| **Mrs Julie Devonport** | **Claimant** |
| **- and -** | |
| **Gateshead Health NHS Foundations Trust** | **Defendant** |

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**Katharine Scott** (instructed by **Baker and Co**) for the **Claimant**
**Judith Rogerson** (instructed by **Ward Hadaway**) for the **Defendant**

Hearing dates: 16, 17, 20, 21, 22 & 23 June 2016

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# Judgment

**Mrs Justice Whipple:**

**INTRODUCTION**

1. Mrs Julie Devonport is the Claimant. She brings a claim for damages for clinical negligence against Gateshead Health NHS Foundation Trust, responsible for the Queen Elizabeth Hospital (the "Defendant" and the "Hospital"). This is the judgment on issues of liability and causation following a six day trial.

2. The Claimant was represented by Miss Katharine Scott and the Defendant was represented by Miss Judith Rogerson. I repeat my thanks to both of them for their helpful submissions and careful presentation of the evidence.

3. I will set out the facts in greater detail below. In summary, in 2008 the Claimant was diagnosed with carcinoma of the cervix stage 2A. She underwent a radical hysterectomy with destruction of lymph nodes performed at the Hospital on 10 November 2008 (the "hysterectomy"). She was released from Hospital within a few days of the hysterectomy, but re-presented at her GP with symptoms of infection on 28 November 2008. Investigations showed that she had developed an abscess in her psoas muscle. That abscess was drained under CT guidance on 18 December 2008. She was discharged home and followed up in the Defendant's outpatient gynaecology oncology clinic. In early 2009, the Claimant started to complain of pain in her right lower abdomen. Investigations showed right hydronephrosis (dilation of the kidney), as well as a cystic lesion developing on her right ovary involving adjacent tissue (the "ovarian mass" of inflamed tissue). She was referred to the urologists who identified a stricture (or narrowing) of the ureter. On 4 June 2009 her right ureter was stented (by inserting a tube, or stent, to protect the ureter). On 7 September 2009 the stent was changed. On 23 September 2009 she underwent surgery under the gynaecologists to remove the ovarian mass, including the right fallopian tube and ovary (a "salpingo-oophorectomy"). Subsequent histology of the excised ovarian mass showed "vegetable matter" in the ovarian tissue which must have come from the bowel. The Claimant continued to complain of pain. The ureteric stent was again changed on 4 January 2010, but the ureteric stricture was now noted to be longer. On 25 March 2010 she underwent re- implantation of the right ureter. Tests showed that her right kidney function was deteriorating further and in October 2010 she presented with right loin pain. Further attempts at stenting were unsuccessful. She eventually underwent right nephrectomy (removal of the kidney). She remains in pain with reduced mobility.

4. The Claimant alleges negligence in two aspects of the care she was afforded throughout this period by the Defendant. The following is a summary.

    i) First, she alleges negligence in the conduct of the hysterectomy. She says that her small bowel was perforated during this operation; that perforation led to leakage of bowel contents which caused the psoas abscess, which in turn caused the ovarian mass to form, which in turn put pressure on the ureter, which led to the kidney problems and all the other problems from which she now suffers.

    ii) Secondly, she alleges negligence in the preparation for and conduct of the salpingo-oophorectomy. She says that the gynaecologists should have

involved the urologists much more closely in forming a joint plan, and if they had done so, a urologist would have been present in theatre for the salpingo-oophorectomy, and if that had happened, the urologist would have taken the opportunity to protect the ureter once it was exposed during surgery, and if that had happened, the ureter would have been preserved intact and no further surgery on it would have been required, and if that had happened, the right kidney would not have failed, and much of the Claimant's current pain and functional deficit would have been avoided.

5. The Defendant denies negligence. The following is a summary of its arguments.

   i) The hysterectomy was carried out with reasonable care and surgical skill and no bowel perforation occurred during the course of it. The Claimant developed an infection following surgery, which was not a consequence of any negligence, rather is a known complication of this surgery. The infection caused the psoas abscess, and in due course led to the ovarian mass, which itself fistulated into the adjacent small bowel. This is how the finding of vegetable matter in the histology is explained.

   ii) The Defendant further argues that the gynaecologists treating the Claimant did coordinate their treatment plan with the treating urologists in a reasonable manner by exchange of letters between the two teams. In any event the outcome for the Claimant would not have been any different even if there had been better or different liaison between the gynaecologists and the urologists.

6. The Claimant had asserted negligence in her treatment by the Defendant in the immediate aftermath of the hysterectomy before she was discharged. By the time of trial, these allegations had been abandoned and I say no more about them.

**LAW**

7. The legal principles are not in dispute and I set them out only briefly.

**Breach of Duty**

8. Negligence in a clinical context is judged by reference to the *Bolam* test (referring to *Bolam v Friern Hospital Management Committee* [1957] 1 WLR 582). A doctor is not negligent if "*he has acted in accordance with a practice accepted as proper by a responsible body of medical men skilled in that particular art".* Thus, it follows that "*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"* (per McNair J).

9. The *Bolam* test is qualified by *Bolitho v City and Hackney Health Authority* [1988] AC 232 in the following way: "*if, in a rare case, it can be demonstrated that the professional opinion is not capable of withstanding logical analysis, the judge is entitled to hold that the body of opinion is not reasonable or responsible."* (per Lord Brown-Wilkinson at 243 C)).

**Causation**

10. *Bolitho* provides guidance on the Court's approach to cases where a negligent omission in a clinical context is alleged to have caused harm. The facts of *Bolitho* involved an alleged negligent failure by a treating paediatrician to attend and intubate a young patient in her care. Once established that the failure to attend was negligent, the Court indicated that there were two questions for the judge to decide on causation: (1) what would the treating paediatrician have done or authorised to be done, if she had attended the child? And (2) if she would not in fact have intubated the child, would that have been negligent? The Court concluded: *"The Bolam test has no relevance to the first of those questions but is central to the second"* (per Lord Brown-Wilkinson at p 240 G). To the extent that the Claimant establishes negligence by omission at the time of the salpingo-oophorectomy, it is agreed that *Bolitho* applies to the consequential causation issues.

11. Finally, in *Wilsher v Essex Area Health Authority* [1988] 1 AC 1074, the House of Lords confirmed that the onus of proving causation lies on the claimant and that, in a case where there is more than one possible explanation for the damage which has occurred, but only one explanation involves negligence, the claimant must prove that the negligent explanation is more likely than any other (non-negligent) explanation to have caused or materially contributed to the damage.

**FACTS IN MORE DETAIL**

**General**

12. The Claimant was born on 8 July 1970 and was 38 years old when these events occurred. Apart from the recently diagnosed carcinoma of the cervix, she was fit and healthy.

13. The Defendant is responsible for the provision of medical services, including gynaecological services, at the Hospital. In common with NHS provision elsewhere, at the time and now, patients with gynaecological cancers were treated by gynaecological oncologists, a team of sub-specialists within the gynaecology department, working within the gynaecology department. The Claimant was diagnosed with cancer of the cervix and so was admitted under the care of the gynaecological oncologists who were responsible for her care throughout the period she complains of.

14. (I take the following description of the system for obtaining specialist urology input from the evidence of Miss Galaal, which was not challenged and which I understand to be accepted on this matter.) There is no urology department at the Hospital. Instead, urology services are provided to the Hospital by the Freeman Hospital in Newcastle for which the Newcastle Upon Tyne Hospitals NHS Foundation Trust is responsible. That Trust is not a defendant to this action. The lead urological surgeon at the Freeman is (or was at the material time) Mr Trevor Dorkin. A urologist within Mr Dorkin's team, Mr Durkan, worked at the Hospital (in Gateshead) and acted as the point of liaison between the Hospital (in Gateshead) and the urologists at the Freeman (in Newcastle). The two hospitals did not share electronic notes, and communication between the two teams was by typed letters. Particularly important communications

were sometimes faxed as well as posted, to ensure that they were received. Otherwise, the two teams simply relied on the post.

**Operation 1: Hysterectomy**

15. The Claimant consented to the hysterectomy on 9 November 2008. The risks included infection, injury to bladder and bowel, and other complications. It is common ground that complications consequent on surgery can occur without any negligence and in the ordinary course.

16. The Claimant was given a single dose of intravenous broad spectrum antibiotics (co-amoxiclav 1.2g) prior to surgery in line with standard procedure at the time.

17. The operation note for the hysterectomy provides a contemporaneous record of that surgery. It was written by Mr Godfrey, who was supervising Miss Ang who was the primary surgeon (I shall come to their factual evidence shortly). The note reads as follows:

> "vaginal pack and catheter clinically !B1
> lower midline incision
> Normal uterus tubes and ovaries
> Routine RHND conserving ovaries
> Vault oversewn but open, vaginal tear sutured from above
> Good haemostasis
> Bilateral visible pelvic nodes 1-1.5cms on left
> Closure in layers loop nylon to sheath subcuticular dexon to skin
> Bard suprapubic catheter
> EBL < 500mls"

18. The Claimant's post-operative recovery was uneventful and there was no sign of any infection. She was discharged from Hospital on 17 November 2008 to be seen for follow up in the outpatient department.

**The Psoas Abscess**

19. On 28 November 2008 the Claimant telephoned her GP reporting stabbing pains in her lower back and hip, and that she was unable to walk much. Her GP examined her and prescribed cephalexin (an antibiotic) based on an assumed diagnosis of urinary tract infection. Her condition did not improve and on 15 December 2008, the Claimant's GP referred her to Sunderland Hospital, where she was admitted to the ward. A CT scan the following day confirmed an infection in the Claimant's right psoas muscle. This is a long muscle which runs vertically along the abdominal wall. Sunderland transferred her back to the Hospital for further management.

20. The Hospital drained the psoas abscess under guided CT scan on 18 December 2008. The report indicates:

> "I note CT (Sunderland) 16.12.08 showing large right psoas abscess.
>
> FINDINGS
>
> A large right psoas abscess if unchanged in size. As before, it expends almost the entire length of the psoas muscle with the largest

> part of the cavity seen in the lower part of the abdomen where it abuts the anterior abdominal wall. Loops of small bowel are closely applied to the medial surface of the right psoas abscess. No definite extraluminal gas to suggest perforation although given the paucity of intraabdominal fat and the close proximity of these loops of small bowel to the abscess, it would be difficult to exclude a perforation as a cause for this abscess.
>
> There is right hydronephrosis. The right ureter is involved with inflammatory change overlying the right psoas muscle. It then passes directly through the region where small bowel loops abut the main part of the psoas abscess in the pelvis. The ureteric obstruction may just be secondary to the inflammatory change but again it would be difficult to exclude an iatrogenic ureteric injury.
>
> No evidence of collection elsewhere.
>
> No other significant abnormality demonstrated."

The conclusion was *"Large right psoas abscess. The cause for this is not demonstrated. Right hydronephrosis."*

21. A decision was made to proceed to percutaneous drainage. A foul smelling thick pus was extracted. The pus was sent for microbiology. The gram stain was reported as follows:

> "Numerous polymorphs present, many mixed organisms seen including Gram negative bacilli and gram positive cocci in chains."

22. The microbiology showed three types of microorganisms to be present:

> "CULTURE
>
> A mixed growth of
>
> 1. Escherichia coli
>
> 2. Haemolytic strep Grp C
>
> 3. Anaerobes"

23. The Claimant was prescribed broad spectrum antibiotics. She had a blood transfusion on 19 December 2008. A CT scan on 23 December 2008 showed that the abscess was now significantly smaller. The drain was removed and the Claimant was discharged home on 24 December 2008.

**The ovarian mass**

24. The Claimant was followed up by Miss Ang and Miss Galaal in the gynaecology outpatient department (I shall come to their factual evidence shortly). On 17 February 2009, the right hydronephrosis was detected by CT scan. At a consultation on 19 February 2009, the Claimant complained of right hip pain. On 12 March 2009, a CT scan reported that the psoas abscess had resolved, but the right hydronephrosis had progressed and there was a hydroureter (stretched or constricted ureter); the

obstruction was in the pelvis where a "*cystic lesion"* had now developed. An MRI scan was recommended in order to try to exclude recurrence of the cancer.

25. On 8 April 2009, Miss Galaal referred the Claimant to the urologists for stenting of her ureter in light of the constriction. The referral was to Mr Durkan, at the Hospital.

26. On 15 April 2009, the Claimant underwent MRI which showed:

> "CONCLUSION
>
> Slightly complex cystic area at the site of the old psoas abscess and possibly a site of lymphadenectomy as well? Appearances could be explained by some residual debris following drainage of the abscess and the development of a lymphocyst in the same area.
>
> There are likely to be adhesions in the same area. The solid area described in one of the cyst[s] could also be explain[ed] by residual debris.
>
> Appearances are probably a mixture of post inflammatory changes plus the development of the lymphocyst on the pelvic sidewall. This seems to be a small lymphocyst adjacent to the internal iliac artery also. Suggest internal review. The right ureter may benefit from stenting."

There was no evidence of recurrence of the cancer around the vault area.

27. On 4 June 2009, the Claimant was admitted to the Freeman Hospital for cystoscopy and insertion of a right ureteric stent under the care of the urologists. She was discharged with a plan to change the stent in three months.

28. The Claimant was seen again in the gynaecology out patients' department on 9 July 2009. Her pain was noted to have improved following stenting. On 21 July 2009, she underwent another MRI scan. This showed a "*new 5.1cm cystic mass in the left side of the true pelvis*". There was no evidence of recurrent disease in the vaginal vault although the report noted that recurrent disease could not be completely excluded. The calibre of the right ureter was noted to be reduced.

29. On 7 September 2009, the Claimant was admitted to the Freeman Hospital for a change of her right stent. A letter dated 15 September 2009 from the urologists (Mr Trevor Dorkin) to the GP, copied to the gynaecologists at the Defendant's Hospital, recorded as follows:

> "she is due to be admitted to the QE next week to have her right ovary removed and she will obviously require a period of recuperation following this. I will therefore arrange for her to have her stent either changed, or removed, in 4 months. I have warned her that if she has a persistent ureteric stricture, we may need to consider open re-implantation of the right ureter."

30. (There is a debate about this letter, specifically, whether it was in fact received by the gynaecologists - Miss Galaal thought it had not been, because it lacked any initial or sign that it had been read. I shall return to this later.)

**Operation 2: Salpingo-Oophorectomy**

31. On 23 September 2009, the Claimant underwent a laparotomy and right salpingo-oophorectomy to remove the mass. Miss Galaal was the lead surgeon, with Miss Ang assisting. The contemporaneous operation note written by Miss Galaal, recorded the findings as follows:

> "Indication: Previous RHND and psoas abscess, now symptomatic right ovarian mass
>
> Findings: 6cm Right ovarian mass, morbidly adherent to right iliac vessels, small bowel and right ureter
>
> Right hydroureter with stent in-siu
>
> Loops of small bowel in POD and adherent to right ovarian mass, ureter and iliac vessels
>
> Filmy adhesions between omentum and ant abdominal wall, bowel loops adherent to both side walls
>
> Normal left tube and ovary
>
> No evidence of disease or pelvic/PA lymphadenopathy
>
> Normal upper abdomen"

She dissected the ovarian mass off the ureter and removed the right ovary and fallopian tube. During the course of the operation, accidental injury to the right iliac vein was noted, and Mr Ashour, a vascular surgeon, attended and repaired the vein. Blood loss was noted as 480ml.

32. The removed mass was sent for histology. The report dated 29 September 2009 recorded the following microscopic findings and conclusion (emphasis added):

> "Sections show fallopian tube with salpingitis. There is a marked acute and chronic inflammation with necrosis and **vegetable matter**. The adjacent ovarian tissue shows a haemorrhagic corpus luteal cyst and associated inflammation."

33. The Claimant was discharged from the Hospital on 29 September 2009. She attended follow up in the outpatients department.

34. On 18 December 2009, Miss Galaal summarised the Claimant's treatment and history in a letter to the Claimant's GP. The concluding paragraph recorded (emphasis added):

> "As you may have remembered this lady had RHND in November 2008 and she developed [a] right psoas abscess 4 weeks post-op, which was drained and treated with IV antibiotics. She developed post-operative pain symptoms in her right leg since then and had right hydroureter which was stented and obviously this mass, **which now shows evidence of previous fistulation to bowel**. There is no evidence of disease recurrence."

35. The Claimant remained under Miss Galaal for follow up, but required no further gynaecological intervention.

36. On 20 May 2010, the gynaecological team at the Hospital submitted a case report concerning the Claimant's case to the Open Clinical Cancer Journal. It was published under the heading: *"Psoas Abscess after Radical Abdominal Hysterectomy: A Case Report and Review of the Literature"* (The Open Clinical Cancer Journal, 2010, 4, 15-19). (I shall refer to it as the "Article"). There were four authors named, including Miss Galaal and Mr Godfrey. Miss Galaal and Mr Godfrey confirmed in evidence that the Article had been based on the Claimant's clinical notes, as well as discussions involving each of them with the other two authors. The Article described the hysterectomy (in detail which went beyond what was shown in the operation note). The authors noted that the blood cultures and material from the abscess were negative, *"suggesting a secondary cause, more probably the bowel".* In conclusion, the Article noted that there are few reports of psoas abscesses in obstetrics and gynaecology, and that this was the first reported case of such an abscess after a gynaecology oncology procedure. The meaning and significance of the Article was much debated at trial, and I shall return to it.

**Urology Follow Up**

37. The urologists changed the stent on 4 January 2010. A letter from Mr Dorkin to the Claimant's GP, copied to Miss Galaal, noted that *"the stricture was extremely tight and careful manipulation was required to inset a guidewire and stent".* He further noted that she had now been advised to have an open re-implantation of the right ureter. A renogram carried out on 25 January 2010 showed that the left kidney was functioning at 48% and the right kidney at 52% but there was slower drainage from the right renal pelvis, although no evidence of any obstruction.

38. On 26 March 2010 she was admitted under the urologists at the Freeman Hospital to have a right ureteric implantation. The operation note recorded:

> "multiple adhesions and difficult dissection to mobilise ureter – adherent to common iliac vein and SVC. Inflammatory mass below pelvic brim left undisturbed. …"

39. Her kidney problems persisted. A renogram on 19 July 2010 showed that the left was functioning at 56% and the right at 44%. The right kidney showed slow drainage, similar to the earlier renogram on 21 January 2010. A DMSA kidney scan on 7 October 2010 showed that the right kidney was smaller than the left kidney, with the right kidney showing a reduced function of 44%. A percutaneous nephrostomy (line into the kidney to allow urine to drain) was inserted on 8 October 2010 to relieve hydronephrosis (obstructed free flow of urine from the kidney). In the end, her right kidney was removed. Her problems continue with pain and impaired mobility.

**EVIDENCE**

40. I heard evidence from the Claimant. I also heard evidence from Mr Godfrey, Miss Ang and Miss Galaal, the treating gynaecological oncologists at the Hospital.

41. Each of the experts in the case had prepared at least one report, and had then met with his opposite number to discuss the case and produce a joint statement. I heard evidence from the following experts:

| **Discipline** | **Claimant** | **Defendant** |
|---|---|---|
| **Gynaecological Oncology** | Mr Stone | Mr Buxton |
| **Urological Surgery** | Mr Harrison | Mr Parsons |
| **Microbiology and Infection Control** | Dr Cowling | Dr Gray |

**FINDINGS**

42. The facts are not significantly in dispute. However, there are two matters which I need to deal with. The first is an issue of disputed fact which relates to the Claimant's case that Miss Galaal told her at a follow up appointment after the salpingo-oophorectomy that *"they had found scar tissue on my bowel which was stated as a matter of fact as having occurred following a 'nick' to my bowel during the hysterectomy which had gone unnoticed"* (from the Claimant's first witness statement dated 24 July 2014 at [64]). The Claimant repeated that account in her second witness statement dated 17 December 2015. She gave me a similar account in oral evidence, explaining that Miss Galaal said this during the course of a follow-up appointment after the salpingo-oophorectomy (the Claimant said she could not be sure of the date), just as she was about to leave, and that she went home shocked at what she had been told. This account had been set out in her Particulars of Claim, signed and dated 21 January 2014 (at [45] which became [57] when the Particulars were amended).

43. While accepting Miss Rogerson's suggestion that in some respects the Claimant's recollection of events all those years ago can be questioned (Miss Rogerson pointed to the absence of any note recording pain after the hysterectomy, for example) I conclude that on this point she has been consistent in her recollection and account throughout the course of this litigation.

44. The defence (and amended defence) put the Claimant to proof of her assertion. But Miss Galaal went further and said in her supplemental witness statement at [8] *"I can categorically confirm that I did not have a conversation with Ms Devonport on* [18 December 2009] *or on any date for that matter, telling her that her bowel had been injured during her previous hysterectomy".* When she came to give evidence to me, Miss Galaal said that her invariable practice was to write notes in clinic by hand, and then to dictate a letter after the clinic to the GP (or other co-treating clinician) containing all the important information. She said that she did have an independent recollection of the Claimant's case because the psoas abscess was so unusual, but she

was heavily reliant on the notes for the details of treatment. Initially under questioning from Counsel (in chief and in cross examination), she maintained her position that the conversation reported by the Claimant never took place. Miss Scott put to Miss Galaal a number of points. In answer, Miss Galaal said that the Article did not mean – and should not be understood to mean - that bowel injury was the probable cause of the Claimant's abscess, and it was possible that the abscess had been caused by infective organisms colonising the genital tract ~~that~~. Miss Galaal denied that she had found any dense adhesion on the small bowel or evidence of fistulation by means of a previous injury when she operated on 23 September 2009. She could be sure that the reported conversation had not taken place because it was not recorded in any clinical note or dictated letter.

45. However, rather late in the day, Miss Galaal accepted in answer to questions I put to her that she "*might have*" said to the Claimant that the bowel had been nicked during the hysterectomy. My questions were prompted by my frank surprise at some of Miss Galaal's answers in oral evidence. First, I could not see that the Article could sensibly be read as meaning anything other than that the probable cause of the Claimant's problems was a bowel leak; the Article made no reference to any other possible cause. Further, the histology report was an important and surprising development in the Claimant's medical case, and I thought Miss Galaal was bound to have discussed it with the Claimant at some point, and that any discussion of it would surely have included discussion about the presence of vegetable matter and how it had got into the ovarian mass. A further problem for Miss Galaal was her reliance on the notes to inform her earlier answers to questions in circumstances where Miss Scott had demonstrated that handwritten clinical notes did not exist in the disclosed records to reflect each and every outpatient appointment recorded to have taken place through the letters which were present in the notes, and thus it seemed likely that some of the notes were missing. This undermined Miss Galaal's evidence to the extent that she relied on the notes in giving her answers.

46. By accepting that she "might have" said the Claimant's bowel had been nicked during the hysterectomy, Miss Galaal effectively abandoned the contrary assertion in her witness statement and came close to conceding the Claimant's assertion on the facts.

47. To the extent that distance remains between the Claimant's version of events and Miss Galaal's evidence, I prefer the Claimant's version of events. I find that Miss Galaal did say to the Claimant that her bowel had been nicked during the hysterectomy. Whether that was in fact the correct explanation is another matter, to which I will turn later in this judgment.

48. The second issue of fact is less significant. It is this: did Miss Ang and Mr Godfrey use diathermy during the hysterectomy? Mr Godfrey said that he would not use conventional diathermy, but might have used argon diathermy, a different and less powerful form of diathermy, where the depth of thermal spread is much smaller than conventional diathermy (or electrodiathermy). Miss Ang said that she could not remember Mr Godfrey ever using conventional diathermy, but she too thought that argon diathermy might have been used. The operation note is silent on diathermy. The clinical notes disclose that diathermy pads were placed on the Claimant pre-surgery but I accept that this is standard procedure and does not help on the issue of whether diathermy was actually used. However, the Article notes that "argon beam coagulation" (ie, argon diathermy) was used. The Article was prepared with input

from Mr Godfrey and is likely to be correct. I find that on balance of probability argon diathermy was used during the course of the hysterectomy.

## BREACH OF DUTY

### Operation 1: Hysterectomy

49. The Claimant's allegations of negligence at the time of the hysterectomy are built on a mosaic of evidence, which taken together is said to support the case that the bowel was perforated or damaged at surgery. The largest piece of this mosaic is the evidence of Mr Stone. In his report dated 8 December 2015, Mr Stone notes that the Claimant was told that the bowel was nicked (and I have found that Miss Galaal did indeed say this), he refers to the histology (including the reference to vegetable matter), and concludes from that the small bowel was *"clearly damaged ... at surgery*" (see [28] – [32]). His opinion is that this represents sub-standard care.

50. Mr Stone went on to suggest that the mechanism of damage involved the psoas abscess developing from a retroperitoneal or walled-off haematoma, which is itself a frequent complication. The haematoma became infected by faecal fluid from the perforated bowel, leading to abscess formation. The mixed growth shown on culture was in keeping with a faecal leak from the bowel. Once the abscess was drained, an inflammatory process was set in train, and that in turn caused the urological problems. At some point a fistula developed with the small bowel, so that vegetable matter leaked (and was found on histology).

51. The experts all accepted that the formation of a psoas abscess after a hysterectomy, this case apart, is unheard of. Mr Stone looked to the literature on psoas abscesses for assistance. He concluded that the available literature and case reports establish an association between psoas abscess and bowel perforation. From this known association, he drew support for his theory that the Claimant's bowel must have been injured at surgery, leading to leakage and formation of a psoas abscess.

52. Mr Stone met with his counterpart Mr Buxton at a joint meeting, the note of which was signed by each of them on 5 and 4 May 2016 respectively. At that meeting, Mr Stone said that surgical trauma to the small bowel of an unrecognised nature was the most likely mechanism of injury. In his evidence at trial, he suggested that the most likely explanation was an injury when the small bowel was caught under a retractor leading to pressure necrosis, which would have led to the bowel breaking down some days later, which would explain the delay in the Claimant presenting with signs and symptoms of infection 18 days after she was discharged from Hospital. He derived some support for this theory from the Article which described the operation in greater detail then was set out in the operation note and recorded *"the incision was carried up to the retractor…".* He rejected Mr Buxton's opposing theory, of infection deriving from flora in the vaginal tract, because he thought the vagina would have been clean after hysterectomy, having been washed with anti-bacterial fluid; and he noted that there was no evidence that the Claimant had a vaginal infection pre-surgery (or indeed post-surgery), and that she had been given prophylactic antibiotics. After Dr Gray had given evidence, Mr Stone submitted a further addendum report dated 23 June 2016 in answer to Dr Gray's evidence (as it had been reported to Mr Stone). He disagreed with Dr Gray's explanation for the psoas abscess (which was based on Mr

Buxton's evidence which I shall come to), and repeated certain points in support of his own theory, outlined above.

53. Before coming onto the Defendant's rival theory, advanced by Mr Buxton and others, I must note a number of problems with Mr Stone's evidence. The first problem is the paucity of Mr Stone's experience in conducting radical hysterectomy with node dissection, of the type undertaken on the Claimant by Mr Godfrey and Miss Ang. Although Mr Stone did, at one stage in his career, carry out radical hysterectomy in cancer patients, he last performed this operation (or something similar to it) in 2000. After that, his Trust employed a gynae-oncology specialist to perform these procedures. Since 2000, Mr Stone has undertaken "ordinary" gynaecology until his retirement from practice in 2011. So, Mr Stone was not operating as a gynae-oncologist in 2008/9, when the events of which the Claimant complains occurred; by then, it was many years since he had performed a radical hysterectomy with node dissection, a specialised procedure only done when cancer is present; and by the time he came to give evidence to me, it was decades since he last conducted that type of surgery. For that reason, I was circumspect about his assertions about the way such surgery was or should have been conducted and the reasonable expectations to place on an ordinarily competent gynae-oncologist operating in 2008/9. Quite simply, he was not within the cohort of gynae-oncologists performing that sort of operation at the material time. By contrast, Mr Buxton, the Defendant's expert, was a consultant gynaecological oncologist, who had undertaken many radical hysterectomies with node destruction in patients afflicted by cancer, from 1993 to the date of his retirement from his NHS consultancy in July 2015. He told me that before his retirement, he used to do about 20 such procedures a year, and then another 60 or 70 cases a year which involved lymph node dissection only (without dissection around the cervix), which are similar. Mr Buxton was, therefore, very well qualified to comment on the usual mode of operating and what could reasonably be expected of a competent gynae-oncologist.

54. The second problem with Mr Stone's theory was that it was devised, for obvious reasons, without the benefit of hearing from the two operating surgeons, Mr Godfrey and Miss Ang. It was based on what Mr Stone read in the Claimant's clinical records and understood from the Claimant to have occurred. The experts in the end agreed that if damage to the bowel during surgery was the cause of the infection leading to psoas abscess, that an injury would have been <u>obvious</u> at the time of surgery. To miss it, Mr Godfrey and Miss Ang would both have been very negligent. The injury did not necessarily have to be a full thickness injury, but it would have to have been more than a subtle serosal injury (which would have resolved spontaneously).

55. Mr Godfrey and Miss Ang both gave evidence. Mr Godfrey is the Defendant's medical director. He has been a consultant gynaecological oncologist for 30 years and was the lead consultant gynaecological oncologist at the Hospital for 13 years, including at the time of the hysterectomy in 2008. He is experienced as a surgeon, and as a trainer of junior doctors. He gave careful and thoughtful evidence. I had confidence in him as a witness and as a doctor. He described the procedure at this operation. He told me that the bowel was packed away at the start of the operation and held under saline packs in the upper abdomen; he kept his hand on those packs while the operation was underway. He described the operation as being "*very structured*". He confirmed that there was no deviation from the standard protocol in

the Claimant's case, this would have been noted if it had occurred. The only problem was a small nick to the vagina which was (noted and) repaired. He confirmed that standard checks were undertaken at the end of the procedure, to ensure that there had been no damage to internal organs and that there was no sign of any bowel leakage.

56. He was asked about four possible mechanisms of damage to the bowel variously identified by the Claimant and her experts, and stated in answer:

i) He did not use retractors around the bowel, which is packed away in the upper abdomen. A retractor is used on the abdominal wall but once placed it is not moved. He did not think retractor damage was likely.

ii) Diathermy is rarely used, but only argon diathermy would ever be used. He would not use conventional diathermy. He could not be sure when argon diathermy had been used on this occasion but in any event he did not think diathermy damage was likely. It would have been visible if it had occurred.

iii) The supra-pubic catheter is put in under direction vision, not blind. The bladder is filled via a catheter inserted vaginally, and then a trochar is inserted via the abdominal wall into the inflated bladder. He did not think damage when inserting the supra-pubic catheter was possible.

iv) There was no other possible surgical trauma which could have given rise to bowel damage.

He was sure that there had been no bowel damage at the time of surgery. If there had been damage, it would have been noted and repaired. His standard, invariable practice is to check around the pelvis to ensure that there is no bleeding and then unpack the bowel and let it fall into the pelvis. The bowel is kept away from the operating field during the surgery. There was, quite simply, no occasion when bowel damage could have occurred. When asked about the Article, Dr Godfrey accepted that the consensus between the authors had been that the cause for the Claimant's problems probably was the bowel, based on the information available to them at the time, but he could not say what the precise mechanism of damage to the bowel had been. He could only say that the surgery had proceeded uneventfully and there had been no hole in the bowel at the time of or as a result of surgery.

57. I also heard from Miss Ang. At the time of the hysterectomy, she was a sub-specialty fellow in gynaecological oncology at the Hospital. She had already completed her subspecialty training in obstetrics and gynaecology and was on the GMC specialist register (and so was, by this time, eligible to apply for a consultant post in obstetrics and gynaecology). She completed her fellowship at the Hospital in 2009 and was appointed a gynaecological oncologist in November of that year. She initially worked as a consultant in Leicester, and then came back to the Hospital, where she still works, in January 2013. By the time she undertook the hysterectomy, she was relatively experienced in the procedure having carried out 11 radical hysterectomies as primary surgeon and 7 as first assistant. I am quite satisfied that Miss Ang was properly trained and experienced to perform this operation. She was also supervised by the very experienced Mr Godfrey, who could have taken over if anything untoward had occurred.

58. Miss Ang explained the operation. She had no independent recollection of it, and was reliant on the operation note and her usual practice when operating to explain what had occurred. She confirmed that the bowel was packed away while the hysterectomy and node excision is performed. She undertook routine checks once the excision was completed, to ensure no damage to internal organs, including the bowel. No bowel damage was identified.

59. She was asked about the four postulated mechanisms of damage. She agreed with what Dr Godfrey had said:

    i) Surgical trauma was not possible because the bowel was packed out of the way, and Mr Godfrey's hand remained on top of the bowel.

    ii) She could not be sure whether diathermy was used. If it was used, it was argon diathermy and this would not cause a perforation; the damage would anyway be noticed at the time.

    iii) No retractors are used over the bowel. A retractor was used to keep the abdominal wall open to the side and was not moved.

    iv) The suprapubic catheter was filled under direction vision and no injury could have occurred at this point.

    Accordingly, she did not think that any one of the Claimant's theories about how the damage had occurred was likely; to the contrary, each was extremely unlikely. I found Miss Ang also to be a careful and honest witness.

60. In summary, I accept the evidence of Mr Godfrey and Miss Ang as truthful evidence of fact, and I was impressed by the integrity and professionalism of each of them. I am satisfied that neither of them noticed any irregularity during the surgery. Further I am satisfied that standard procedures and checks were used during the operation. I conclude that the possibility that they both missed an obvious bowel perforation is frankly unlikely. This is a conclusion I must weigh in the balance: it tends against Mr Stone's theory.

61. I then come to Mr Stone's specific suggestion that the bowel was damaged by the retractor: the third problem with his evidence. Mr Stone's description of the retractor and its placement was simply not recognised by Mr Buxton as forming a part of modern surgical practice in a radical hysterectomy. Mr Buxton said that a modern retractor has very smooth surfaces (not the hinge and screws suggested by Mr Stone) and is only used to retract the lateral abdominal wall, without intruding into the abdominal cavity. Mr Buxton doubted that there would be any need to move the retractor during surgery, and therefore doubted the suggestion that a loop of bowel could become trapped as Mr Stone suggested. Further, he said that the patient would have been positioned with her head tilted downwards which would prevent the small bowel escaping back into the operative field. Mr Harrison, whose evidence I shall come to, agreed with Mr Buxton that the retractor was an unlikely mechanism of injury. I am unpersuaded of Mr Stone's preferred theory of how the damage happened.

62. The fourth and related problem was that Mr Stone's specific suggestion of retractor involvement was (he thought) supported by a reference in the Article to the incision being carried "up to the retractor" which, he said, meant that the retractor must have been manipulated in some way. Mr Parsons disputed this: he thought the incision "up to the retractor" read in context must mean that the incision was towards the lateral external iliac nodes lying under the inguinal ligament, nowhere near the bowel which had been packed away. Mr Stone's reliance on the Article in this way did not impress me. I thought he was, by making this point, clutching at straws.

63. The fifth and final problem with Mr Stone's theory was the reliance on the literature and case reports to support the association between psoas abscess and bowel perforation. The problem with the literature and case reports, as Mr Buxton said, is that they relate to a different cohort of patients, namely those with established bowel disease. One inference to draw from that literature was that the existence of bowel disease is, in and of itself, the explanation for the bowel breaking down and leaking into adjacent tissues causing a psoas abscess in those cases which were reported. If so, that explanation would not apply here, because the Claimant did not have bowel disease. And so the question remains, why did she end up with a psoas abscess? The literature and case reports relied on by Mr Stone seemed to me to beg the very question to be answered, rather than to provide any helpful guidance.

64. All in all, I conclude that Mr Stone's theory that the bowel was damaged during surgery remains a possibility, but one which has a number of problems inherent in it, not least the difficulty of reconciling it with the evidence of the two operating surgeons.

65. Mr Stone's evidence did not stand alone. Dr Cowling, the Claimant's expert consultant microbiologist asserted that, on a strong balance of probability, the mix of flora found by the microbiologists following the abscess drainage on 18 December 2008 derived from the bowel and not from the vagina. Dr Cowling's opinion, if I accept it, plainly supports Mr Stone because it points to infection through transmission of bowel content (by leakage from the small bowel, exactly as Mr Stone suggests). Dr Cowling's view was offered on a balance of probability, and he accepted that it was "*possible"* that the flora came from the vagina (answer to question 1(c) of the Defendant's agenda for the joint meeting). Through Dr Cowling, and Dr Gray in response, there was extensive discussion at trial about the microbiology results, in particular the appearance of the organisms seen on gram stain and the likely origin of the organisms which were cultured in the laboratory (and shown in the report dated 18 December 2008). Dr Cowling produced extensive literature which he said supported his view that the greater likelihood was that those organisms (E Coli, Streptococcus C and Anaerobes) when found in combination came from the bowel rather than the female genital tract. He pointed to facts peculiar to this patient, including the fact that she was taking omeprazole (a proton pump inhibitor which reduces the amount of acid in the stomach), to explain how those flora might have co-existed in her small bowel.

66. I am not in a position to judge to a nicety the relative likelihood of those organisms in combination coming from bowel or vagina. It seemed to me that much of Dr Cowling's argument proceeded on the basis of supposition rather than hard data or evidence, and was very theoretical, even speculative in nature. In the end, the experts agreed that either source – bowel or vagina - was possible and thus that the

microbiology evidence could fit either theory. However, I was particularly struck by one piece of evidence given by Dr Gray, consultant microbiologist who works for part of his time at the Birmingham Women's Hospital, where he frequently examines – or sees reports by other microbiologists relating to - samples from women who have developed infection after undergoing a hysterectomy, where there is no suggestion at all of any bowel involvement. He said that he commonly sees a mix of flora in his patients which is similar to that reported on the Claimant on 18 December 2008. From that he concludes that her mix was entirely consistent with infection post-hysterectomy. I accept Dr Gray's evidence of what he has seen in practice. I also accept his conclusion that this mix of organisms is not definitive of, or even suggestive of, bowel as the source of the infection. That being so, I reject Dr Cowling's evidence that such a mix is much more likely (on a strong balance of probability, he said) to come from the bowel than the vagina. I conclude that the microbiology is, in the end, equivocal as to the source of the infection. It is compatible with infection from the bowel or the vagina. The microbiology evidence does not therefore provide any solid support for Mr Stone's theory.

67. Before leaving the microbiology evidence, I should add that of all the experts who gave evidence in this case, I found Dr Gray to be particularly helpful. Dr Gray had thought very carefully about this case, which he recognised as difficult and unusual. He had approached the case with an open mind, and indeed was ready to alter his analysis as the evidence unfolded. Miss Scott suggested that the modest shifts in his analysis betokened uncertainty, and should lead me to doubt his evidence generally. I do not agree. This is a complex case, and I valued Dr Gray's willingness to alter his views as the evidence unfolded in the search for what he considered to be the correct answer to the conundrum presented by this Claimant. I shall return to his evidence shortly.

68. Finally, the Claimant relied on urology evidence from Mr Harrison, whose expert opinion was that the psoas abscess was caused by a bowel perforation at the time of the hysterectomy, which led to contamination and infection around the area of the psoas muscle. Mr Harrison is a consultant urologist with a particular interest in spinal cord injury. He told me that he does a lot of pelvic surgery and regularly operates on the small intestine. He relied on (i) the CT scan of 18 December 2008 which he thought was suggestive of abscess caused by small bowel perforation, (ii) the culture of the same day which he thought was highly suggestive of an abscess arising from bowel perforation, and (iii) the finding of vegetable matter within the tissue removed on 23 September 2009 which was pathognomic (ie determinative) of bowel perforation. In short, he thought it was far more likely than not that a bowel perforation led to the infection, and indeed said that he was unable to find any alternative convincing explanation for the psoas abscess (see the joint statement, answer to Claimant's agenda question 2). He, and his counterpart for the Defendant, Mr Parsons, suggested that evidence from experts in microbiology might assist (and so it was that Drs Cowling and Gray were consulted, rather late in the day).

69. When he came to give evidence, Mr Harrison confirmed that the three aspects of the evidence outlined in the foregoing paragraph had "jumped out at him" when he reviewed the clinical notes. He thought that the contamination which had led to the psoas abscess must have been "gross" (which the experts later agreed meant "significant") in order to cause the abscess. As to the mechanism of injury, he agreed

with Mr Buxton that Mr Stone's theory about damage by retractor was unlikely, because the bowel was packed away during surgery. He thought the bowel had probably been injured when the supra pubic catheter had been inserted, at which point a loop of bowel must have escaped and become trapped between the abdominal wall and the inflated bladder, which got injured when the trochar was inserted. Mr Harrison had experience of a similar injury occurring in his own hands, during the course of a bladder reconstruction (on that occasion, the injury had not been recognised at the time but signs of infection appeared quickly and bowel repair was carried out the following day).

70. Mr Harrison discredited the Defendant's theory because there was no evidence of any pelvic side wall abscess (which he thought was a necessary part of the Defendant's hypothesis). Further, he said that the small bowel would not fistulate into an area of inflamed tissue, as the Defendant suggested had occurred: he said that the small bowel would simply not behave that way; rather, the bowel wall would become thicker in order to protect itself from breach. Finally, he said that on the Defendant's theory he would have expected signs of infection within 7 to 10 days.

71. On two aspects of his evidence, Mr Harrison was on his own amongst the medical witnesses (expert and factual). The first is his contention that the damage probably occurred when the supra-pubic catheter was inserted. Mr Parsons thought that Mr Harrison's own experience of this happening was an irrelevance, because the operation Mr Harrison described was a bladder reconstruction, where the operating conditions are entirely different from hysterectomy. Mr Parsons did not accept that the injury could have occurred in the manner described by Mr Harrison. He explained how Mr Godfrey and Miss Ang would have performed the catheterisation, which would have left no opportunity for such an accident. Neither of Mr Godfrey or Miss Ang had been pressed on the possibility of damage during insertion of the catheter (possibly because Mr Harrison only articulated this theory after they had come and gone); both said they thought that damage at that point of the surgery was impossible. Neither expert gynaecologist was pressed on the possibility of damage during catheterisation (possibly, for the same reason - they too had come and gone before Mr Harrison articulated this theory), and each seemed content with the operating surgeons' explanation of how the supra pubic catheter was inserted, and their view that perforation at this stage was nigh on impossible. Specifically, Mr Buxton had pointed to the diagram in the notes depicting the position of the catheter, which was in keeping with his own understanding of the procedure for inserting a supra-pubic catheter, and the procedure which had been explained by the two treating surgeons. In the end, I was not persuaded that Mr Harrison's suggested mechanism of damage during insertion of the supra-pubic catheter was even possible, let alone likely. To the contrary, it ran counter to the other evidence, factual and expert, that I have heard. I reject it.

72. The second area where Mr Harrison was isolated in his view, was in his description of how the bowel behaves, and specifically his dismissal of the Defendant's case that the bowel had fistulated into the adjacent inflamed ovarian mass. On this point, he was not supported by Mr Parsons, who said that the bowel can and does behave like that and could well have fistulated into the inflamed mass. More specifically, Mr Parsons described that this could have happened following the formation of a "phlegmon" of bowel (by which I understood him to mean an area of small bowel becoming stuck to

bowel and other tissue); he said that the tissues within the phlegmon could have become devascularised, causing local ischeamia in the small bowel, leading to a break down of the bowel wall, and a bowel leak into the mass. That fistula would then probably have self-resolved which explains why it was no longer patent (although the small bowel was found to be morbidly adherent) at the second surgery in September 2009. Dr Cowling supported Mr Parsons' "phlegmon analysis" as possible, and agreed that the mass could have become adherent to the bowel and then fistulated. Dr Gray also agreed that this was a possible explanation. All these experts took a view which was directly contrary to Mr Harrison's view. I preferred the majority view, which seems to me to be inherently more likely: the bowel could have become adherent to the ovarian mass and the fistula could then have appeared. On this point too, I reject Mr Harrison's evidence.

73. I must address one other aspect of Mr Harrison's evidence. Mr Harrison thought the delay in manifestation of the infection was difficult to reconcile with the Defendant's theory and relied on that delay in support of his own favoured theory of perforation during the hysterectomy. However, I received a number of explanations from the experts for how the infection, on either theory, could have lain quiescent for some days or weeks before becoming symptomatic. Specifically, in answer to Mr Harrison, it was said that the haematoma which became infected (on the Defendant's case) may have been protected by adjacent structures and so been contained for some days; Dr Gray said that the growth of microorganisms was not always predictable or immediate, depending on the density of bacteria present, and pointed to the NICE Clinical Guideline dated October 2008, "Surgical Site Infection", which defines surgical site infections as those which occur within 30 days following surgery. I conclude that it is possible to reconcile the time delay with either theory and that the timing of the onset of symptoms was, in the end, an equivocal factor, compatible with each party's case.

74. Overall, Mr Harrison's evidence did not take the analysis much further. Much of what he said was based on his instinctive response to the Claimant's clinical course and the findings on investigation (notably the microbiology report of 18 December 2008 and the histology report of 29 September 2009). I have reviewed the evidence reflecting on these reports already: both are compatible with the Defendant's case, neither helps me to determine where the infection came from. Mr Harrison supported his view by reference to two specific points, neither of which I have been able to accept.

75. I am left, after reviewing the mosaic of evidence which forms the Claimant's case, with a fundamental question, on the Claimant's case, about *how* this perforation occurred. The two possibilities put forward by the Claimant's experts (Mr Stone, retractor damage; Mr Harrison, damage during insertion of the supra-pubic catheter) have been disproved. No medical witness (expert or factual) suggests any other mode of damage is likely. The upshot is that I have not been given any credible explanation for how, precisely, the damage came to occur during the hysterectomy. This is a big problem for the Claimant.

76. Against that, I turn to the Defendant's rival theory. I have reviewed the factual evidence offered by the Defendant already. At this point, I wish to add record one further observation about the factual evidence of Miss Galaal and Miss Ang in relation to the salpingo-oophorectomy. Both said in evidence that when they operated

on 23 September 2009, they found no adhesions indicative of earlier bowel involvement. But it was common ground amongst the experts that the bowel had fistulated, explaining the vegetable matter on histology; further, the experts agreed that the reference in Miss Galaal's operating note to a "*6cm Right ovarian mass, morbidly adherent to right iliac vessels, small bowel and right ureter"* (my emphasis) was entirely consistent with (and suggestive of) a fistula between the ovarian mass and the small bowel having formed at some point, although by the time of this surgery that fistula had closed (the experts told me that the appearance of "*morbidly adherent*" tissue was to be contrasted with the "*filmy adhesions"* elsewhere noted which were typical following a laparotomy). The experts therefore seemed to be at odds with the treating surgeons on what was found, and noted at the time. If it matters, I prefer the experts' agreed view which reflected the operation note precisely: there was evidence, namely morbid adhesions, suggestive of an earlier fistula found at the second operation on 23 September 2009.

77. Turning to the cause of the fistula: Mr Buxton's view was that the original infection came from flora present in the vaginal tract, not the bowel. First, he dealt with the four suggested mechanisms of damage (outlined above, as they were put to each of the treating surgeons), and indicated his agreement with the treating surgeons that none of those seemed likely. He thought that damage in any of those ways would have become symptomatic within 7-10 days and he found it difficult to explain the delay in manifestation if the Claimant was correct that the bowel had been breached, or injured so that it broke down post-operatively. His theory started with the proposition that the vagina would have carried a heavy load of bacteria, because it is not a "clean" part of the body, and because the cancer would attract additional bacteria. When the cervix was removed at hysterectomy, blood and mucus would have spilt into the lower abdomen. A haematoma in or adjacent to the surgical site – a known complication of this surgery - would provide a perfect culture medium for those bacteria to grow. The spread of bacteria from the vagina or cervix to the site of the haematoma could be by means of the surgeon's gloves or the surgical instruments, which would have been moved around the pelvis and come into contact with adjacent tissues – resulting in "inoculation" of bacteria. That was, he suggested, the likely mechanism of infection. Further, he said that pelvic infections are common following such surgery, despite antibiotic cover being administered prophylactically, so the fact that the Claimant got an infection is not in and of itself surprising. He recognised that the unusual feature of this case is the abscess in the psoas muscle, but that muscle lies close to the area of surgery and could have become involved by a process of infection spreading to adjacent tissues. If so, that would be an unusual aspect of an otherwise regrettably common complication.

78. Mr Buxton referred to the possibility of an infection first taking seat in the pelvic side wall, a point of which Miss Scott made a great deal in closing argument and which Mr Harrison also latched onto (because there was no evidence of any infection at any time in the pelvic side wall). But I did not understand Mr Buxton to suggest that an infection in the pelvic side wall was a necessary part of his theory. Rather, I understood him to say that infections post-surgery are often found in the pelvic side wall, but in this case, an alternative might be that the infection took hold deep in the pelvis where tissue had been excised, and spread from there to the (roughly adjacent) psoas muscle. That infection led to inflammation in the fallopian tube and ovary, to which small bowel became adherent, at which point a fistula formed: this was a

communication between the small bowel and the inflamed ovarian mass, which explained the vegetable matter found on histology. The fistula settled spontaneously, which he thought was not surprising given that the lower bowel was not obstructed, and that was why there was no remaining fistula at surgery in September 2009, only the morbid adhesions to show where it had been.

79. Mr Buxton's theory was supported by Mr Parsons. Specifically, Mr Parsons supported the possibility of inoculation of bacteria via the surgeon's gloves or instruments. He alternatively suggested spread of infection via the lymph nodes but that suggestion gained no support from either microbiologist and I say no more about it.

80. Mr Buxton's theory was powerfully supported by Dr Gray. He confirmed that a cancerous cervix would attract a heavier load of bacteria than seen typically in a healthy cervix. These bacteria are likely to colonise the vagina, but may not cause any symptoms of infection. Further, these bacteria will survive the vaginal swabbing which is undertaken as part of the surgery – this is not "clean" surgery. The procedure involved removal of the "dirty" cervix and uterus first in sequence, and then removal of the lymph nodes in the lower pelvis. Dr Gray thought that bacteria from the cervix and vagina could have remained on the gloves and instruments used in this latter part of the operation, and so have inadvertently inoculated other pelvic tissues. That inoculation could have been "significant" (or "gross", as Mr Harrison had suggested would be necessary), particularly if there is a large bacterial load in the vagina. Although the Claimant was given intravenous antibiotics prophylactically, this operation lasted three hours, and the prophylactic effect of the antibiotics would have diminished towards the latter part of the surgery, just when the lymph nodes were being dissected out. Further, it is established (and was agreed between the experts in this case) that prophylactic antibiotics are only ever roughly 50% effective at preventing infection post-surgery, and were not a complete protection against subsequent infection.

81. Dr Gray told me that he had thought a lot about this case (I believed him). He said that he was considering whether, in light of his conclusions, he should recommend to colleagues that a second dose of antibiotics should be given prophylactically during this sort of surgery, and antibiotic cover continued beyond surgery, to prevent such bacterial infections. I encourage Dr Gray to discuss this case, and his views on it, with colleagues. His theory travels beyond the narrow circumstances of this case: if it is correct, then any patient undergoing similar surgery is at risk of infection, from bacteria in the vagina or around the cervix being inadvertently inoculated onto other tissues during the surgery; this is a risk which can and should be mitigated by preventive measures.

*Conclusion on Hysterectomy*

82. If pressed to back one or other of the rival explanations put forward in this case, I would unhesitatingly prefer the Defendant's explanation for the infection and psoas abscess. The Defendant's explanation unifies all the evidence in the case, including the powerful testimony of the treating surgeons that nothing untoward occurred during surgery. It leaves just one unusual feature to be explained: how the infection came to form an abscess in the psoas muscle, which is otherwise unheard-of following radical hysterectomy. But once understood that infection in the lower pelvis is a known and relatively common complication of radical hysterectomy, the precise location of the infection in this case, in an adjacent muscle, becomes less surprising. I conclude that the abscess in the psoas muscle can best be explained as a particularly unusual feature of an otherwise, sadly, unsurprising case.

83. I am not satisfied that the psoas abscess (and its sequelae) were on balance of probability caused by the negligence of the Defendant, its servants or agents. I believe a non-negligent explanation is more likely.

84. To dispose of the case, it is enough that I conclude that the negligent explanation for the Claimant's problems is no more likely than the non-negligent explanation. On that basis, the case must fail, applying *Wilsher*, see above.

**Operation 2: Salpingo-Oophorectomy**

85. The allegations of negligence in relation to the second operation focus on the preparation for the surgery, specifically the alleged failure to involve the urologists. They are pleaded as follows:

    i) On or before 23 September 2009 failing to have a multi-disciplinary discussion with a urologist in connection with the procedure.

    ii) On or before 23 September 2009 failing to take advice from a urologist in connection with the procedure.

    iii) Failing to undertake a joint procedure with a urologist when the right ovary and associated mass was removed on 23 September 2009.

    iv) Failing to treat the ureteric stricture during the laparotomy on 23 September 2009 by way of either ureterolysis, omental wrapping, segmental ureteric resection, or ureteric re-implementation.

86. I can deal briefly with the first allegation of negligence. The experts were uniform in their agreement that it would be unusual for a urologist formally to attend a multi-disciplinary meeting to discuss a gynaecology patient, and that this allegation of negligence could not be supported. That allegation fails.

87. The focus of the Claimant's case was on the system for liaison between the gynaecologists and other clinicians. Miss Scott argued that the system described by Miss Galaal was inadequate in this case, given the Claimant's particular presentation and history, and that if a proper system had been in place (ie direct contact between

the treating clinicians), joint surgery would have been undertaken with a different and better outcome.

88. I therefore need to set out in a little detail the exchange of correspondence between the gynaecologists and the urologists. On 25 August 2008 Miss Galaal wrote a letter to the Claimant's GP, copied to Mr Durkan (urologist at the Hospital), recording that she had reviewed the Claimant in surgery, the Claimant remained in pain, and that the Claimant had, after discussion, opted for surgery to remove the right pelvic cyst (as it was thought to be).

89. The Claimant was then listed for a right salpingo-oophorectomy (and deroofing of the lymphocyst) in the hands of the gynaecologists on 23 September 2009.

90. The Claimant was during the same period being seen by the urologists at the Freeman Hospital. By letter dated 15 September 2009 (the text of which I have set out above), Mr Dorkin (urologist at the Freeman Hospital) recorded a change of right ureteric stent on 7 September 2009 and his plan to keep the Claimant under review; he acknowledged in terms his awareness of the gynaecologists' plan to operate to remove the ovarian mass.

91. This letter is contained within the notes disclosed by the Freeman Hospital, but it does not appear in the Hospital's own notes and Miss Galaal could not be sure that she received it. Miss Galaal was therefore unable to confirm that she was aware of the urologists' plan before she undertook the salpingo-oophorectomy, but said that knowledge of the urologists' plan would not have made any difference to her anyway, because she assumed, based on her experience, that the urologists would just want to manage the Claimant conservatively. For that reason, she did not initiate any specific joint discussion with the urologists about the Claimant's management. When it came to the surgery, she simply divided the ovarian mass off the ureter; this was something she was used to doing, it was within her competence.

92. Mr Stone criticises this approach. He accepted that it was normal for the different treating clinicians to correspond by letter. But he thought that a discussion needed to take place between the gynaecologists and the urologists in advance of the salpingo-oophorectomy in this case; further, there needed to be a discussion with the patient advising her that she had a choice as to whether she wished to have surgery on her ureter at the same time as the ovarian mass was removed, or whether she wished to have the mass removed first and then wait and see if another procedure was necessary. He thought this would have been *"normal civilised behaviour".*

93. Mr Buxton disagreed. He did not consider it mandatory for Miss Galaal or anyone from the gynaecology department to have a specific discussion with the urologists in advance of the second operation. Miss Galaal knew the ureter was protected by the stent; she was entitled to assume that the stent would be changed from time to time under the urologists; it was reasonable for her to decide to remove the ovarian mass at surgery without involvement of the urologists. Further, there was nothing particularly unusual about this case at this stage, because the psoas abscess (which had admittedly been unusual) was resolved, and the ongoing problems of constricted ureter and pain thought to be due to the ovarian mass was not extraordinary.

94. Mr Harrison was vocal in his criticism of the Defendant's management of the Claimant at this stage, saying that there should have been a clear joint plan between the gynaecologists and the urologists in advance of surgery. He commented that the two teams seemed to be working in bunkers in separate hospitals. He thought a urologist should have been present in theatre to have assessed the ureter once it was exposed and make a decision at that point. If a urologist had been present, then that urologist probably would have intervened and carried out some sort of procedure to improve the functioning of the ureter: this procedure would have been something less than a re-implantation, either a ureterolysis (freeing the ureter) or a resection (freeing the ureter by cutting it above and below the area of adhesion, and rejoining the two ends). However, Mr Harrison accepted that a responsible body of urologists – albeit a minority, he thought - would have opted to do nothing faced with the exposed ureter at surgery. He added that this would have been a very specialised operation, beyond the capabilities of an "ordinary" urologist, and he thought that only Mr Dorkin could sensibly have undertaken it.

95. There are, again, a number of difficulties with Mr Harrison's evidence. The first is his questionable capacity to comment on the standard of care provided by the gynaecologists. The Claimant's case was targeted on Miss Galaal, for her failure to liaise with the urologists. Secondly, if there was a failure at this stage of the Claimant's treatment, it was surely a failure by the urologists – it was for them, if anyone, to suggest joint surgery in order to protect the ureter: the ureter was after all their concern and came within their specialism. As I have noted, this is not how the case was pleaded. Thirdly, as became clear once Mr Harrison was pressed, his view of what should have happened goes far beyond the Claimant's pleaded case that "*a urologist*" should have been present for the joint procedure: see paragraph 57(xiv) of the Amended Particulars of Claim. Mr Harrison's view was that Mr Dorkin, the lead urological surgeon at the Freeman Hospital in Newcastle, should have been present at this operation. The case is not pleaded in that way: if it had been, I daresay Mr Dorkin might have been asked to provide a witness statement indicating whether he was free or would have been willing to attend at surgery. But in any event, explained in this way, the Claimant's case seems to me to go far beyond identifying the reasonable minimum standard of care which the Claimant was entitled to expect, and to have become a "counsel of perfection".

96. From the evidence which was available to me, I am not in any event persuaded that the urologists can be criticised for failing to offer their surgical services at the time of the salpingo-oophorectomy. It is clear that the urologists were aware of Miss Galaal's plan for the Claimant, from Miss Galaal's letter copied to them dated 26 August 2009 and from Mr Dorkin's own letter back dated 15 September 2009. That letter set out Mr Dorkin's plan for the Claimant which was to wait and see if the ureter recovered after that surgery, and operate *if* there was a persistent ureteric stricture. Mr Parsons thought that this was reasonable management of the Claimant from a urological point of view. I accept that evidence: the urologists were entitled to wait and see whether the Claimant's urological problems settled once the ovarian mass was removed.

97. In answering Mr Harrison's evidence, Mr Parsons thought that it was reasonable for Miss Galaal and her team simply to have got on with the salpingo-oophorectomy, and to have operated on the stented ureter without first discussing the case with the

urologists. This reflected ordinary practice in the NHS: "*these things do go on. It is not unreasonable."*

98. Overall, I prefer the Defendant's evidence. Mr Buxton's view reflected a reasonable standard of care. Mr Parsons' evidence was telling: that these things do go on, and this process between two sets of specialists represent the norm. That persuades me that the care provided in relation to the salpingo-oopherectcomy did meet the *Bolam* standard. It was not negligent. That is not to say that it could not have been better: the ideal would have been for Miss Galaal to have telephoned the urologists to discuss the Claimant's case and check that both teams knew each other's treatment plans, and that nothing had been missed. But ideal is not the same as reasonable. Miss Galaal was not negligent in acting as she did.

99. If I had determined that Miss Galaal was in breach of duty, I would have decided that her breach did not in any event cause any damage or loss, applying *Bolitho*. The urology plan was clearly a "wait and see". If Miss Galaal had consulted the urologists, the strong likelihood is that they would have declined to be present at the operation. This flows from Mr Dorkin's letter of 15 September 2009. I am satisfied, based on Mr Parsons evidence, that this would have been a reasonable plan in the circumstances That answers the two *Bolitho* questions against the Claimant: even if the urologists had been invited to take part in the planned surgery, they would reasonably have declined to do so, and the operation would have proceeded precisely as it in fact did, with the gynaecologists operating alone.

100. Mr Parsons was asked about what a urologist would have done, *if* a urologist had in fact been present at the surgery. For reasons I have given, I do not believe this factual hypothesis arises for consideration, and so Mr Parsons' answers bear no significance to the outcome of this case. But I record Mr Parsons' suggestion in re-examination that a urologist present at surgery probably would have carried out an "omental wrap" after dissecting out the ureter. I make two comments on that suggestion: (i) It is not clear to me how Mr Parsons' answer is to be reconciled with Mr Harrison's view that only a specialist urologist such as Mr Dorkin could have performed any surgery on this ureter. It was not clear whether Mr Parsons' answer was predicated on a very experienced urological surgeon being hypothetically present. (ii) It is not clear to me what difference this would or might have made to the outcome. Although Mr Parsons suggested that an omental wrap "*probably would have been enough*" (that is what my note records him saying, anyway) my understanding of his evidence set in context was that the outcome would still have remained very uncertain; the Claimant's ureter problems may have persisted and run the course they did in any event. I would not want the Claimant to think, on the basis of what Mr Parsons or any other expert said, that she would have been cured of her problems if only a urologist had been present at the second operation: I did not understand Mr Parsons to be nearly so categoric about what the outcome would or might have been.

*Conclusion on Salpingo-Oophorectomy*

101. The Defendant by its servants or agents was not negligent in any of the ways alleged by the Claimant, in its preparation for or conduct of the salpingo-oophorectomy, and associated removal of the ovarian mass.

## CONCLUSION

102. The Claimant developed a psoas abscess following radical hysterectomy on 10 November 2008. This was an unusual and significant complication of surgery. I am unable to attribute the infection or its consequences to negligence at the time of surgery.

103. The Claimant was in substantial pain from early 2009 onwards. She had kidney infections and her ureter required stenting to prevent it becoming constricted. Surgery was undertaken on 23 September 2009 to remove the mass which was thought to be causing these problems. I am unable to identify any negligence in relation to the second operation on that date.

104. Unfortunately, the ureter problems did not resolve after that operation and further treatment was needed. The Claimant underwent re-implantation of her ureter on 26 March 2010. Her right kidney size and function deteriorated further. Eventually, her right kidney was removed. She continues to have ongoing pain in her abdomen and to be significantly restricted in her day to day living.

105. I am very sorry that this has happened to the Claimant. But I have not found the Defendant to have been negligent in her treatment. It follows that this claim must be dismissed. Nonetheless, I hope that this trial, and the extensive evidence which was called during the course of it, has helped the Claimant to understand better what happened to her, and that some of her questions at least are now answered. At times, the matters under discussion in this trial became exquisitely personal to the Claimant. I commend her for her quiet dignity throughout the course of the trial. I wish her all the best for the future.